

Treating Hepatitis C in Primary Care: Results from a pilot program



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ASHM 2014

Conflict of interest

David Baker: Travel grants, advisory board membership, speakers payments, preparation of educational material, clinical trials : MSD, Roche, Gilead

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Introduction: National strategy

Third National Australian Hepatitis C Strategy called for:

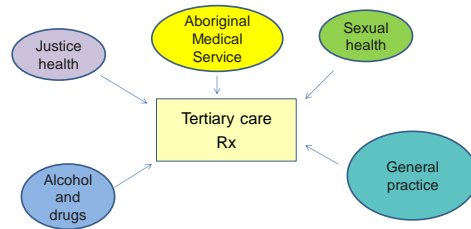
Increased treatment uptake to reduce progression to advanced liver disease (aim > 6000 patients / year)

Investigate innovative projects to increase participation for primary care health teams in hepatitis C management

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Traditional model for hepatitis C treatment



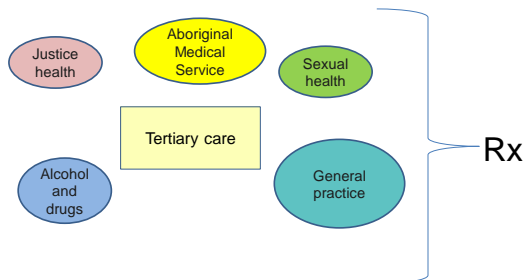
Currently <4000 patients treated pa (1-2%)

Gidding HF, Topp L, Middleton M, et al. The epidemiology of hepatitis C in Australia: notification, treatment uptake and liver transplantations, 1997-2006. J Gastroenterol Hepatol 2009; 24:1648-54

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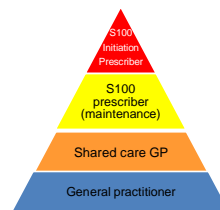
Need for other approaches



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Background: models of care



Activities	Additional Training
Initiate S100 medications	Advanced S100 training course, annual CPD
S100 prescriber (maintenance)	S100 prescriber course, annual CPD
Monitoring, limited treatment involvement	Introductory course
Diagnosis, basic evaluation	Nil

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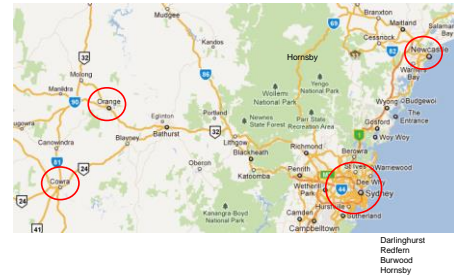
Method: participating clinics

7 participating primary care practices –

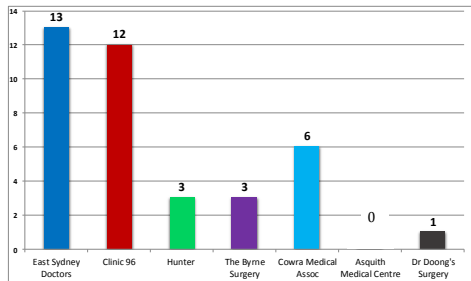
- Darlinghurst – inner city Sydney GP
- Redfern – inner city Sydney GP focusing on opiate substitution
- Hornsby – suburban GP
- Burwood – suburban GP (not providing opiate substitution)
- Cowra – rural GP
- Orange – rural AOD clinic
- Newcastle – urban AOD clinic

6 of 7 sites providing opiate substitution Rx

Method: participating clinics



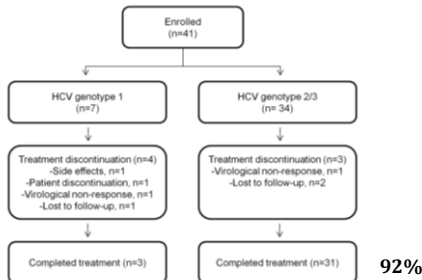
Results: patient enrolment



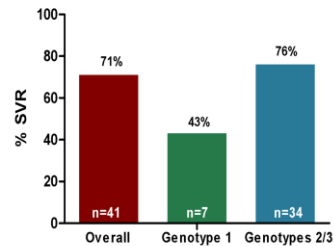
Results: patient demographics

Enrolled 41		
Age	Average 44	Range 28 - 70
Sex	Male	30
	Female	11
Genotype	1	7
	2	5
	3	29

Results: treatment completion

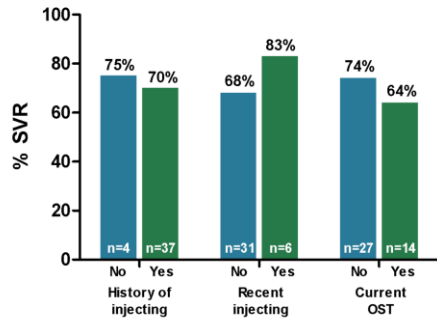


Results: treatment response

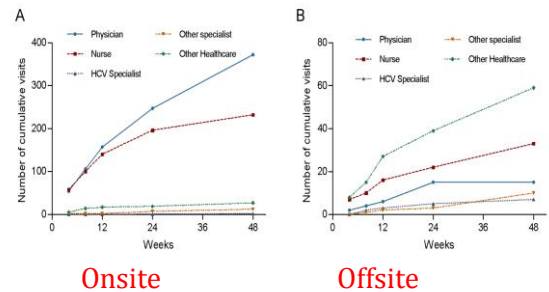


Baker, D et al. European Journal of Gastroenterology & Hepatology. 26(9):1003-1009, September 2014

Results: treatment response



Results: cumulative onsite and offsite visits



Results: Serious adverse events

Description	Side effect date	Planned duration of treatment	Completed treatment
Admission to hospital following depression with occasional suicidal thoughts. Participant reported anxiety accompanied by nausea, vomiting, anorexia, and agitation.	9-Dec-11 (Week 12)	24 wks	No
Two admissions to the psychiatric ward of the hospital following poly-substance withdrawal.	Episode 1: 25-Nov-10 (Week 24)	24 weeks	Yes
	Episode 2: 30-Nov-10 (Week 1 post-treatment)		
Admitted to hospital with a pulmonary embolism.	NA	48 weeks	Yes
Admission to hospital with pneumonia and persistent chest infection.	03-Nov-10 (Week 24)	48 weeks	Yes
Admission to hospital. Lung Biopsy confirmed sarcoid lung disease. IFN-Sarcoidosis skin and lung involvement.	NA	48 weeks	No

Discussion

Response rates of 71% (SVR) consistent with standard of care in hospital-based clinics

Barriers to treatment with interferon include significant adverse events and the labour-intensive requirements of treatment

Qualitative review

"...patients appreciated the continuity of care that this treatment model affords, the convenience of accessing treatment from their GP and being treated by a GP they trusted."

Hopwood M; Treloar C, 2013, 'Under the watchful eye of a benevolent dictator?: General practitioner and patient experiences of hepatitis C treatment initiation', *Australian Family Physician*, vol. 42, pp. 900 - 903

The future

New direct-acting antivirals (DAA) with low toxicity and ease of use will (should) allow many more patients to be treated in the primary care environments

Need for expansion of HCV education and training to follow-up on promising initial community-based treatment initiatives

No more pilots ! Nicole Allard

Acknowledgment

Participating clinics and staff: Annie Balcomb, Richard Hallinan, David Richmond, John Smart, Julian Keats, Nicholas Dong, Claire Johnson

ASHM: Sonja Hill, Levinia Crooks, Bob Batey, Nicki Woolley, Vanessa Towell

Kirby Institute: Greg Dore, Amanda Erratt, Pip Marks, Maryam Alavi, Jason Grebely

NCHSR: Carla Treloar, Max Hopwood

NSW Health: Claire Honey, Lisa Ryan

Patients

Thanks

