November 2001 · Vol. 50, No. 11

Clinical Inquiries

What are the current treatment and monitoring recommendations for hepatitis C virus (HCV)?

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EVIDENCE-BASED ANSWER

Patients diagnosed with HCV should have serum liver function tests and get a baseline HCV RNA level (viral load), since treatment decisions are affected by these laboratory values.[1-3] Genotype testing is indicated for treatment decisions and prognosis.

Therapy with interferon and ribavirin (dual therapy) has been shown in randomized placebo-controlled trials to lead to sustained viral response in 30% to 50% of patients compared with 6% to 21% with PEG-interferon alpha-2b (Viraferson PEG) therapy only.[4-7] Genotype 1 should be treated with dual therapy for 48 weeks and all other types treated for 24 weeks.[3] Evidence is lacking on the optimum monitoring approach for patients taking dual therapy; consensus recommendations are given in the . Recent evidence shows that treatment with PEG-interferon alpha-2b and ribavirin with weight-based dosing achieved an 82% sustained viral response.[8] (Grade of recommendation: A [dual therapy]; D [all other recommendations].)

EVIDENCE SUMMARY

In patients who are not undergoing therapy, repeat viral load testing is not indicated. Change in viral titer does not predict disease progression in untreated disease.[3]

Several randomized trials have shown that dual therapy with PEG-interferon alpha-2b (3 million units subcutaneously 3 times weekly) and ribavirin (1000 mg to 1200 mg orally each day) is at least twice as effective as interferon alone. The best results were seen in women who had a genotype other than 1, low viral loads, and absence of cirrhosis at the outset.[5] Improvements in histology, viral load, or alanine aminotransferase (ALT) levels predicted improved quality of life in dual-therapy patients, and sustained responders had improved work function and productivity.[3,8] Long-term sustained viral response was at least 50% at 2 years after dual therapy. Long-term response rates have been 30% with dual therapy in genotype 1 and 60% to 70% with genotypes 2 through 6.[4]

The safety profiles for dual therapy and monotherapy are similar.[7] Discontinuation is greater for those taking dual therapy than taking monotherapy, more so with 48 weeks of therapy (20%) than with 24 weeks of therapy (9%).[6,7] Treatment adherence is critical, and compliance with 80% of doses maximizes response.[8]

RECOMMENDATIONS FROM OTHERS

The Centers for Disease Control recommendations are a key source for information about the epidemiology of, prevention of, screening for, and occupational exposures to HCV.[2] Therapy is not recommended for patients with persistently normal ALT levels, advanced cirrhosis, current ethanol intake, intravenous drug use, major depression or severe psychiatric disease, renal transplant, untreated thyroid, or autoimmune disorders, or for pregnant or breast feeding women. There is no consensus on whether patients with compensated cirrhosis, persistent ALT elevations (but few histologic changes), or those younger than 18 years or older than 60 years should be treated with dual therapy.

CLINICAL COMMENTARY

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The evaluation and management of HCV can be complex; in many settings it is treated by a specialist. However, the magnitude of the hepatitis C epidemic is such that primary care physicians will need to increase their knowledge in the areas of screening, diagnosis, and patient education, and they must keep current with the literature on hepatitis C. In the future, treatment of hepatitis C will be a routine aspect of primary care.

Editor's note: See **www.jfponline.com** for **additional clinical commentary** and an for the treatment of HCV.

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