Identification and management of persons with chronic viral hepatitis in Europe

France

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VHPB meeting "identification and management of chronic viral hepatitis in Europe" 18-19 march 2010, Budapest, Hungary.
Burden of disease (1)

• HCV infection
    • Estimation of HCV ab and HCV-RNA prevalence,
    • Data on risk factors
    • Awareness of HCV infection
  – Modelling of the epidemic: 2004, revised 2009
Burden of HCV infection

- Prevalence varied according to age, country of birth and precariousness
- Number of chronically infected persons: 232,000
- Estimated annual incidence: 2,700 – 4,400
- Number of deaths attributable to HCV (2001): 2,646
Clinical stages of patients newly referred for HCV infection in hepatology reference centres

<table>
<thead>
<tr>
<th>Stage</th>
<th>2001* (n=3906)</th>
<th>2006* (n=2729)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal ALT values</td>
<td>15.4 %</td>
<td>12.1 %</td>
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<tr>
<td>Chronic hepatitis</td>
<td>61.4 %</td>
<td>61.8 %</td>
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<tr>
<td>Cirrhosis</td>
<td>8.1 %</td>
<td>10.0 %</td>
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<tr>
<td>Decompensated cirrhosis</td>
<td>1.2 % (10%)</td>
<td>1.5 % (12%)</td>
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<tr>
<td>Hepatocellular carcinoma</td>
<td>0.7 %</td>
<td>0.9 %</td>
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* 26 centres en 2001, 24 in 2006
Modelling of HCV related mortality: impact of the treatment

ALT-E population: -26% = 16,700

ALT-N population: -14% = 1,000

Year

Annual incidence of HCV-related mortality

S. Deuffic-Burban et al, Hepatology 2009
Burden of disease (2)

• HBV infection
  – No recent epidemiological data since 1990s
  – 1 national cross sectional population-based serosurvey of adults residing in metropolitan France: 2004
    • Estimation of HBs Ag and anti-HBc Ab prevalence
    • data on risk factors
    • Awareness of HBs Ag chronic carriage
  – Mandatory notification of acute hepatitis B: 2004
  – Surveillance network of hepatology reference centres: started in 2008 (in substitution of HCV surveillance)
Burden of HBV infection

• Prevalence:
  – Anti-HBc: 7.3%
  – HBs Ag carriage: 0.65%
    • Men: 1.1%, women 0.21%
    • Strongly related to continent of birth, e.g. Sub-Saharan Africa: 5.25%

• Incidence:
  – 2,580 new infections/year = 4.1/100,000

• Mortality:
  – Number of deaths attributable to HBV (2001): 1,330

• Surveillance network:
  – 78% of newly referred patients come from endemic countries
Screening strategy

• Targets: Populations known to be at risk of infection, in order to:
  – Avoid transmission to household, sexual or occupational contacts
  – Allow earlier access to appropriate care in order to prevent complications (cirrhosis and cancer)

• Goals:
  – achieve a 30 % reduction in HCV/HBV related morbi-mortality (law of the 9/08/2004 relative to Public health policy)
<table>
<thead>
<tr>
<th>Target population</th>
<th>Identification process</th>
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<tbody>
<tr>
<td>• HCV: recommendations of the French Agency of evaluation (2001)</td>
<td></td>
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<tr>
<td>• HBV:</td>
<td></td>
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<tr>
<td>• Pregnant women (mandatory)</td>
<td></td>
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<tr>
<td>• Before proposal of vaccination of at risk populations</td>
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<tr>
<td>• First line: GPs</td>
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<tr>
<td>• Social security medical centre</td>
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<td>• All physicians</td>
<td></td>
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<tr>
<td>• Self-request</td>
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</table>
Screening programme

Implementation

• Campaigns for the general public and health care professionals (media, newspapers, posters)
• Booklets at free disposal for physicians and for patients
• Training programmes
Screening programme

Results

• HCV:
  – Proportion of patients aware of their HCV positivity evolved from 24% in 1994 to 56% in 2004
  – Highest proportion of treated patients among European countries
Proportion of patients aware of their HCV status according to source of infection

F. Dubois, Concours Med 2001
Enquête InVS 2003-2004
Cumulative treatment rate in 21 countries (end of 2005), according to national sources of prevalence

Fig. 4. Country-specific cumulative treatment rate indicating the number of patients ever treated with peginterferons per 100 prevalent HCV cases (HCV prevalence rates in the 21 countries according to national sources: Austria 0.75%, Belgium 1.00%, Czech 0.20%, Denmark 0.70%, Finland 0.60% (estimated from neighbouring countries), France 0.84%, Germany 0.55%, Greece 1.05%, Hungary 0.80%, Rep. Ireland 0.71%, Italy 3.00%, the Netherlands 0.25%, Norway 0.60%, Poland 1.50%, Romania 4.50%, Russia 1.45%, Spain 1.50%, Sweden 0.50%, Switzerland 0.75%, Turkey 1.00%, United Kingdom 0.55%; Overall 1.29%. Source: Muhlberger, 2008, unpublished observations [2]) by country until end of 2005.
Screening programme

Results

• HCV:
  – Proportion of patients aware of their HCV positivity evolved from 24% in 1994 to 56% in 2004
  – Highest proportion of treated patients among European countries

• HBV:
  – Proportion of patients aware of HBs Ag positivity: 46%
Costs of screening programme and the follow up

**Payment of the screening programme**

- **HCV:** screening test is free of charge for individuals, with 100% coverage by the Social Health Insurance
- **HBV:** 65% of the cost of markers used for screening (HBs Ag anti-HBs and HBc Ab) is reimbursed by the SHI; new guidelines and screening algorithm are being developed to allow full (100%) coverage by the SHI

**Payment of follow-up**

- Patients with chronic active liver disease and patients with cirrhosis are eligible to full coverage of their treatment and follow up by the SHI
Treatment strategies (1)

- **HCV:**
  - Reference therapy (PEG-IFN & Ribavirin) can be offered to all patients needing a treatment, following the recommendations of the French Conference of consensus (2002);
  - Indications have been extended to patients with normal ALT, non responders or relapsers to a first treatment;
  - Contraindications to treatment have been progressively reduced with the use of adjuvant treatments.
  - First prescription is restricted to specialists
  - Preliminary eligibility to full coverage by the SHI
Treatment strategies (2)

• HBV:
  – All antiviral drugs currently approved by the EMEA are available in France.
  – First prescription restricted to specialists
  – Patients eligible to full coverage by the SHI

• Follow-up of HCV/HBV treatment
  – shared management by specialists and GPs in order to lighten the burden for hospitals
  – Actually, mainly by hospital specialists
Impact of the screening strategy on the health care system

• Need for:
  – a better network between hospitals, GPs, physicians in special settings
  – Balance between health care system and influx of newly diagnosed patients

• Screening/treatment programme costs a lot
  – Cost of testing
  – If successful, cost of treatment
  – Leading in long term to saving money

• Slight impact on the prevalence of HCV infection
## Evaluation of screening, follow-up and treatment strategy

<table>
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<tr>
<th>Strengths</th>
<th>Challenges</th>
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<tr>
<td>• Good results for HCV:</td>
<td>• Improve the level of HBV diagnosis</td>
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<tr>
<td>• % patients diagnosed</td>
<td>• lead the populations the most at risk to screening:</td>
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<tr>
<td>• % patients treated</td>
<td>• Migrants in regular and irregular situation</td>
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<tr>
<td>• Impact on morbi-mortality already visible</td>
<td>• Drug users</td>
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<td>• Efficient system of surveillance</td>
<td>• Achieve an appropriate management of these patients</td>
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<tr>
<td>• Follow up of the epidemics</td>
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Evaluation of screening, follow-up and treatment strategy

Lesson learnt/ opportunities

- 2009-2012 National Plan for hepatitis B and C:
  - In the continuity of previous plans
  - Reinforce HBV and HCV screening, especially towards migrants, precarious populations and prisoners
  - Actions will be planned at a regional level by the new regional health agencies
  - Committee in charge of the follow-up and boost of the actions
  - Evaluation conducted by the end of the plan period
  - Quantitative goal: 65% and 75% of patients with HBV and HCV infection respectively will be aware of their infection