

2023 Spring Conference

Mon 24th – Wed 26th April Gateshead, UK

Microelimination of Hepatitis C among people living with diagnosed HIV in England

James Lester, UK Health Security Agency



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Conflict of Interest

In relation to this presentation, I declare that I have no conflict of interest

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Microelimination of Hepatitis C among people living with diagnosed HIV in England

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24th April 2023

- Microelimination is a pragmatic approach to elimination, concentrating efforts and resources within a particular group or population.
- In 2018 BHIVA set a target to achieve 80/90/100% microelimination of hepatitis C by April 2019/2020/2021 respectively for people living with diagnosed HIV.
- People living with HIV are a key population to target for microelimination of hepatitis C owing to:
 - A higher prevalence of HCV compared to those who are HIV negative.
 - People living with HIV-HCV coinfection facing increased likelihood of complications of HCV infection.
 - Infrastructure for HIV care facilitating the delivery of direct acting antivirals (DAAs)

Methodology

- Using data collected by the comprehensive national HIV and AIDS reporting system (HARS), we
 identified a cohort of 3,172 of 68,974 people seen for HIV care between March 2015 and March
 2016 coinfected with HIV and HCV and living in England.
- Of these, 137 were excluded, 12 of whom had died before April 2016, and a further 125 who were never seen for care after this period.
- 1,045 of the remaining 3,035 could be matched to HCV treatment data.
- For those who could be matched to treatment data, we looked at their latest treatment outcome.
 For those who we could not match, we looked at if they had achieved 28 weeks of viral clearance by the end of 2022.
- We calculated the prevalence of HCV coinfection in those attending HIV services in 2015-2016 overall, and the prevalence of HCV coinfection within this same cohort by the end of 2022.



Results – variation in clearance between clinics



Results – characteristics associated with clearance

Not cleared	d Cleared			
496 (20.7)	1901 (79.3)	White (REF)		
35 (24.5)	108 (75.5)	Black African		
10 (22.7)	34 (77.3)	Black Caribbean	•:	
6 (18.2)	27 (81.8)	Black other		
14 (29.8)	33 (70.2)	Indian/Pakistani/Bangladeshi		
39 (19.0)	166 (81.0)	Other/Mixed		
6 (10.3)	52 (89.7)	Other Asian/Chinese		
30 (29.1)	73 (70.9)	Not Stated		
253 (15.4)	1385 (84.6)	Sex between men (REF)		
179 (34.8)	335 (65.2)	Injecting drug use		
92 (25.5)	269 (74.5)	Sex between men and women		
26 (24.8)	79 (75.2)	Blood/Blood Products		P-value
86 (20.9)	326 (79.1)	Undetermined	·	
18 (20.7)	69 (79.3)	24-34 (REF)†	•	p≤0.05
236 (20.7)	905 (79.3)	34-49	•	– 🔶 p>0.05
299 (20.3)	1177 (79.7)	49-64 †	•	
83 (25.5)	243 (74.5)	65++		
252 (16.7)	1255 (83.3)	London (REF)	•	
32 (21.1)	120 (78.9)	East Midlands	_	
42 (23.9)	134 (76.1)	East of England	:	
9 (18.0)	41 (82.0)	North East		
61 (25.0)	183 (75.0)	North West		
82 (21.4)	302 (78.6)	South East		
41 (31.1)	91 (68.9)	South West		
82 (36.9)	140 (63.1)	West Midlands	· · · · · · · · · · · · · · · · · · ·	
35 (21.5)	128 (78.5)	Yorkshire and Humber	•	
			0.3 1.0 3.0	
			OR (95% CL log scale)	

Results – reduction in prevalence



Results – characteristics of those who did not clear infection by 2022



Limitations

- The HARS HCV field does not specify what evidence is required to categorise an individual as having evidence of HCV, and may not be consistently updated. This could lead to false positives within the initial cohort, and subsequent observations.
- HARS does not collect NHS numbers, so linkage to other datasets must be carried out using less specific identifiers. This likely leads to underestimation of viral clearance.
- HARS completion differs by clinic, which will impact upon how accurately HCV status is recorded and updated, as well as the performance of data linkage.
- HCV treatment data completeness varies significantly by region, which could lead to underestimation of clearance in some regions.
- We do not explicitly consider reinfection within this analysis, and so non-clearance will reflect both those who have not received treatment, and those who have been reinfected following effective treatment.

Conclusions and discussion

- Using conservative definitions for viral clearance, a substantial decline in prevalence was seen in this cohort, with 79% of those who were initially positive showing evidence of SVR or viral clearance by the end of 2022.
- This represents considerable progress despite disruption caused by the COVID-19 pandemic, and is likely to be an underestimate due to reinfection and incomplete data linkage.
- The decline in prevalence was greatest in GBMSM, with 85% clearing HCV by the end of 2022. It was significantly lower in PWID, with 68% clearing HCV.
 - Further action is needed to improve linkage to care for PWID, and to ensure robust access to harm reduction strategies to prevent reinfection.
 - GBMSM no longer comprised the majority of the cohort by the end of 2022, but they did remain the largest group coinfected.
- Ongoing updates to HCV status in HARS are crucial for tracking progress towards microelimination. Future work will include working with clinics to assess the accuracy and completeness of the HCV status field.

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