Seek treatment for hepatitis C

Medical attention can help fight approaching health, economic crises

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Special to The Star

It is admirable that Mike McGraw and Karen Dillon undertook their efforts to investigate important issues of the hepatitis C epidemic.

There is no doubt that the disease remains mostly underappreciated and quietly devastating. They have done us a great service in exposing the tremendously flawed approach the federal government has taken toward protecting the blood supply and delineating the Food and Drug Administration's failure to inform those blood transfusion recipients most at risk. I hope their article will be a catalyst for change.

However, the authors misunderstood many facts concerning the treatment of hepatitis C. They portrayed an unbalanced and negative experience of most patients undertaking treatment. Thi may have discouraged the people in most need of care from seeking help.

The experiences and opinions hepatologists (liver specialists), such as myself, and other hepatitis C experts locally and nationall were not covered in the article despite their interviews by the authors.

What is most important to understand is that of the 4 million t 5 million Americans infected wit the hepatitis C virus, 20 to 25 percent will develop cirrhosis of the liver (replacement of the liver with scar tissue) and will likely progress to liver failure or liver cancer. This process takes 30-40 years to develop.

There already is a significant shortage of donors for liver transplant, and hepatitis C already tops the list for indications for such a transplant. Post-transplant, hepatitis C almost always recurs.

There are also currently no beneficial treatments for liver cancer other than transplant for the few who qualify. Our most important goal, therefore, is to eradicate the virus or slow its progression, before the development of cirrhosis and liver cancer.

Certainly not everyone infected with hepatitis C is a candidate for treatment. In fact, if we were able to delineate those who are progressing to cirrhosis from those who are not, 70 to 80 percent of patients would not need treatment. Most would die with their disease and not from it.

Understanding the length of someone's infection (based upon their risk factors), their current liver condition (based upon a liver biopsy), and the strain or genotype of their infection helps to guide us in properly selecting patients most likely to benefit from therapy.

Seventy percent of U.S. patients have genotype 1 hepatitis C virus and have a 55 percent chance of a "cure" (long term viral eradication) with 48 weeks of anti-viral treatment.

The best candidates for treatment with this strain of the virus are those with advanced scarring or an unknown length of infection. The other 30 percent of infected people have genotype 2 or 3 and have a 95 percent chance of cure after 24 weeks of treatment.

While most of the patients who undertake treatment have side effects, most are able to continue working and lead productive lives.

These are not artificial statistics. These results are realistically achievable when patients are treated in centers where an experienced team can guide patients through treatment with proper side effect management and care.

Unfortunately, the limited negative data that was referenced in *The Star's* article was an unbalanced representation of a much larger body of peer-reviewed, published studies that show tremendous success in patient outcomes and compliance.

These studies formed the basis of a recent National Institutes of Health consensus conference, which advocated treatment in the manner aforementioned. These studies did not in fact "cherry pick" their patients as referenced in *The Star's* article. The little data that was presented in *The Star's* article was not referenced, and the one negative study from a Cleveland Metropolitan hospital that was cited drew from a known noncompliant patient population. Patients in this study were also treated with older, less effective forms of therapy.

While most of the patients who undertake treatment have side effects, most are able to continue working and lead productive lives. Fatigue and depression are the most common hurdles, but they can be managed effectively.

The treatment is short term, and long-term consequences of treatment are quite rare. Even in patients who do not respond with a viral cure, many studies have shown a decrease in scarring of the liver and a smaller chance of developing liver cancer.

The virus does not return in a more virulent form as incorrectly quoted in *The Star's* article. Maintenance therapy with interferon has been shown to slow the progression of liver scarring and may bridge treatment failure patients to future therapies.

Many clinical protocols utilizing new agents and trying to maximize existing agents are available for patients who have been nonresponders to previous therapy. An entire new class of agents is on the way, though their use alone or in combination with present drugs is at least two to three years away from significant clinical testing.

In the properly selected hepatitis C patient population, medical treatment is the only weapon against a fast approaching health and economic catastrophe. As our practice is the second busiest center for the treatment of hepatitis C in the United States, we speak from experience in our knowledge of patient outcomes and the current literature.

We hope that patients at risk for hepatitis C will seek medical attention for screening and that those infected be encouraged to seek treatment if they are proper candidates. We recognize that treatment can be difficult, but far less so than the anguish of waiting on a transplant list or a slow death from liver failure or liver cancer.

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