

BHIVA National Clinical Audit of HIV and Hepatitis C Virus (HCV) coinfection

Reynie Raya on behalf of the BHIVA Audit and Standards Sub-
committee

Disclosure

- None

Introduction

- 5-10% of people living with HIV (PLWH) in the UK are estimated to have HCV coinfection¹⁻²
- The availability of direct acting antivirals (DAAs) has accelerated cure rates of HCV infection in the UK
- BHIVA micro-elimination target – 100% of PLWH with HCV to be cured by 2021³

1. Thornton A. (2015). Viral Hepatitis and HIV Co-infection in the UK Collaborative HIV Cohort (UK CHIC) Study. University College London.
2. Ireland, G., Delpech, V., Kirwan, P., et al. (2018). Prevalence of diagnosed HIV infection among persons with hepatitis C virus infection: England, 2008–2014. *HIV medicine*, 19(10), 708-715.
3. <https://www.bhiva.org/BHIVA-calls-for-accelerated-efforts-to-prevent-and-cure-hepatitis-C-infection> - 10 October 2018

HCV coinfection audit 2021

- Part of the annual BHIVA audit programme - initially planned for 2020, but postponed until April 2021 due to COVID-19
- Aims:
 - To audit routine monitoring and assessment of people with HIV/HCV coinfection attending UK HIV care
 - To describe clinical policies for the management of those with HIV/HCV coinfection during the COVID-19 pandemic

Methods

- Clinic survey
 - HIV clinics in the UK
 - Listed in BHIVA mailing list
- Retrospective case-note review
 - Adults aged ≥ 16 years
 - Detectable HCV RNA
- Data collection via online questionnaires May-July 2021

Results: clinic survey



Clinic survey: n= 95



Case-note reviews

Antibody/RNA status of those with HIV/HCV co-infection

HCV Ab+ve: ~4000

RNA+ve: ~5%

DAA: ~3.5%

HCV Ab+ve=83 clinics;
HCV RNA+ve=93 clinics;
approved for or receiving DAA treatment=88 clinics

Clinic management (n=95)

Service management	Regional specialist	15	15.8%
	Coinfection clinic	19	20.0%
	Referred to hepatology service	40	42.1%
	Referred to coinfection clinic	20	21.1%
Repeat HCV treatment	Would be offered	71	74.7%
	Might be offered	10	10.5%
Provision of:	Peer support for HCV	32	33.7%
	Home/ community visit	40	42.1%
Partner notification	HIV and HCV	76	80.0%
	HIV but not HCV	18	19.1%
	Done elsewhere	1	1.0%

Measures taken to encourage HCV treatment

No specific approach

12.0%

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Regular testing	7.2%
Regular targeted testing	5.6%
Regular MDT review	1.6%
Regular engagement and provision	7.2%

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Regular targeted testing	5.6%
Regular MDT review	1.6%
Regular engagement and provision	7.2%
Provision of information	4.8%
Provision of peer support	3.2%
Targeted communication	0.8%
Other support	2.4%

Impact of the COVID-19 pandemic on coinfection

Little/no impact: 56.1%


Some impact: 43.9%

12.1% delayed/reduced monitoring
7.6% delayed treatment initiation
4.5% delayed appointment
7.6% dispense treatment change
6.1% reduce service generally
4.5% switching to telemedicine
1.5% other

Results: case note review



Clinic survey: n=95 clinics



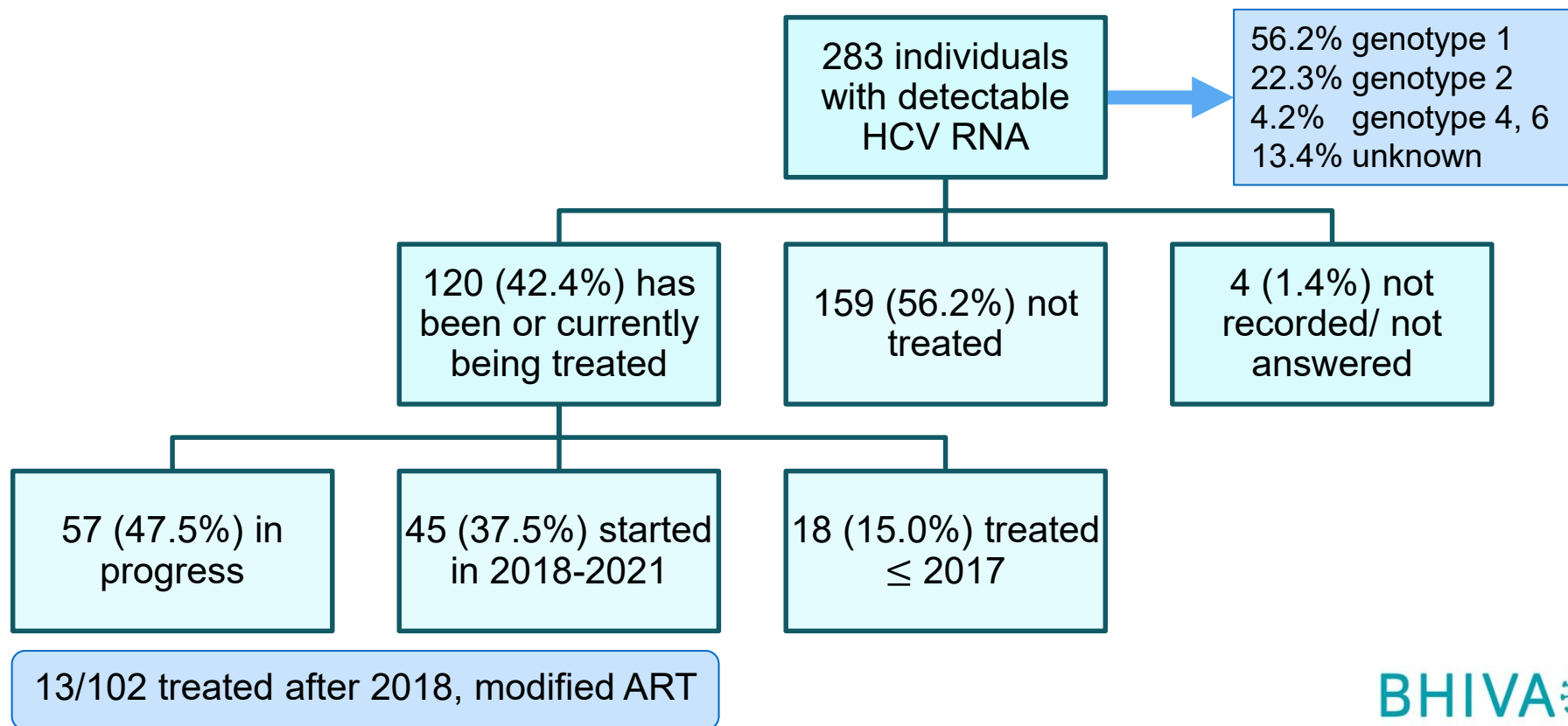
Case-note reviews: n=283 from 74 clinics

Characteristics of those with detectable HCV RNA (n=283)

Median (IQR) age, years	42 (37 – 49)	
Male (including trans)	211	74.6%
Exposure risk for BBV*		
Sex between men	91	32.2%
Sex between men and women	90	31.8%
Injecting non-chemsex drugs	168	59.4%
Injecting chemsex drugs	36	12.7%

* Multiple exposures could be reported

Hepatitis C treatment management



Reason for no HCV treatment (n=159)

	n	(%)
Treatment is currently planned	53	(33.3)
Recently acquired HCV – may clear spontaneously	11	(6.9)
Recently diagnosed and/or re-engaged in care	2	(1.3)
Lost-to-follow-up/switched clinics	1	(0.6)

* Multiple reasons could be given

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Not engaging in care	87	(54.7)
Not contactable	26	(16.4)

* Multiple reasons could be given

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Considered unlikely to adhere well to treatment	10	(6.3)
Likely to be at significant risk of re-infection after treatment	7	(4.4)
Has complex clinical or treatment issues	6	(3.8)

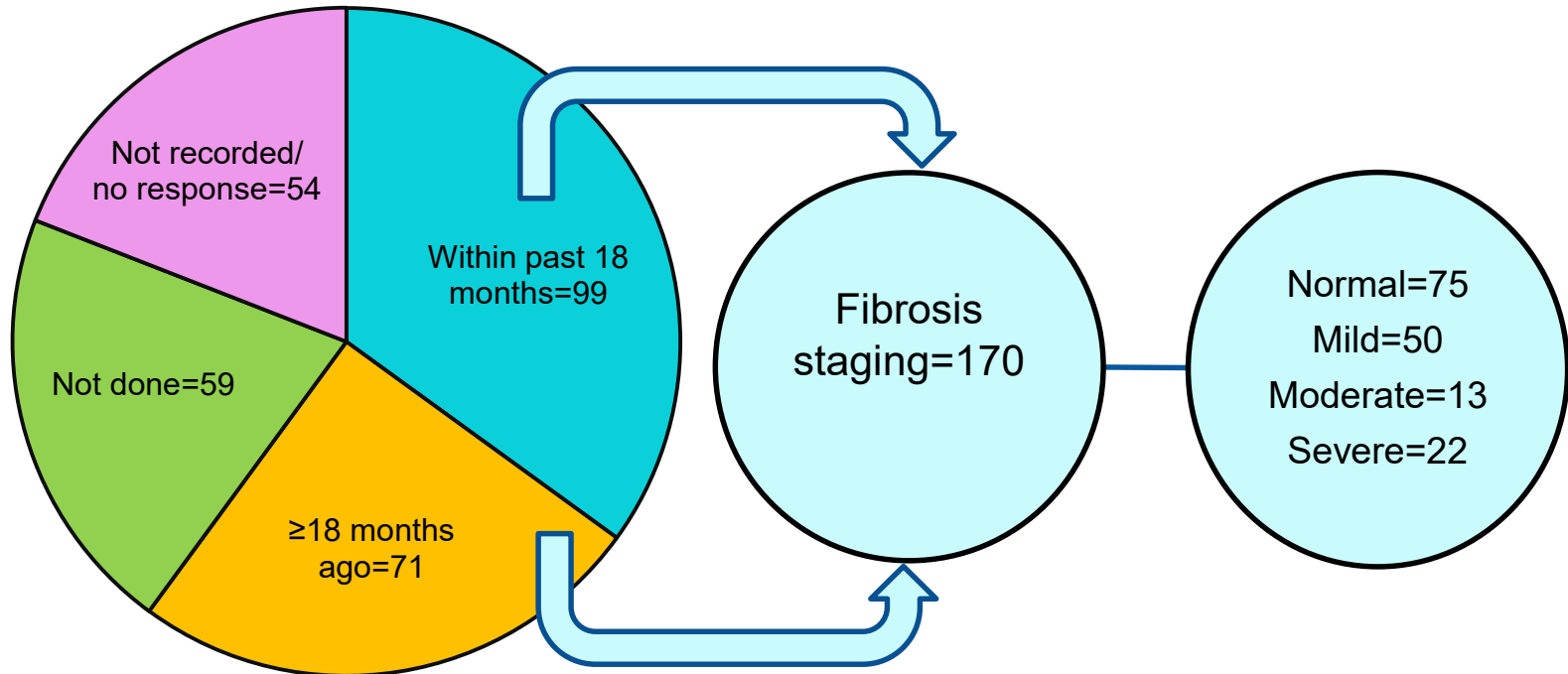
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Has complex clinical or treatment issues	6	(3.8)
Does not wish to be treated	22	(13.8)
Does not believe treatment is effective	2	(1.3)
Believes treatment would be toxic	3	(1.9)

* Multiple reasons could be given

Last assessed for fibrosis (n=283)



Auditable outcomes, those with HIV/HCV coinfection

BHIVA Guidelines 2013	Audit
% of people with documented counselling regarding HCV transmission and safe sex	75.3%
% of those who are successfully immunised for HBV who receive annual or bi-annual anti-HBs screening	91.2%
% of people who have been assessed for staging of liver disease	60.1%
% of those who are HCV viraemic with fibrosis assessment using elastography in the last year	35.0%
% of those who are cirrhotic who have: a) 6-monthly ultrasound	63.6%
b) 6-monthly alpha-fetoprotein	59.1%

Conclusions

- The small number of HIV/HCV coinfecting individuals in the UK should support the micro-elimination of HCV in this country
- Most of those who are HCV antibody-positive have either completed or planned treatment
 - Main reason for continued lack of treatment in the small number who have not been treated, relates to lack of engagement in care
- The challenges of the COVID-19 pandemic have resulted in novel and creative approaches to the way that clinics manage those with coinfection

Recommendations

- Continue to screen for HCV coinfection and re-infection
- Facilitate HCV-related health promotion
- Together with hepatology services:
 - encourage engagement in care and uptake of HCV treatment
 - encourage fibrosis assessment and management of liver disease

Acknowledgements

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