2015 Hepatitis C - Treat or Wait?
A collection of news articles and research weighing the risks and benefits of treating HCV now vs waiting for future therapies

May 18 EASL - Delaying HCV therapy worsens treatment efficacy
VIENNA ? Delaying treatment for hepatitis C virus infection until an increased fibrosis-4 score is reached negatively impacted the efficacy of the treatment among veterans, according to data presented at the 2015 International Liver Congress.

Jeffrey S. McCombs, PhD, associate professor at the University of Southern California School of Pharmacy, Los Angeles, Calif., and colleagues, analyzed data of 187,860 veterans with HCV from the electronic medical records at Veteran Affairs between 1999 and 2010. The patients selected for analysis had one or more reported fibrosis-4 (FIB-4) values, which the researchers looked at to estimate the impact on patient risk of treatment initiation before and after the patient’s FIB-4 values increased, and to conclude whether or not treatment can or should be delayed.

The impact of time to treatment initiation and time to three different definitions of an elevated FIB-4 level were estimated using a time-dependent Cox proportional hazards models, according to the research.

“What we have done is go back and look at the treatment of VA patients over a 10-year period ending in 2010 before the new medications and ask questions about what we can learn about the way treatment proceeded prior to new drugs,” McCombs said during his presentation. “We are building a story about essential need for new medications. It grew into an analysis [where we asked] can we come up with ways of allocating the scarce resources in a way that we can all get through this crisis and arrive at a point where we can eradicate this disease and not break the bank, so to speak.”

According to the results, beginning HCV therapy prior to a patient reaching a FIB-4 value greater than 1.00 reduced morbidity by 41% and mortality by 36%. Beginning treatment after FIB-4 reached 1.00 was effective, but decreased the reduced morbidity risk to 30%. However, this did not occur if treatment initiation was delayed until reaching a FIB-4 value greater than 3.25.
The risk reductions associated with treatment initiation before reaching a FIB-4 of more than 3.25 were 34% for the composite event and 45% for mortality. However, if treatment was initiated after a FIB-4 value of over 3.25 was attained, these risks decreased to 11% and 25%, respectively.

These adverse effects of delaying treatment until after reaching a FIB-4 value greater than 3.25 were because patients already treated would have viral load suppression and a reduced impact of viral load suppression on morbidity, according to McCombs presentation.

“We’re trying to provide information [so] you can go to your peers and argue that if we’re going to have some sort of a system where we will delay therapy to patients at most risk, which is essentially trying to get around a cash flow problem, how do you do it? What do you watch? How long do you wait?” Mc Combs said.

Reference:

Disclosures: The researchers report no relevant financial disclosures.

April 5

Another study confirms detrimental effects of delaying hepatitis C treatment
Liz Highleyman
Produced in collaboration with hivandhepatitis.com

Deferring antiviral therapy for hepatitis C until a person progresses to advanced liver disease has clear drawbacks including lower treatment effectiveness and an increased risk of clinical events and death, according to a study of US veterans presented at the European Association for the Study of the Liver (EASL) 50th International Liver Congress last month, in Vienna, Austria.

May 5

Delaying HCV Tx Reduces Likelihood of Eradication
by Ed Susman
Contributing Writer, MedPage Today

VIENNA -- Delaying treatment of hepatitis C virus infection markedly increased the risk of not being able to clear the virus in these patients, according to a new retrospective analysis that looked at patients treated before the introduction of targeted hepatitis drugs.

When patients with fibrosis-4 (FIB4 greater than 3.25) liver scarring were treated early in the course of their disease, the number to treat to reach an undetectable viral load was 180, but when treatment was delayed in these patients, the number to treat to get an undetectable viral load soared to 325 individuals, said Jeff McCombs, PhD, associate professor of pharmaceutical economics and policy at the University of Southern California.

In his oral presentation at the International Liver Conference, sponsored by the European Association for the Study of the Liver, McCombs noted that his report involved patients in the era before targeted therapies became common. He illustrated that patients with less advanced fibrosis scores (FIB4>1 or FIB4>1.45) are not affected by the time when their disease is treated as far as numbers to treat were concerned.

"Delaying treatment until after a patient’s FIB4 level exceeds 3.25 has a clear detrimental effect on treatment effectiveness," McCombs reported.

The number to treat for early disease stage for those patients diagnosed with FIB4>1 was 142; the number to treat among those patients with delayed therapy was 128. For patients diagnosed with FIB4>1.45, the number to treat was 137 for early therapy and 144 for later treatment, McCombs said.

During the time period of his study, McCombs said, treatment was mainly based on interferon, pegylated interferon, and other hepatitis drugs.

He said the idea behind his retrospective work was to determine if there is a way to "allocate the scarce resources we all have to eradicate this disease -- an opportunity that does not come along often in medicine -- without breaking the bank. Can we delay therapy in some sort of reasonable way?"

The researchers accessed data from the VA electronic medical records system, identifying patients through hospital code or positive laboratory tests and tracking patient admissions, laboratory test results, outpatient encounters, outpatient medications, demographics, and vital signs. McCombs said that hepatitis C virus infection was diagnosed in about 5.4% of patients already treated would have viral load suppression and a reduced impact of viral load suppression on morbidity, according to McCombs presentation.

The researchers considered treatment success as the time to the first viral load at zero. Sustained virologic response (SVR) was not referred to in that time frame, he said. The researchers were looking for what came first: a viral load of zero or a composite event that included cirrhosis, decompensated cirrhosis, hospitalization related to hepatitis C infection, development of hepatocellular carcinoma, or death.

McCombs and his colleagues used multiple variables in their analysis including sex, age, race, ethnicity, and hepatitis C virus genotype. They also factored in the patients’ medical histories and diabetes status at baseline, as well as the time to achieving undetectable viral load, time to abnormal laboratory values, FIB4 levels, and time to treatment.
During the study period, he said that 25% of the patients actually started therapy -- 75% of patients diagnosed with hepatitis C viral infection refused treatment in the population studies. Of the 25% who accepted therapy, just 16% achieved a viral load of 0 -- "which is a whopping 4% of the entire population." His study included 187,860 patients.

Today's landscape differs significantly from the interferon-treatment era, said David Bernstein, MD, director of the Center for Liver Disease at North Shore-LIJ Medical Group, Manhasset, N.Y., and professor of medicine at Hofstra North Shore-LIJ School of Medicine.

"People refused treatment when offered interferon because those were awful treatments compared with today's drugs. The Veterans Affairs population is not representative, because many of those patients have a lot of comorbidities and the patients' doctors may have not even offered those treatments," he told MedPage Today.

"I don't have anyone refusing treatment these days," he said. "The problem is not the direct-acting antiviral treatments, it is access to treatment."

McCombs, in his talk, said that previous studies indicated that viral load suppression reduced the risk of future liver events by 27% and reduced the risk of mortality by 45%.

Initiating treatment before FIB4>1.00 reduced morbidity by 41% and death by 36%. Initiating treatment after FIB4>1.00 remained effective but diminished the morbidity risk reduction achieved to 30%, McCombs reported. "This is not the case if treatment initiation is delayed until after FIB4>3.25. The risk reductions associated with treatment initiation before FIB4>3.25 were 34% for the composite event and 45% for death but if initiated after FIB4>3.25 were only 11% and 25%, respectively."

He added, "These detrimental effects of delaying treatment until FIB4>3.25 were due to a reduction in the likelihood that treated patients would achieve viral load suppression and a reduced impact of viral load suppression on morbidity."

Bernstein, in commenting on the study, said he is not sure if delaying treatment with direct-acting antivirals would be detrimental. "The truth of the matter is that I don't think we know the answer because we have not done any real prospective study to answer that question," he said.

"We do believe that from data that we have, and his data would substantiate that, that delaying treatment in patients with significant liver fibrosis certainly can be detrimental to people's health," Bernstein said. "When someone has minimal disease, we don't know it will cause harm. We do know that the 5-year all-cause mortality is reduced in people who are treated."

McCombs disclosed no relevant relationships with industry. Bernstein disclosed no relevant relationships with industry.

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Available treatments for hepatitis C virus cost-effective when initiated early

New treatments for hepatitis C virus (HCV) may be highly effective but are associated with substantial costs that may compel clinicians and patients to consider delaying treatment. However, a new study shows that immediate treatment of HCV-infected patients with moderate or advanced liver scarring is cost-effective. Immediate treatment of patients with minimal or no scarring can be cost-effective as well, particularly when lower treatment costs are assumed.

"The devastating effects of hepatitis C continue to threaten the health of many Americans, with baby boomers at particular risk. This analysis of treatment available for hepatitis C describes specific scenarios when immediate or earlier treatment can be both cost-effective and increase quality of life," said Dr. John Ward, co-author of the Hepatology study and director of CDC’s Division of Viral Hepatitis.

Source

March 15

Hepatitis C: what treatments work? - Patient information from the BMJ Group

Hepatitis C: what treatments work?

Hepatitis C is an infection that can harm your liver. Many people don't know they have it, because there are often no symptoms for many years. Treatments can get rid of the virus.

What happens when you have hepatitis C?

The virus that causes hepatitis C is carried in human blood. You can catch it if blood from someone with the virus gets into your bloodstream and the virus is carried to your liver. Some people's bodies fight off the virus naturally, without any treatment.

This happens for between 15 and 45 in every 100 people who are infected with the virus. But many people aren't able to fight off the virus on their own. If you have had the infection for more than six months, doctors say you have chronic hepatitis C.

Some people live for many years with chronic hepatitis C, without having any health problems. But it can cause scarring in your liver and stop your liver working properly.

If your liver isn't working properly, all the jobs that it does are affected. These include breaking down waste products in your body, fighting infection, and breaking food down into a form your cells can use for energy.

Up to 20 in every 100 people who have chronic hepatitis C eventually get scarring in their liver (cirrhosis) if they don't have treatment. Over time, cirrhosis can cause life-threatening problems, including liver cancer.

Should I have treatment - and when?

Treatment for hepatitis C takes several months, and it can have some unpleasant side effects. So it can sometimes be difficult to decide if, and when, to have treatment. Here are some of the things you need to think about. You can talk them over with your doctor to decide what is best for you.
Were you infected recently?
If you have recently been infected with hepatitis C, you and your doctor may decide to hold off on treatment to see whether your body is able to fight off the infection on its own. You will need to have regular tests to check on the virus. If you have had the infection for six months or longer, it is unlikely that your body will get rid of the virus without treatment.

How old are you?
If you are younger than 18 or older than 60, the benefits of treatment may not be as clear as they would be for someone at a different age. For example, not much research has looked at the effects of hepatitis C medicines in children. And someone who is older might have other health issues that could make treatment more difficult, or harmful. These are issues you should discuss with your doctor.

Is your liver damaged?
If you have hepatitis C, but you don't have any signs of liver damage, your doctor may say you don't need treatment now. But you might get liver damage in the future. You need to keep in touch with your doctor and have regular tests.

If you have mild liver damage, there's a better chance that treatment will work than if your liver damage is more serious. You need to weigh up the chance that liver damage may get worse, against the side effects of treatment.

If you have serious liver damage, your doctor will probably suggest that you have treatment as soon as you can.

Will you be able to cope with the side effects?
You may get unpleasant side effects during treatment, which can be difficult to cope with. However, this is less likely with newer medicines for hepatitis C (see below). It's important that you fully understand the possible side effects, so you can weigh these against the possible benefits of treatment.

What treatments work?
Medicines can help you get rid of the hepatitis C virus. This may stop any liver damage from getting worse and prevent future damage.

Types of medicines
Interferon used to be the main medicine for hepatitis C. However, there are several newer treatments that often work better than interferon, cause fewer side effects, and require a shorter length of treatment.

Another advantage of the newer treatments is that you take them as tablets or capsules. Interferon requires an injection.

The newer medicines include:
- Dasabuvir
- Ledipasvir
- Ombitasvir
- Paritaprevir
- Ritonavir
- Simeprevir
- Sofosbuvir

You take these medicines once or twice a day. You might take more than one of these drugs at a time, or combine them with older medicines called peginterferon (a type of interferon) and ribavirin. People also sometimes have treatment just with peginterferon combined with ribavirin.

Treatment usually lasts between 12 and 24 weeks. However, if you have peginterferon and ribavirin on their own, treatment lasts for 48 weeks.

What treatments your doctor recommends depends on a few things.

What type of hepatitis C virus do you have?
There are six types of hepatitis C virus. They are called genotypes, and they are numbered 1 to 6. What genotype you have affects which medicines are most likely to work for you. Most people with hepatitis C in Western Europe have genotype 1, 2, or 3. You will have a blood test before you have treatment to find out which genotype you have.

Do you have certain medical conditions?
If you are pregnant, taking some of these medicines may harm your baby. Talk to your doctor about your options. You may want to wait until after you've had your baby to start treatment.

If you have kidney disease, heart disease, or bad liver damage, you may not be able to take ribavirin. That's because it can make these conditions worse.

Have you been treated for hepatitis C before?
Treatment for hepatitis C doesn't always work. And, sometimes, it works for a while and then the virus flares up again. If you have had treatment for hepatitis C before, you can have treatment again. However, you may be offered different medicines.

What medicines are available where you live?
The newer medicines for hepatitis C have not yet all been approved in some countries. You can talk to your doctor about what treatments are available where you live.
Medicine side effects
The newer treatments for hepatitis C can cause side effects, but these are usually not serious. Side effects can include tiredness, problems sleeping, a rash, itching, headaches, diarrhoea, and nausea.

The older hepatitis C medicines - peginterferon and ribavirin - have several side effects, which can be difficult to cope with.

Common side effects of peginterferon include tiredness, aches and pains, nausea, losing weight, feeling irritable and depressed, and losing your hair (but it grows back).

Common side effects of ribavirin are tiredness, feeling irritable, skin rashes, a stuffy nose, and coughing. These medicines can also cause more serious problems.

They include anaemia (you have too few red blood cells), problems with your thyroid gland; serious infections; a problem where your body makes hardly any white blood cells; a problem where your body makes hardly any platelets, which help your blood to clot; and severe depression.

While you are taking these treatments, you will have regular blood tests to check for some of these problems.

Follow-up
The only way to see if treatment is working is to have blood tests to check for the virus. If your test is positive, you still have the virus in your blood. If your test is negative, you have no sign of the virus in your blood.

Most people have blood tests for the virus after four and 12 weeks of treatment. People with genotype 3 have an additional test after 24 weeks. If there is no sign the medicines are working, your doctor will probably advise you to stop taking them.

The virus can come back after treatment is over. To be certain that the treatment has worked, doctors test for the virus again six months after you finish treatment. If there is no sign of the virus, doctors say you have a sustained virological response (SVR for short).

Among people with the most common genotypes (1, 2, and 3), those with genotype 1 used to have a much lower chance of getting rid of the virus through treatment than people with genotype 2 or 3. However, the newer treatments have changed this. Now, the vast majority of people have no sign of the virus six months after they finish treatment.

HCV RNA Does Not Always Mean Treatment Failure
Medscape Medical News, March 12, 2015

Delaying Hep C Therapy for HIV/HCV Coinfected People Is Risky
Hepatitis C: Hunting the silent killer
Chronic infection can lead, after years or sometimes decades, to problems: inflammation and then scarring (cirrhosis) of the liver in a third of patients, liver disease in a fifth of patients and, in a small minority, liver cancer. A common symptom before and during liver damage is exhaustion, sometimes coupled with depression, digestive problems, skin conditions, sleep problems and pain, whose causes can often be misattributed. This, together with the fact that many remain asymptomatic for years, has led to its "silent killer" tag. Around 350,000 people die globally each year because of hepatitis-C-related liver diseases.

Experts Discuss: Cost-Based Treatment Decisions Comparing Adverse Events of HCV Drugs And More...
improve survival. With the advent of the highly effective oral-only therapy, the cure for hepatitis C is very close, if it is not already here. The recent approvals of single once-a-day combination pill of sofosbuvir and ledipasvir (Harvoni, Gilead) and the combination from AbbVie (Viekira Pak) are yet another landmark in this regard. Several other regimens expected to be approved in the near future, most, if not all, patients with HCV can be cured. With the spectacular SVR of over 95 percent, minimal to no side effects, and a mere eight to 12 weeks treatment course, these drugs are expected to revolutionize HCV treatment. These mighty pills, however, come with a very hefty price tag that is outrageous for many. So, here is our dilemma: now that we have the cure that we wished for, can we afford to have it?

Until the recent arrival of the direct acting antivirals, peg-interferon/ribavirin was the standard of care for HCV. Although the cost was lower, so was the SVR rate, with daunting side effects and a long list of contraindications. A recent study showed that the cost of telaprevir-based triple regimen (48-week course) was about $189,000 per SVR if management of side effects are included along with the cost of medication, office visits and laboratory testing. In comparison, the cost of sofosbuvir/simeprevir, a regimen that just got approved, for 12 weeks is about $150,000 with over 85 percent SVR. Therefore, the $94,500 price tag of the 12-week course of Harvoni or $85,000 for Viekira Pak with over a 90 percent cure rate may actually be the most cost-effective regimen we have seen thus far. However, owing to excellent safety, tolerability and absence of contraindications, these drugs have wider indications and literally everyone with HCV (e.g., barring those on dialysis) can be eligible for the treatment. This is feared to result in significant overall increased cost burden to the already restrained health-care budget.

With the targeted screening of baby boomers (who constitute three-fourths of all HCV cases in the U.S.), an additional 1 million HCV cases eligible for treatment are expected to be identified in the U.S. In the past, we relied on liver biopsy (with its own risks and added costs) for disease staging and treatment prioritization. Now, we have inexpensive serum biomarkers (FIB-4 and APRI) and transient elastography (Fibroscan) available obviating the need of liver biopsy for disease staging in most cases. This may further increase the pool of patients to be treated. About 2 million people with HCV with insurance coverage are expected to be eligible for treatment over the next five years, which will cost payors about $188 billion based on current pricing. This has caused a significant ripple among policymakers, and the insurance carriers are imposing additional prior authorization requirements, approving treatment only for those with the most advanced disease, if not denying it outright. On the other hand, patients who have been waiting for the interferon-free treatment for so long are demanding to be treated right away. And as more patients are being identified by targeted screening, this burden will only increase.

Here is our dilemma: now that we have the cure that we wished for, can we afford to have it?

While some advocate treating everyone on a first-come, first-served basis, this is not possible in a resource-limited setting, such as our current U.S. health-care system. Therefore, given that HCV is generally a slowly progressive disease taking decades before developing into advanced fibrosis or cirrhosis, and in light of the anticipated approval of more drugs in the near future, which are expected to drive down the cost by competition, the most cost-effective approach at the moment may be to treat those with the more advanced disease, while keeping the rest of the pool in close monitoring so they can be treated down the line.

Certainly, this approach may not be acceptable from the perspective of the individual patients or the treating physicians, the best advocate for these patients. However, given the current high cost, this appears to be the optimal approach from the societal perspective. After all, we in the field of hepatology are not unfamiliar with rationing treatment to the sickest first; we have been doing this for long time for organ allocation to liver transplant recipients. Nonetheless, with more stakeholders in the horizon, we all are looking forward to the day when we can treat and cure every single patient with HCV without having to worry about the cost. So, for now, it appears HCV treatment is so close for some, yet so far for most others.

Dr. Sterling is on the advisory board for Gilead, Bristol-Myers Squibb, Salix, Bayer, Jansen and AbbVie. He also receives research support from Gilead, Bristol-Myers Squibb, Roche and Merck. Dr. Sterling is also the Virginia Governor of ACG.

Dr. Dharel has no conflicts to disclose.

References

Jan 31 2015
Weekend Reading - Patient Friendly Audio discussing interferon-free regimens for the treatment of HCV
Topics Include
Treatment in genotype 1a and 1b, with or without cirrhosis
Biggest HCV cure is patient adherence
Duration of therapy for patients with cirrhosis
Monitoring patients who achieve SVR for liver cancer.
Current recommendations in treating Genotype 3.
Initiating treatment, wait or treat.
and more.....

Of Interest 2014
This Issue Of HCV Next - Treat Now or Wait, Millennials, Drugs and HCV

Complex debate on the decision to treat HCV with currently available therapies or wait for more options.

Elsewhere on the website - Archives - 2014