Acute HCV Infection in an Injection Drug User

CASE PRESENTATION

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FAIRBANKS, AK

Disclosures

- No conflicts of interest to disclose

Curing Disease

- *How many chronic diseases did you **cure** in your practice this year?*

Curing Disease

- Why treat HCV?

Curing Disease

- Why treat HCV?

SVR (cure) associated with:

- 70% Reduction of Liver Cancer
- 50% Reduction in all cause mortality
- 90% Reduction in Liver Failure

Lok A. NEJM 2012; Ghany M. Hepatol 2009; Van der Meer AJ. JAMA 2012

- **HCV cirrhosis risk = 40% over 30 years**
- **Hepatocellular carcinoma (HCC) risk in HCV Cirrhosis = 17% over 5 years**
- **When we cure 30 patients with HCV we will prevent:**
  - **12 cases of HCV related cirrhosis**
  - **2 cases of HCV related HCC**

Compared to another bread and butter primary care treatment:

- **If we treat 104 patients with hypercholesterolemia with statins (For 5 years), we will prevent 1 first time heart attack and ¾ of a stroke**

CASE

- 24 yr old male w/ PMH significant for homelessness, schizoaffective disorder, likely FAS, polysubstance dependence including alcohol, heroin and methamphetamines with recent IVDU.

- Admitted to local psychiatric ward x1.5 mos for ongoing psychosis and suicidal ideation

- Transaminitis during hospital admission, not noted initially by admitting provider
  - 3/17/2018:
    - ALT/SGPT: **470**** (21-72 unit/L)
    - AST/SGOT: **63**** (17-59 unit/L)
    - Alk Phos: **104** (38-126 unit/L)
    - T bili: **0.4** (0.2-1.3 mg/dL)

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  - 3/27/2018: elevated LFT's acknowledged by provider on routine labs
    - ALT/SGPT: **1066**** (21-72 unit/L)
    - AST/SGOT: **132**** (17-59 unit/L)
    - Alk Phos: **124** (38-126 unit/L)
    - T bili: **0.3** (0.2-1.3 mg/dL)

3/27/2018

- Creatinine 0.96, BUN 20
- Hemoglobin 14.1, hematocrit 43.6; Platelets 235
- INR 1.0, PT 12.5

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- HCV Ab: ***Reactive***
- HCV RNA: ***17,700 IU/mL***
- HCV ***Genotype 1a***
- Hep A IgM Ab: Negative
- Hep Bcore IgM: Negative
- Hep BsAg: Negative

3/27/2018

- Negative US abdomen

3/27/2018

- Negative US abdomen

- Transaminitis thought possibly secondary to adverse drug reaction to Abilify as enzymes nearly normalized in subsequent days after discontinuing medication
- HCV infection presumed chronic.

- Discharged to half way house about one week later.

- CAIHC Clinic:

Hospitalization follow up appointment 4/10/18

  - Pt in safe and sober living environment with medication administration assistance
  - Pscyhiatric status somewhat improved, no active suicidal ideation, occasionally responding to internal stimuli, and reports intermittent hallucinosis.
  - No physical complaints, exam normal

- 6 pm call from lab with critical values:
  - ALT/SGPT: **742**** (21-72 unit/L)
  - AST/SGOT: **1908**** (17-59 unit/L)
  - Alk Phos: **159** (38-126 unit/L)
  - Normal bili, PT/INR, platelets.

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  - **CT a/p negative for thrombosis/infarct, normal hepatobiliary tracts, normal liver, small 9 mm porta hepatic node, no ascites**

- HIV-1 antigen, HIV-1/HIV-2 Ab: **not detected**
- Liver, kidney microsome Ab: **negative**
- CMV Ab: **not detected**
- EBV IgM: **negative**
- ANA: **negative**
- IgG: **wnl**
- Smooth muscle Ab: **negative**
- Ferritin: **wnl**

- Is this patient a good candidate for HCV treatment?

- Why not treat?
- Why treat?

- APRI= 0.42
- FIB-4= 0.24
- MELD= 9
- Child-Pugh= 5(A)

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- **Genotype 1a**, treatment naïve
- **Mavyret** (glecaprevir/pibrentasvir) 300 mg/120 mg 3 tablet po QD with food x 8 weeks

- As of 10/08/2018:
- Continues to live at half way house
- Transaminitis resolved
- HCV RNA: ***not detected***