Acute HCV Infection in an Injection Drug User

CASE PRESENTATION
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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

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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)
Transaminitis during hospital admission, not noted initially by admitting provider

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- ALT/SGPT: 470** (21-72 unit/L)
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- Alk Phos: 104 (38-126 unit/L)
- T bili: 0.4 (0.2-1.3 mg/dL)

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
3/27/2018

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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
- Psychiatric 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 bilirubin, PT/INR, platelets.
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 bilirubin, PT/INR, platelets.

- 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)

- Genotype 1a, treatment naïve
APRI= 0.42
FIB-4= 0.24
MELD= 9
Child-Pugh= 5(A)

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