Identification of patients with chronic hepatitis B/C – the UK

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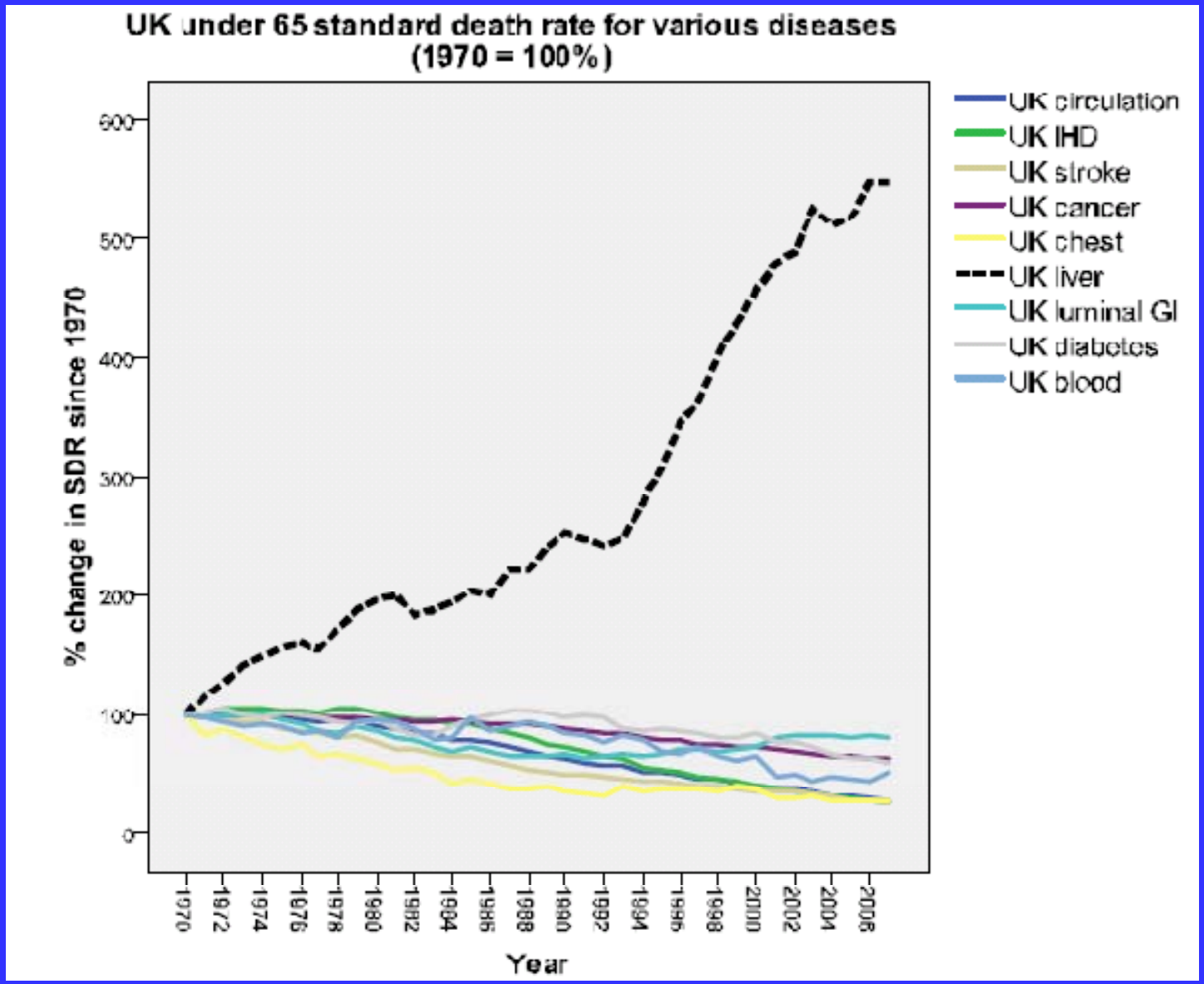
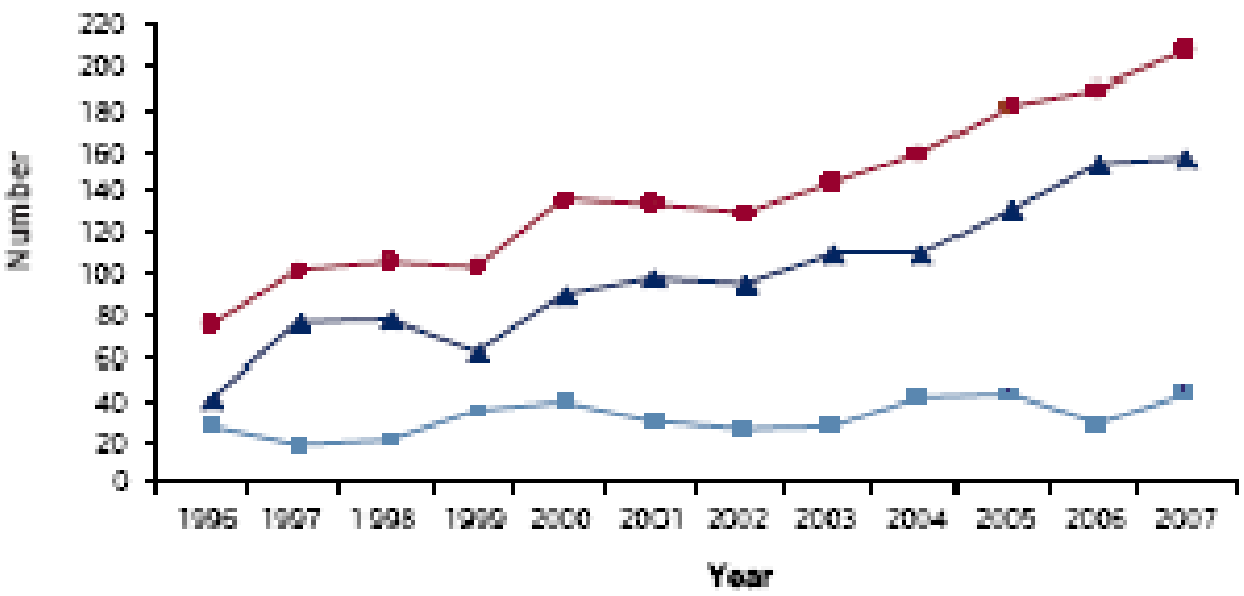
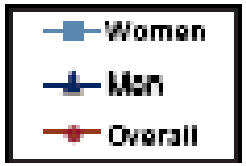

UK under 65 standard death rate for various diseases
(1970 = 100%)
% change in SDR since 1970
600
500
400
300
200
100
0
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
Year
UK circulation
UK IHD
UK stroke
UK cancer
UK chest
UK liver
UK luminal GI
UK diabetes
UK blood

Deaths from end stage liver disease, or HCC, in those with HCV mentioned on their death certificate in England





*Defined by codes or text entries for ascites, varices, or hepatic encephalopathy / failure.
Data source: Office for National Statistics

AGH Working Group Report

- Epidemiology (Global, UK)
- Natural History, Disease Burden (Global UK), Interventions
- Current UK Guidance on Testing
- Recommendations
- Case-Finding Modalities

Chronic HBV infection Epidemiology - UK

- Prevalence 0.3% = 180,000 cases
- 6-7000 new cases per year
- 95% chronic HBV in the UK arises outside the UK
- Evidence of ↑ prevalence in BME
  - Blood donors
  - Antenatal screening
  - BME populations incl Chinese, Somali, Pakistan, Bangladesh

Hahné S et al. Incidence and routes of transmission of hepatitis B virus in England and Wales, 1995-2000: implications for immunisation policy
J Clin Virol 2004; 29:211-220

	To England and Wales	From England and Wales	Net immigration
Migrating persons	300, 820	210, 600	90,220
Estimated no. of migrating persons with chronic HBV infection	9,922	3,351	6,571

Chronic HCV infection Epidemiology - UK

- Chronic HCV – 2-250,000
- HCV epidemic driven by IDU
- Evidence of ↑ prevalence in BME
  - Blood donors
  - Antenatal screening
  - BME populations - Pakistan
- HCV compensated cirrhosis
  - 2005 n = 3705 (95% credible interval: 2870-4975)
  - 2015 n = 7550 (95% credible interval: 5120-11 640)

BME populations in UK

- Estimated 7.7 million
- At least 2 million born in high/intermediate HBV prevalence countries
- Therefore at least 120,000 with chronic HBV
- Evidence that chronic HBV/HCV in BME in UK is more severe
- Why?
  - Infection with more pathogenic genotypes of HBV,
  - Later diagnosis of HCV
  - Higher rates of co-morbidities

Interventions

- Treatment
  - NICE approval for IFN/nucleos(t)ide analgues for HBV
  - NICE approval for PEGIFN/RV for HCV
- Prevention
  - Selective vaccination for HBV

Recommendations

"Individuals from minority ethnic groups living in the UK are at increased risk of dying from the complications of viral hepatitis. In view of the high prevalence of infection in these populations and the highly cost effective interventions that will reduce mortality and morbidity The Working Group makes the following recommendations: "

Recommendation 1 - Case finding for HBV and HCV infections in ethnic minority communities should be instituted to identify and treat those at risk.

Which minority ethnic populations should be targeted for hepatitis case-finding?

? Separate lists for HBV and HCV

? Minimum prevalence cut-off level

Recommendation 2 - Case-finding for both HBV and HCV infection should be targeted to those minority ethnic communities originating from the countries with a high or intermediate prevalence of HBV infection (as defined by WHO).

Within the targeted minority ethnic populations, should there be prioritisation of specific sub-groups?

Criteria considered:

- Immigrant generation
- Age

Recommendation 3 - If prioritisation of case-finding is necessary, this should be targeted at first generation immigrants.

Testing protocol, Care Pathways

- Testing algorithms (i.e. which tests) identified in Appendix
- Care Pathways – HBV/HCV infected individuals should be referred for further assessment and management to an appropriate specialist (details in Appendix)

Contact Tracing

Recommendation 4 - …. extended contact tracing and testing of all contacts for HBV and/or HCV infection should be performed. [This] should include family members (spouse, grand-parents, parents, siblings, and children) and all individuals living in the same household. Contacts who are negative for evidence of HBV infection should be offered HBV immunisation.

Responsibilities for implementation of recommendations

Recommendation 5 - The responsibility for developing and leading on a local strategy for HBV and HCV case-finding should reside with PCTs (or equivalent bodies). This responsibility extends to monitoring and auditing of the implementation of the strategy.

Methodologies for case-finding

- General Population Based Screening Programme
- Systematic Case Finding in High Risk Populations (High risk screening)
- Opportunistic Case Finding
- Voluntary testing session (active case finding)

Tailor the method to fit the situation

Role of PCTs in supporting case finding

- Encouragement of health-care professionals to actively offer testing to individuals who fall within the sub-group of interest (a “top-down” approach)
- Encouragement of individuals within the sub-group of interest to seek proactively appropriate testing (a “bottom-up” approach).

Underpinning both strategies is the need for professional and public education

Support for local health care providers

- What information will primary care professionals need to know?
- How can PCTs engage with primary care professionals?
- What mechanisms exist to support active case finding by professionals?
- Data issues
- Minimising Health Inequality.

Raising awareness in communities at high risk

- What information will ethnic minority populations need to know?
- Engagement with local voluntary services and local community leaders
- Examples of good practice included in Appendix