Defense Health Agency, J-7, Continuing Education Program Office

Clinical Communities Speaker Series

Review of Current Trends and Best Practices in Primary Care

May 2020 CCSS S04: Hepatitis C for Primary Care: From Diagnosis to Cure and Beyond

1. What is the difference between hepatitis C virus (HCV) vs A&B?
Dr. Rife: In addition to the response I gave during the Q&A, I would additionally refer to the Centers for Disease Control and Prevention (CDC) website for additional details on hepatitis A & B. These are 3 distinct viruses that just have the common nomenclature of causing inflammation of the liver.

2. If your patient has antibodies to hepatitis C and no viral load, is there a time period you should obtain a follow-up viral load? If both viral loads are non-detectable, are they considered hepatitis C free or cured? Or do they always have a risk of relapse? I have had patient state they cannot donate organs because once diagnosed with the infection they were considered always infected.
Dr. Rife: If a patient has a positive hepatitis C virus (HCV) antibody and negative viral load in the absence of treatment, it is presumed that the patient spontaneously cleared. It takes 2-3 weeks after exposure for the viral load to become detected, but it takes 4-10 weeks for the antibody to become positive.
A patient is considered "cured" if their viral load remains undetectable 12-weeks post-treatment, or what is referred to as having achieved a sustained virologic response-12 (SVR12). Some providers may also choose to additionally recheck the viral load 24-weeks post-treatment or what is referred to as SVR24. If a patient achieves SVR, no additional monitoring of their HCV viral load or risk of relapse is warranted unless a suspicion arises due to a rising aspartate aminotransferase (AST) & alanine transaminase (ALT) and/or new risk factor exposure. Patients who achieve SVR from treatment are not protected from reinfection. However, patients without risk factors for reinfection have a very rare/low risk of relapse and should not be routinely monitored for unless the patient has a rise in their AST and ALT.
This is in contrast to hepatitis B virus (HBV). Patients ever exposed to HBV indicated by a positive HBV core antibody-total may indefinitely carry a risk of reactivation. The American Gastroenterological Association (AGA) has HBV reactivation prophylaxis guidelines that outline who is at risk of HBV reactivation and when prophylaxis is warranted or should be considered. Patients ever exposed to (HCV) will indefinitely have a positive HCV antibody and are at this time indefinitely disqualified from donating blood. However, it is becoming more common to allow HCV patients to donate organs and to just have the recipient undergo HCV treatment after organ donation.

3. Any ideas on the physiologic basis between HCV and diabetes mellitus (DM)?
Dr. Rife: Please see our attached manuscript that discusses some of the proposed physiologic bases for HCV increasing rates of DM. It is likely multifactorial, with a key role being the effects of the increased inflammatory cytokines of patients with HCV.

4. Is there a specific threshold for viral load to withheld HCV treatment?
Dr. Rife: No, there is not a viral load threshold for withholding HCV treatment. Per the American Association for the Study of Liver Disease (AASLD) guidelines, all patients with chronic HCV should be evaluated for HCV treatment.