British HIV Association
BHIVA

BHIVA guidelines for the management of hepatitis viruses in adults infected with HIV 2013

Update September 2014: Consensus statement on the guidelines for treating hepatitis C in patients with HIV

Further update due January 2015

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Consensus statement

Since the BHIVA guidelines for the management of hepatitis viruses in adults infected with HIV were published in January 2014, new data have been presented confirming the benefits of individual direct-acting antivirals (DAAs) with pegylated interferon (PEG) and ribavirin (RBV) and in combination in interferon-sparing regimens for the treatment of chronic hepatitis C (HCV). Several of these have now received European approval and other drugs are likely to be approved later in 2014 or in 2015. This update to the guidelines reflects the current situation and is intended to assist those involved in the management of chronic HCV/HIV co-infection, including patients, in making decisions on treatment. Updates to this guideline will be provided as and when new data become available.

General recommendations

1. The writing group recognise that availability of drugs and national or local directives may restrict the choice of options.
2. All patients with HCV/HIV co-infection should be seen in a specialist joint clinic by experienced physicians with a knowledge of HIV and HCV.
3. Patients with Child–Pugh B and C should be cared for in a transplant networked centre.
4. All patients should be considered for therapy irrespective of their fibrosis stage.
5. No patient should receive PEG if ineligible.
6. Only patients who have relapsed from pegylated interferon/ribavirin (PEG/RBV) therapy should be considered for retreatment with a PEG-containing regimen.
7. Patients with cirrhosis on therapy should be carefully monitored for decompensation irrespective of whether they are receiving PEG.
8. DAAs should form the backbone of all treatment options irrespective of genotype (GT), fibrosis stage or past treatment status.
9. 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.
10. All patients should be considered for, and have access to, clinical trials of DAA-based regimens.
11. The options for treatment of acute HCV should be discussed with all patients and should cover the benefits of immediate versus deferred therapy.

Table 1. Updated recommendations for first- and second-line treatment of HCV in patients with HIV.

First-line options for treatment			Length of treatment (weeks)		References
			Naïve/relapse	Experienced	
GT1	SOF	PEG/RBV[1]	12	NR	[1–3]
		RBV	24	24	[4–6]
		DAC	12	24[2]	[7]
		SMP	12	24[2]	[8]
GT2	SOF	RBV	12	12	[1,5,6,9,10]
GT3	SOF	PEG/RBV[1]	12	NR	[11]
		RBV	24	24	[5,6,9,10]
GT4	SOF	PEG/RBV[1]	12	NR	[1]
Second-line options for treatment			**Naïve/relapse**	**Experienced**	**References**
GT1	SMP	PEG/RBV[1,3,4]	24–48	NR	[12–14]
GT3	SOF	DAC	24	24	[7]
GT4	SMP	PEG/RBV[1,4]	24–48	NR	[15]
	DAC	PEG/RBV[1,4]	24–48	NR	[16]
	SOF	RBV	24	24	[5,6,17]

Notes to Table

PEG: pegylated interferon; GT: genotype; RBV: ribavirin; SOF: sofosbuvir; DAC: daclatasvir; SMP: simeprevir; NR: not recommended.

1. Naïve/relapse and PEG/RBV eligible only.*
2. Consider 24 weeks with cirrhosis and/or prior null response to PEG/RBV +/- NS3/4 protease inhibitor.
3. Only GT1b or GT1a Q80K polymorphism negative.
4. Response-guided therapy (RGT).

*Patients who are ineligible for interferon and ribavirin therapy include those with:

a. Current or prior psychiatric illness, poorly controlled epilepsy;
b. Autoimmune hepatitis or other autoimmune disorders;
c. Major uncontrolled depressive illness;
d. Impaired bone marrow function;
e. A history of pre-existing cardiac disease including arrhythmias;
f. Advanced cardiac, renal or other systemic disease;
g. Decompensated hepatic disease;
h. Hypersensitivity to pegylated interferon or ribavirin;
i. Significant intolerance to interferon with discontinuation because of an adverse event.

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