Chronic hepatitis C virus infection: Everyone should be treated.

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Chronic hepatitis C virus (HCV) infection is a worldwide scourge that is responsible for significant morbidity and mortality. Many patients experience complications of end-stage liver disease and require liver transplantation. Cirrhosis in the setting of HCV is a major cause of hepatocellular carcinoma (HCC). HCV is the leading cause of liver transplantation in the Western world and is a significant cause of mortality. Yet, cirrhosis does not develop in the majority of patients, and the natural history is characterized by decades of disease until advanced liver disease complications occur. This has prompted the question whether all patients with HCV require treatment.
In recent years, oral regimens have been approved that are well tolerated and yield sustained virological response (SVR) rates in excess of 95% for most HCV patient populations. However, because the medications are expensive, there has often been a “rationing” of care, such that only patients with advanced liver disease are provided therapy by third-party payers or governmental agencies. This is based on the premise that patients with advanced liver disease are the closest to experiencing development of decompensated liver disease and/or HCC.

This policy, however, is shortsighted. It has become increasingly clear in recent years that HCV is associated with numerous troublesome extrahepatic medical comorbidities, unassociated with the stage of liver disease, that lead to poor quality of life and increased extrahepatic mortality. Further, it has been shown that successful treatment of HCV leads not only to improved liver-related mortality, but also to improved all-cause mortality. There is also evidence that costly and devastating medical problems such as diabetes mellitus,

renal failure attributed to cryoglobulinemia, and lymphoma occur in association with HCV. There is a growing literature regarding the increased prevalence of diabetes mellitus and insulin resistance in patients with HCV. There is reason to believe that the incidence of these issues may decline with successful treatment of HCV. In fact, the prevalence of insulin resistance and diabetes mellitus has been shown to improve in patients whose HCV has been successfully treated.

For several other reasons, it is also counterintuitive to wait to treat until advanced liver disease develops in HCV patients. First, it has long been known that once cirrhosis develops, patients remain at increased risk for development of HCC despite viral eradication.In fact, some groups are concerned that clearance of HCV in some settings may increase the risk for HCC. It would be best to clear HCV before the development of cirrhosis. Furthermore, patients who develop cirrhosis have a lower chance of attaining SVR or require increased length of therapy with or without ribavirin with the current therapeutic regimens. Awaiting the development of a more dangerous condition that has a lower success rate with therapy is unjustifiable. From a public health standpoint, it would also be wise to treat as many patients as possible to decrease the pool for transmission to uninfected people. Allowing patients to remain untreated when they do not have advanced liver disease, and are contagious, is unwise and will permit more transmission of the virus in the community.

A policy of treatment of as many HCV patients as possible could not be advocated if there were not regimens that are well tolerated and highly effective in almost all patient populations. Fortunately, such regimens exist. A recommendation that supports treatment of as many HCV patients as possible cannot be endorsed without mention of the cost of therapy. Hopefully with the advent of new

products and negotiation with pharmaceutical companies, the price of therapy will continue to decline such that it becomes possible for third-party payers and governmental agencies to do the right thing: treat patients with HCV and cure them.

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