National Institute for Health and Clinical Excellence

PUBLIC HEALTH PROGRAMME – HEPATITIS B AND C – WAYS TO PROMOTE AND OFFER TESTING
Comments to be received no later than 5pm on 8th August 2012.

Stakeholder Comments

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<th>Name:</th>
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<td>BHIVA</td>
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**Section number**
Indicate section number or ‘general’ if your comment relates to the whole document.

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| Page 7      | We would suggest that best practice guidelines for treating HIV/Hepatitis are additionally added. For guidelines on managing patients with HIV and hepatitis B or HIV and hepatitis C co-infection, please refer to:**British HIV Association guidelines for the management of co-infection with HIV-1 and hepatitis B or C virus 2010**
G Brook, J Main, M Nelson, S Bhagani, E Wilkins, C Leen, M Fisher, Y Gilleece, R Gilson, A Freedman, R Kulasegaram, K Agarwal, C Sabin and C Deacon-Adams on behalf of the BHIVA Viral Hepatitis Working Group*
British HIV Association (BHIVA), BHIVA Secretariat, Mediscript Ltd, London, UK
Keywords: HIV, hepatitis B, hepatitis C, guidelines, treatment
Accepted 27 August 2009
These are in the process of being updated |

<table>
<thead>
<tr>
<th>Page 8</th>
<th>All patients with Hepatitis B and C should be tested for HIV</th>
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<td><strong>Reasons</strong></td>
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<td>• Shared mode of transmission</td>
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<td>• Impact of hepatitis B and C on HIV</td>
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<td>• Impact of HIV on hepatitis B and C</td>
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<td>• Treatment guideline differs in HIV co-infected population</td>
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**British HIV Association guidelines for the management of co-infection with HIV-1 and hepatitis B or C virus 2010**

In addition, awareness programmes should target hepatitis B and hepatitis C and HIV. These awareness programmes should be inclusive and linked.

Please add extra rows as needed

Please return the comments form to: HepatitisB&C@nice.org.uk

*NB: The Institute reserves the absolute right to edit, summarise or remove comments received on during consultation on draft guidance where, in the reasonable opinion of the Institute, they may conflict with the law, are voluminous or are otherwise considered inappropriate.*
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| 3.39 Snorting drugs and sex have been recently recognised as routes for hepatitis C infection about which there is little data. | Page 32 | **Acute HCV infections in HIV positive men who have sex with men**
There is little data outside HIV cohorts and this should be appropriately referenced:


Ghosn J, Deveau C, Goulard C et al. Increase in hepatitis C virus incidence in HIV-1 infected patients followed up since primary infection. Sex Transm Infect 2006; 82: 458–460

Browne R, Asboe D, Gilleece Y et al. Increased numbers of acute hepatitis C infections in HIV positive homosexual men; is sexual transmission feeding the increase? Sex Transm Infect 2004; 80: 326–327


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**Testing / screening**

**HCV**

No mention is given to the frequency of screening for hepatitis C if the test is negative. These are available for HIV infected patients. In addition, HIV infected antibody may take up to a year to become positive, so we recommended performing a pcr test, if the patient presents with abnormal LFT with negative serology and there is no other explanation.

**British HIV Association guidelines for the management of co-infection with HIV-1 and hepatitis B or C virus 2010**

**Recommendations**

All HIV-positive patients with unexplained transaminitis should be evaluated for acute HCV infection (with HCV antibody and RNA testing).

HIV-infected MSM should be tested for HCV antibody on an annual basis.

HIV-infected MSM should be informed about current understanding of acute HCV infection and possible transmission risks.