HEPATITIS C

RCGP LEARNING

BASICS

Epidemiology and complications

- ~56,000 adults in England have chronic hep C.
- Due to more effective treatment:
  - Prevalence ↓ by 57% since 2015.
  - 7.2% of those who inject drugs have chronic hepatitis C, ↓ from >25% in 2014.
- Complications:
  - Cirrhosis (20-30% at 20 years) → liver failure.
  - Hepatocellular carcinoma (1-3% annually).
  - In pregnancy - ↓ birth weight, high risk vertical transmission.

Transmission

- Contact with infected blood:
  - Sharing needles or personal items (razor, toothbrush).
  - Infected blood products before the early 1990s.
  - Inadequate sterilisation of medical equipment.
  - Needlestick injuries.
  - Tattoos/body piercing.
  - Sexual contact is unusual in monogamous heterosexual relationships, ↑ if multiple partners, other STI, anal sex or HIV.

DIAGNOSIS

Symptoms and investigations

- Chronic - anxiety, depression, ↓ memory or concentration ('brain fog'), fatigue, myalgia, nausea/vomiting, RUQ pain, jaundice, signs of chronic liver disease.
- Acute - nausea/vomiting, RUQ pain, temp >38°C, joint aches, loss of appetite.
- ~ 70% asymptomatic during acute infection.
- +ve antibody test → test for Hep C RNA:
  - +ve RNA = chronic infection.
  - -ve RNA = treated successfully in past/cleared spontaneously → antibody stays +ve but not immune to reinfection.
- Remember window period (3-6 months) – risk of false -ve if testing too soon after exposure.
- If high risk and immunocompromised, check RNA even if antibody -ve.

Who to test

- Ever injected/snorted/smoked drugs, shared razor/toothbrush with an at-risk person.
- UK transfusion pre 1991/UK blood products pre 1986.
- Transfusion or blood products, medical treatment, tattoo, acupuncture or piercing in a country where screening doesn't happen/risk is high.
- Prisoners, looked after children, homeless.
- HIV +ve men who have sex with men.
- Born/brought up in high-risk country.
- Mother had hep C when pregnant.
- Household/sexual contact of someone with hep C.
- All who test positive for HIV or hepatitis B.
- Healthcare workers after needlestick (occupational health).
- Anyone with raised liver transaminases.

MANAGEMENT

Primary care

- Refer hepatology.
- Check FBC, U&E, LFT (incl ALT and GGT), clotting, HbA1c, TFTs, ferritin, hep B, HIV, hep A immunoglobulin.
- Consider STI screen and offer hep B vaccination (and hep A if at risk).
- Advise on ↓ progression (e.g. ↓ smoking/alcohol.)
- Advise on preventing transmission.
- Partners need testing (can refer to sexual health if would rather this is done anonymously).
- Signpost to support e.g. Hepatitis C trust or British Liver Trust.
- Monitor co-morbidities e.g. those with diabetes may become hypoglycaemic with DAAs.
- Signpost to compensation scheme if born before 29.8.03 and hep C may be due to NHS treatment with blood or blood products pre-1991.
- Notify public health if diagnosed in acute phase.

Secondary care and commissioning issues

- Move to direct-acting antiviral therapy (DAA) has revolutionised care; previously injectable interferons had high side-effects and drop-out rate.
- Now oral treatment for 8-12 weeks.
- Most effective if given before cirrhosis develops.
- 90% clearance.
- Some patients may need reassuring if they/people they know had problems with interferon treatment in the past.
- Commissioning issues:
  - How easily can people access tests? Do testing services seek out those at risk (drug users, homeless, those who use addiction services).
  - Do local services offer dried blood spot/point of care tests?
  - Adults in England can order a home test from NHS England – is this publicised in your area?