

CDC *Vital Signs* Town Hall Teleconference

Hepatitis C: Testing Baby Boomers Saves Lives
Q&A

May 14, 2013
2:00–3:00 pm EDT

Dr. Dan Baden: All right, thank you very much for those excellent presentations. I'd like to remind everyone that you can get in queue to ask a question by pressing star 1. You'll record your name when prompted and you'll be announced into the conference by the operator when it's your turn to ask a question.

I encourage you all to take advantage of this opportunity to share strategies, lessons learned, challenges, success stories, all those types of things. To start us off, I've got a couple of questions.

How successful are efforts to get hepatitis C infected persons into treatment?

Dr. John Ward: This is John, I can take it. I can start and then Katie and Shauna can add on. We've had variable degrees of success in HIV, we often talk about test and treat continuum starting with detection of the infection and then entry into care and starting of treatment.

And we have constructed a similar cascade or continuum for hepatitis C based on the national survey data NHANES as well as in an observational cohort study that we're conducting with four medical centers around the country.

And we estimate that about two-thirds of persons who are tested—now granted, these are in managed care plans so this might be the best case scenario—are referred into about two-thirds get a test for viremia. And if

positive, about, you know, half of those get into care, into full care, for their hepatitis C infection.

And then overall, about 14% of those in care have been treated and cleared of their infection which is a much smaller percentage than that for HIV, another chronic viral infection. So I think testing is just the start of the story.

You have to really make sure care, and if treatment is needed, happens to really achieve the full health benefits of a testing program. So we look at the whole continuum of testing, care, and treatment; thoughts from others?

Shauna Onofrey: This is Shauna. It's certainly something we're trying to look more closely at with our surveillance data to try and get a sense of access to care and treatment apart from a surveillance standpoint. To really touch on that is something that really, I think, folks know more about on the frontline.

I think with some of the new treatments that are coming out we certainly hear about from our partners, about folks with more interest in some of the newer treatments.

Dr. Dan Baden: Okay, great.

Dr. John Ward: Before we leave that -- let me just say that our estimation that I just described will be published in the *New England Journal of Medicine* tomorrow.

Dr. Dan Baden: Oh, very timely then.

Dr. John Ward: Yes.

Dr. Dan Baden: All right, Operator, are there any questions in queue?

Coordinator: Yes, we do have one question in queue at this time from Andrea Crisp with Cherokee Community Health; your line is open.

Andrea Crisp: Could you speak a little bit about the treatment? Some training I've had on treatment discusses the strict regimen and if you miss one dose, you're out of treatment.

Dr. John Ward: Well, like I mentioned, current treatment, three-drug regimen, two of those are oral medications, and then you have a weekly injection of pegylated interferon. The specific drug for hepatitis C right now is either telaprevir or boceprevir. They require—I think—it's two-eight hour dosings of multiple pills.

And then you're continuation of therapy, as I have seen it monitored, is based on your viral load which is indicative of the response to treatment. So I haven't really seen that much about missing one dose kicking you out of treatment.

But, by missing doses, you may miss those metrics of what is your viral load at particular points in time of your treatment, such as week 8, week 12, week 24 are critical decision points, and week four. So if you're missing doses, you may have viral load that's too high.

And then there's a stop algorithm, but you would stop therapy. So adherence is very important for you to maximize the opportunities to meet those viral load measures and continue treatment to completion.

Andrea Crisp: Thank you.

Dr. John Ward: Thank you for the question.

Coordinator: We have another response from (Mary Louise Wongsley) of PHL. Your line is open.

(Mary Louise Wongsley): Hi, this question is for Dr. Ward. So you stated, if I heard you correctly, that about 30% of hep C patients clear the virus on their own. That's a relatively high percentage for a virus that's pretty nasty, as far as I'm concerned.

Do you have any data or references that indicate what biological, physiological methods occur to clear the virus?

Dr. John Ward: No, that's really a great question, and sort of like the \$64,000 question, because if we knew that, we could maybe increase the likelihood of developing a hepatitis C vaccine. You know, what's clear is obviously the antibody itself, it's not strong enough to clear the virus because you have antibody in the presence of active replication.

So it's the T cell side of the immune system that's important. And we haven't found the specific markers yet that are indicative of clearance. So that's still an open question for science.

(Mary Louise Wongsley): Thank you.

Dr. John Ward: Thank you.

Coordinator: I'm showing no other questions at this time. Again, it's star 1 on your touchtone phone if you have questions or comments.

Dr. Dan Baden: I have another one. What are the barriers that clinicians encountered when ordering the RNA test?

Katie Bornschlagel: Thank you. We learned about several barriers in the course of doing our follow-up on the “It Takes Two” project. And one big barrier, of course, is clinician awareness about the need for RNA testing. Some clinicians had a protocol where they ordered a RIBA which is another antibody test after the initial positive screening antibody test.

So the “It Takes Two” project was a great way to address that and just make clinicians aware. Other barriers are a little harder to address. There were a lot of methadone clinics that are funded to do the hep C antibody test. And they’re just not funded to do the PCR test, so they can’t do it.

They do have referral mechanisms in place and they refer people out for the RNA test. But a lot of drug users feel that if they go to a mainstream clinical care site for their care, they would experience stigma or not be treated with respect. They would be seeing clinicians who don’t understand the particular needs of drug users. So they’re less likely to follow up on those referrals.

Another big problem was patients who were tested for antibody in jail or in detox where they were just in for a couple of days. And the patient is gone by the time the antibody result comes back positive. If the patient is homeless or hard to reach, it’s hard to get them back in follow-up testing.

And we’re continuing to learn more about barriers.

Dr. Dan Baden: Very good, thank you; Operator?

Coordinator: We have some more questions that have come into queue. Our first one is from Kirsten Bean, Green County Combined Health District. Your line is open.

Kirsten Bean: Hi, I was interested to hear, especially in Massachusetts, about the increase in reported cases in infants. And I was wondering if any of the conference presenters had heard anything about linking positive mothers, linking their medical records to the babies.

Because what I've found with pregnant moms that I test positive for HCV, sometimes once the baby is 18 months old, that child is not even in the mother's custody. So no one even thinks to test the baby for hep C when they're 18 months old.

Has anybody come across that or heard of programs in other states that are maybe doing a better job with follow-up for infants born to hep C positive mothers?

Shauna Onofrey: Hi, this is Shauna. So we've actually been reaching out to some of the providers who have been doing the testing for the infants that are reporting here in Massachusetts. And I think you're absolutely right.

It does seem like here there are a number of physicians who will test babies who are either in foster care or have been recently adopted, particularly if they know anything about the mother's risk history. We did get that reported a number of times.

Like you said, there's that window of time. I think that we do have some physicians who are also choosing to test early and are testing with the RNA test to look for circulating virus.

But that's something we're interested in doing as well is also looking at our vital signs, our birth records, and see what information we can get from that. But this is something we've just kind of started scratching the surface of at this point in time.

Kirsten Bean: Sure.

Dr. Dan Baden: Operator?

Coordinator: Thank you. Our next response will be from (Beth Ann Eichler) of the Florida Department of Health. Your line is open.

(Beth Ann Eichler): Hi, I had a question about the HCV RNA testing recommendations for cases that have a confirmatory test based on signal to cutoff ratios. Are you still recommending HCV RNA testing for those that are confirmed by signal to cutoff?

Dr. John Ward: Yes. The new algorithm does not really make a distinction based on signal to cutoff ratio because of a concern that persons who, even though they have low antibody, may still have virus. And so you still need to do that second test to confirm the presence or absence of hepatitis C virus. So the new algorithm does not have a signal to cutoff component.

Dr. Dan Baden: Okay, thank you, and I think we've got one more question.

Coordinator: Our final question is Brett Miller, Positive Impact. Your line is open.

Brett Miller: Hi, this is Brett Miller, Positive Impact in Atlanta, Georgia. Currently, this may be outside the scope of this call, but co-infection for HIV and hepatitis C: do we have any information on that as well? And are there recommendations for hep C testing done for all those that are HIV positive?

Dr. John Ward: The current guidelines from CDC, beginning in 1999, recommend at least a one-time test for hepatitis C for all persons who have been diagnosed with

HIV. I think where we are now and about one out of every four persons with HIV are co-infected with hepatitis C.

Liver disease, as I'm sure the caller is aware, is a leading cause for mortality now for people with HIV. And much of that is caused by hepatitis C. So it's a very important co-infection for people with HIV.

I think what we are finding now in some cities, like New York, is a sexual transmission of hepatitis C virus among HIV positive gay men. And so we are currently looking at ways to strengthen testing recommendations, particularly for that part of the HIV-infected population.

Dr. Dan Baden: All right, thank you very much for the great discussion and the great presentations. Before we close, we would like you to give us feedback on how we're doing with these teleconferences and how we can make them more beneficial to you.

You can email your suggestions to us at ostltsfeedback@cdc.gov that's O-S-T-L-T-S, feedback, one word, at cdc dot gov. We hope you'll be able to join us for next month's call which is going to focus on food borne illness. That will be on June 11.

And once again, thank you to our presenters and everyone who attended the call. This ends our call. Goodbye.

Coordinator: We thank you all for your participation in today's conference. Again, that concludes the call and you may now disconnect. Thank you.