

**BHIVA AUTUMN CONFERENCE 2014**

*Including CHIVA Parallel Sessions*



**Dr Ed Wilkins**

**North Manchester General Hospital**

*9-10 October 2014, Queen Elizabeth II Conference Centre, London*

## Dr Ed Wilkins

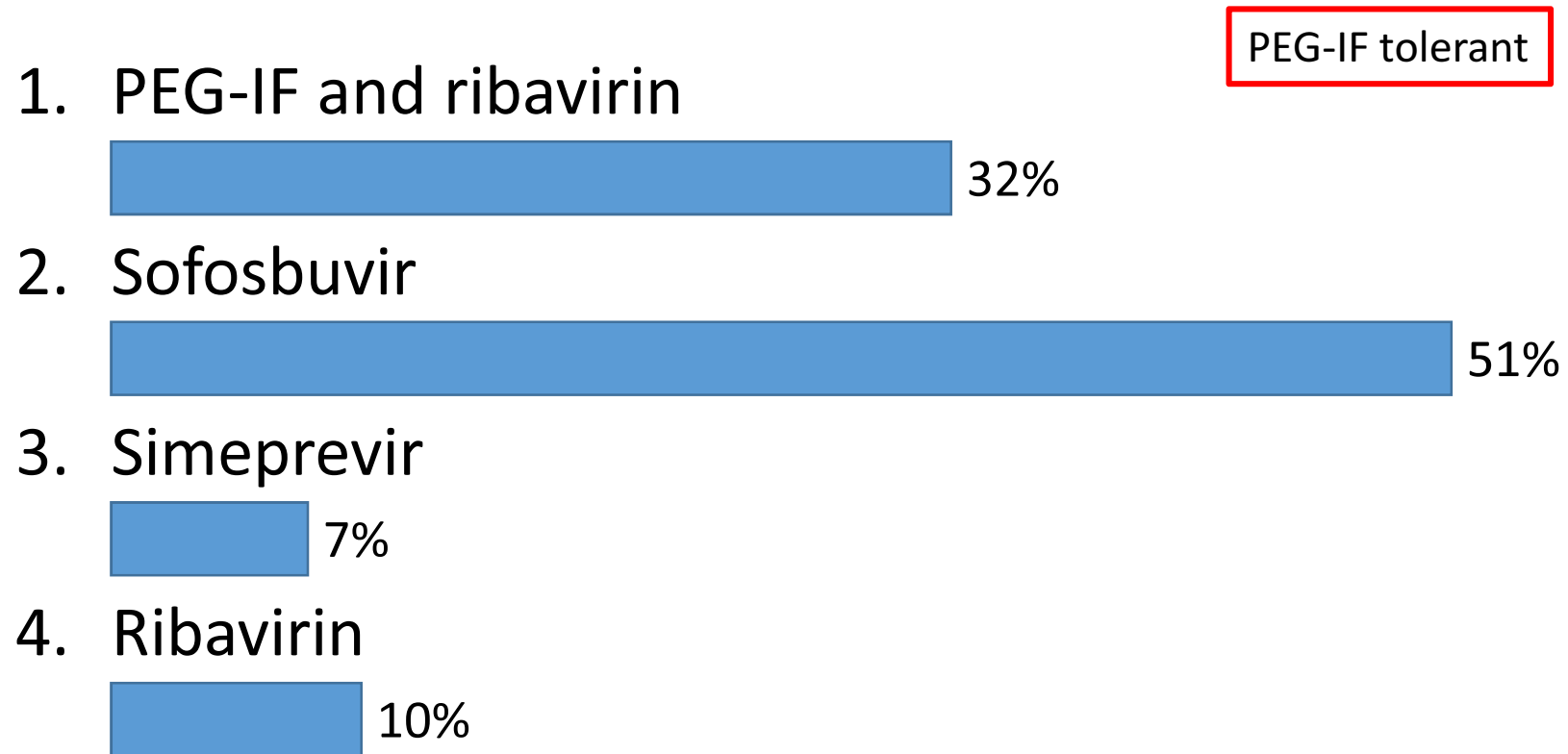
### North Manchester General Hospital

| COMPETING INTEREST OF FINANCIAL VALUE $\geq$ £1,000: |  |
|--|--|
| Speaker Name   | Statement  |
| <b>Dr Ed Wilkins</b>                                 | I have received honoraria for giving sponsored lectures and attending advisory boards as well as sponsorship to attend international conferences from AbbVie, BMS, Gilead, Janssen, MSD, and ViiV. |
| Date   | October 2014   |

# BHIVA hepatitis guidelines update for HCV treatment

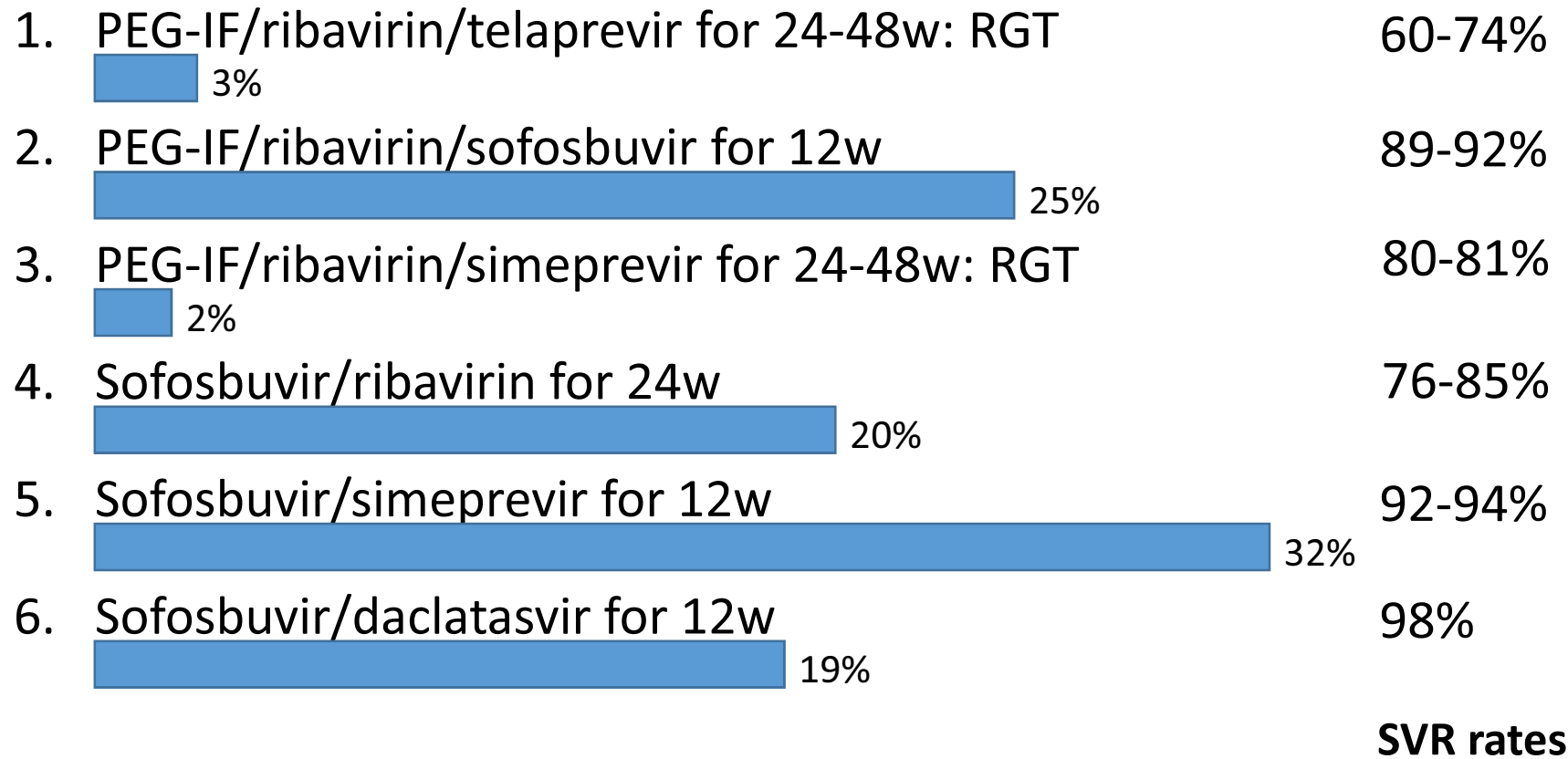
Ed Wilkins

# What do you believe should be the current backbone of HCV treatment?



# Naïve/relapse GT1 – which treatment would you like to be able to give?

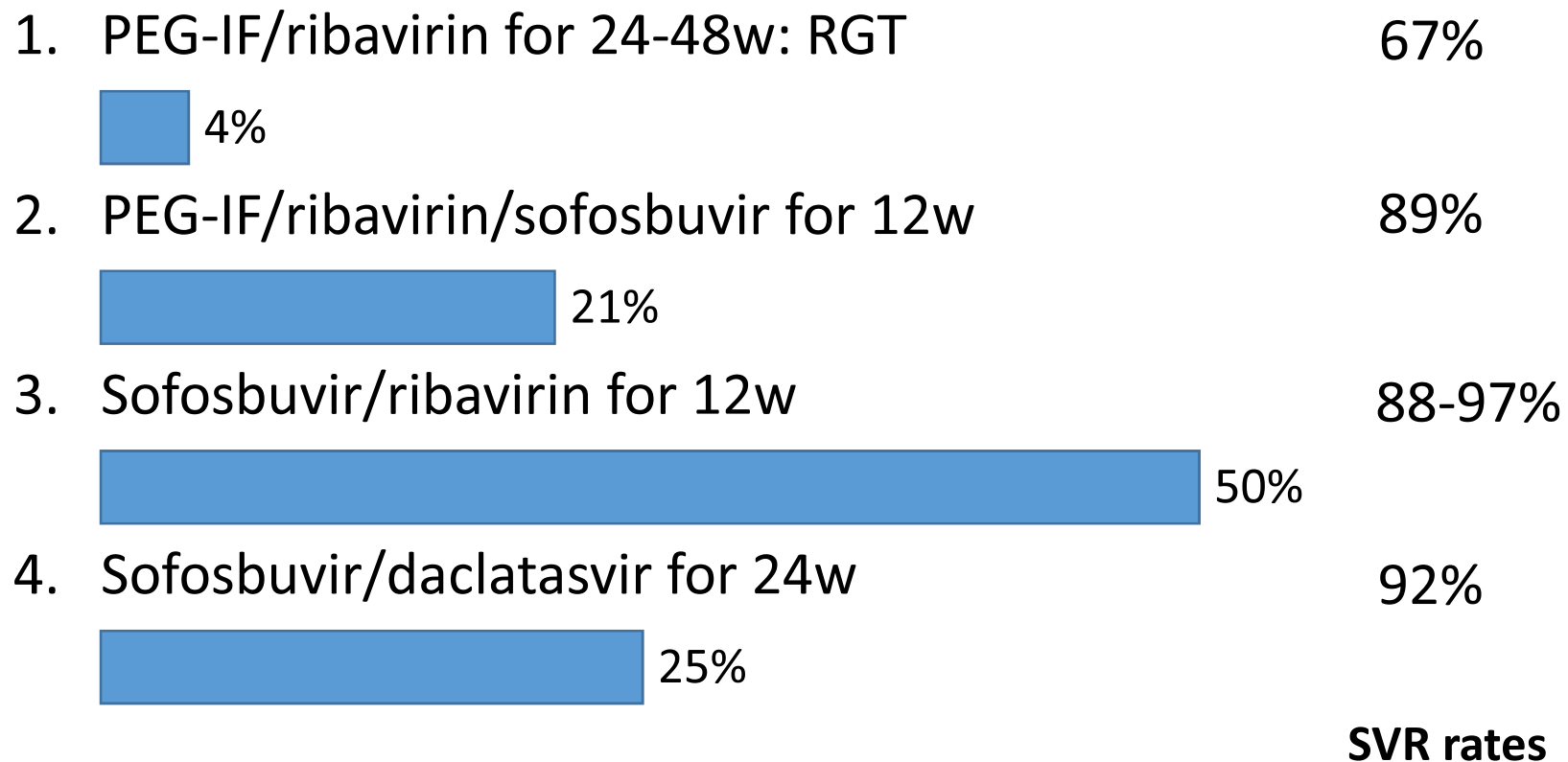
PEG-IF tolerant



RGT = response guided treatment

# Naïve/relapse GT2 – which treatment would you like to be able to give?

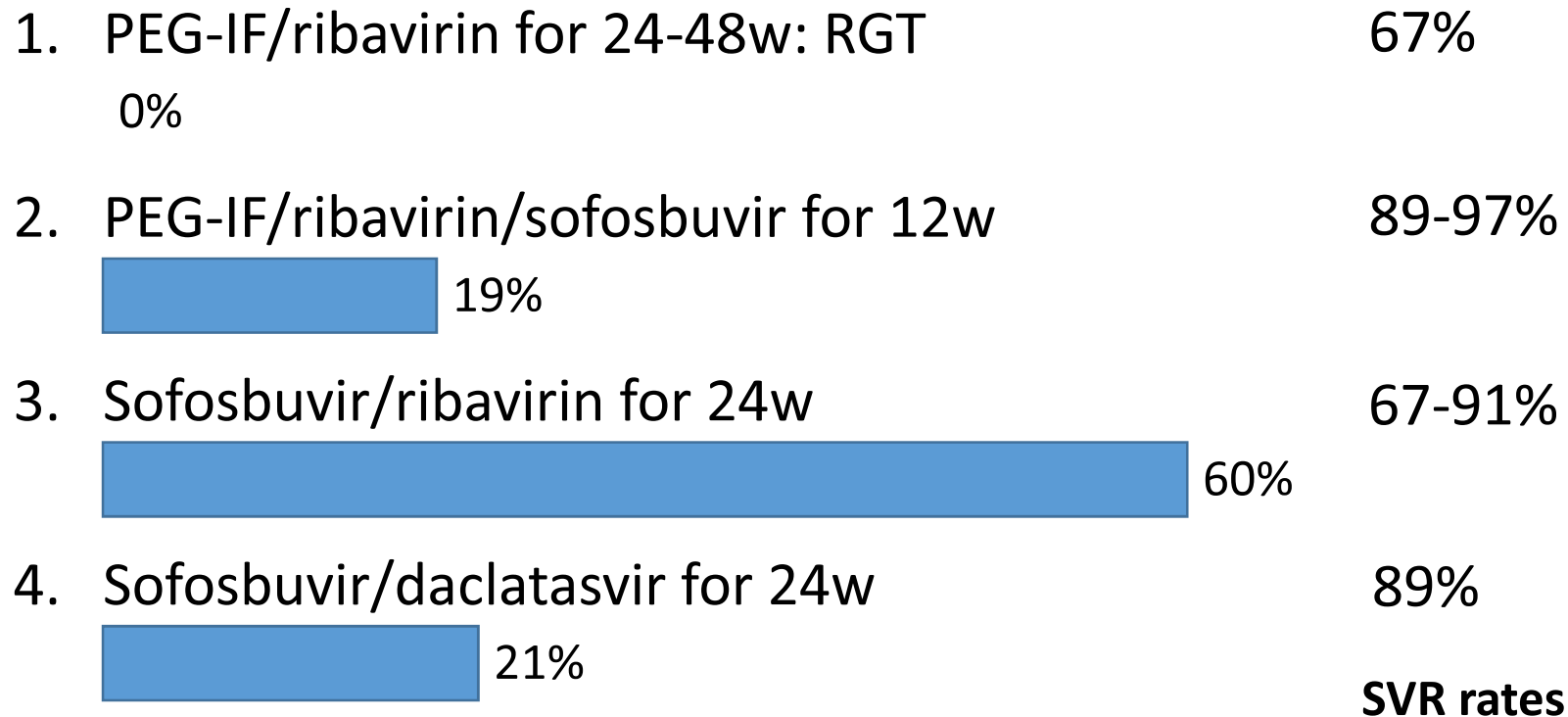
PEG-IF tolerant



RGT = response guided treatment

# Naïve/relapse GT3 – which treatment would you like to be able to give?

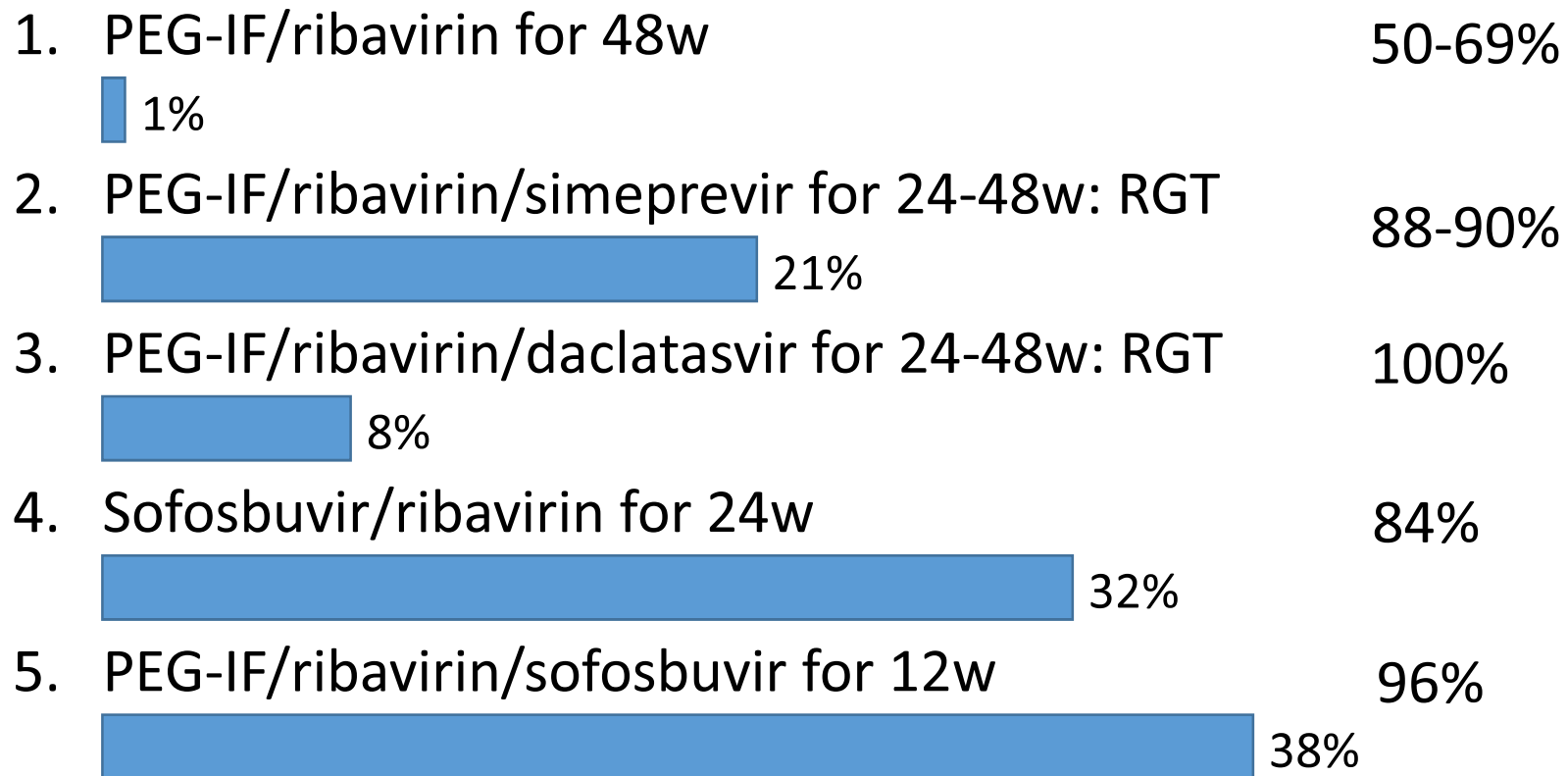
PEG-IF tolerant



RGT = response guided treatment

# Naïve/relapse GT4 – which treatment would you like to be able to give?

PEG-IF tolerant



RGT = response guided treatment

SVR rates



# Recommended first line options

| First line options for treatment |            |                                   | Naïve/relapse | Experienced |
|----------------------------------|------------|-----------------------------------|---------------|-------------|
| GT1                              | Sofosbuvir | PEG-IF and ribavirin <sup>#</sup> | 12w           | NR          |
|                                  |            | Ribavirin                         | 24w           | 24w         |
|                                  |            | Daclatasvir                       | 12w           | 24w*        |
|                                  |            | Simeprevir                        | 12w           | 24w*        |
| GT2                              | Sofosbuvir | Ribavirin                         | 12w           | 12w         |
| GT3                              | Sofosbuvir | PEG-IF and ribavirin <sup>#</sup> | 12w           | NR          |
|                                  |            | Ribavirin                         | 24w           | 24w         |
| GT4                              | Sofosbuvir | PEG-IF and ribavirin <sup>#</sup> | 12w           | NR          |

# PEG-IF tolerant only  
 \* Consider 24 weeks with cirrhosis and/or prior null response to PEG-IFN/R +/- NS3/4 PI

# Recommended second line options

| First line options for treatment |             |                       | Naïve/relapse | Experienced |
|----------------------------------|-------------|-----------------------|---------------|-------------|
| GT1                              | Simeprevir< | PEG-IF and ribavirin# | 24-48w&       | NR          |
| GT3                              | Sofosbuvir  | Daclatasvir           | 24w           | 24w         |
| GT4                              | Daclatasvir | PEG-IF and ribavirin# | 24-48w&       | NR          |
|                                  | Sofosbuvir  | Ribavirin             | 24w           | 24w         |
|                                  | Simeprevir  | PEG-IF and ribavirin# | 24-48w&       | NR          |

# PEG-IF tolerant only  
 < Only GT1b or GT1a/Q80k negative  
 & RGT (response guided treatment)

# Position statement

- The writing committee recognise that availability of drugs and national or local directives may restrict the choice of options
- All patients with HCV/HIV co-infection should be seen in a specialist joint clinic by experienced physicians with a knowledge of HIV and hepatitis C
- Patients with Child-Pugh B and C should be cared for in a transplant networked centre
- All patients should be considered for therapy irrespective of their fibrosis stage
- No patient should receive PEG-IF if ineligible
- Only patients who have relapsed from PEG/RBV therapy should be considered for retreatment with a PEG-IFN containing regimen

# Position statement (contd.)

- Patients with cirrhosis on therapy should be carefully monitored for decompensation irrespective of whether they are receiving PEG-IF
- **DAA(s) should form the backbone of all treatment options irrespective of GT, fibrosis stage, or past treatment status**
- All patients receiving DAA-based therapy or with GT5 or GT6 should be referred to, or be part of a formalised clinical network with, a specialist centre
- All patients should be considered for and have access to clinical trials of DAA-based regimens
- The options for treatment of acute hepatitis C should be discussed with all patients and should cover the benefits of immediate vs. deferred therapy

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