

Hepatitis C micro-elimination among people on opioid agonist therapy is a low-hanging fruit

Bruggmann Philip^{abc}, Maeschli Bettina^b

^a Arud Centre for Addiction Medicine, Zurich, Switzerland

^b Swiss Hepatitis, Zurich, Switzerland

^c Institute of Primary Care, University of Zurich, Switzerland

In Switzerland, hepatitis C (HCV) claims as many lives each year as road traffic accidents do [1]. Those affected by this chronic viral disease have an increased risk of a number of serious medical conditions inside and outside the liver. Today, HCV can be treated with very high success rates and without severe side effects with one to three tablets per day over 8 to 12 weeks. The antibody test is simple and inexpensive, and virus detection in the case of positive antibodies is a reliable and established procedure. The cost for both diagnostics and therapy, are covered by the mandatory health insurance.

The requirements for the elimination of hepatitis C are therefore fulfilled. Accordingly, the Swiss Hepatitis Strategy, a network of dedicated specialists, have set themselves the goal of eliminating HCV in Switzerland by 2030, which is in line with the World Health Organization 2030 agenda. However, a study now published in *Swiss Medical Weekly* by Schürch et al. on the HCV cascade of care among patients in opioid agonist therapy (OAT) shows that Switzerland is not yet on track to meet this target [2].

People who use drugs are badly affected by chronic hepatitis C. As a result of the pragmatic national drug policy in Switzerland, the majority of persons with an opioid dependency are on OAT and therefore in the healthcare system. For years, national guidelines have recommended that all OAT patients be regularly tested for hepatitis C and, if tested positive, referred for treatment [3]. The latest guidelines by the Federal Office of Public Health FOPH and Infodrog (its Office for the Coordination of Addiction Facilities) recommend that people who use drugs be tested for HCV every year [4]. If a chronic infection is detected, the guidelines urge healthcare providers to immediately integrate those patients into care. These measures not only provide high-quality care for OAT patients, but also prevent new infections within this high-risk group. Therefore, the question arises: Why do we not perform better in providing HCV care for OAT patients?

As Schürch et al. show, the problem lies mainly with the decentralised setting of OAT [2], with patients receiving OAT from their general practitioner. Otherwise, effective management of HCV care would be possible, as the case of the HCV cohort presented shows. The deficiencies in the HCV cascade of care through this decentralised setting

are, in our opinion, a direct result of the fact that public health authorities and politicians underestimated and neglected hepatitis C for a long time.

Viral hepatitis was always overshadowed by human immunodeficiency virus (HIV), despite the fact that its burden of disease is not less severe. In the past, the consequences of a chronic infection with viral hepatitis were downplayed and viral hepatitis, in contrast to HIV, was never perceived as a threat to the general public [5]. We are now paying the price for this lack of awareness: the gaps in the cascade of care and the significant mortality rate among OAT patients are direct consequences of this neglect. In light of the highly effective antiviral treatment available, liver cirrhosis and liver cancer, as well as deaths from viral hepatitis, should be at a very low rate. Yet they are not. Apparently, the good news regarding the new and well-tolerated medication and of the latest research confirming the danger of hepatitis C outside the liver has not yet reached the majority of OAT patients.

However, we should now continue to add momentum and build effective centralised care structures as described by Schürch et al [2]. A key instrument will be the integration of viral hepatitis into the next national HIV programme starting in 2022. The Swiss national parliament and the federal council recently passed an according motion [6]. This will allow us to coordinate the activities and resources necessary for the goal of elimination. Since viral hepatitis and HIV have similar transmission routes and are prevalent in the same high risk groups, combining efforts to eliminate both viral hepatitis and HIV will allow us to take advantage of synergies with respect to awareness, education and easy access to tests and treatment: a win-win situation.

In the meantime, we should look to improve HCV care in the existing decentralised setting. Already in place is HepCare, a project of the association Swiss Hepatitis, which aims to strengthen the role of general practitioners and psychiatrists in HCV care [7]. As the prescription of the direct acting antiviral medication (DAA) is still restricted to specialists, HepCare enables general practitioners and psychiatrists to treat their HCV patients themselves without having to refer them to a specialist. This can make a big difference since general practitioners often have established a trust-based relationship with their OAT patients.

Correspondence:

Philip Bruggmann, MD,
Arud Centre for Addiction
Medicine, Schützengasse
31, CH-8001 Zurich,
[p.bruggmann\[at\]arud.ch](mailto:p.bruggmann[at]arud.ch)

The specialist will issue the prescription based on a file consultation, thus offering easy access to treatment. We should also discuss lowering the threshold for HCV counselling, testing and treatment, for example through services in pharmacies, where many OAT patients regularly collect their opioids, in psychiatric wards and prisons.

In conclusion, micro-elimination of HCV among OAT patients is possible if we manage to create more awareness among both patients and medical staff, and if we can establish easily accessible services in a well-defined setting. HCV micro-elimination in this vulnerable population group is within reach. Picking this low-hanging fruit will be a crucial step towards the elimination of HCV in Switzerland by 2030.

Financial disclosure

No financial support was reported.

Potential competing interests

PB has received project, research and travel grants, as well as speaker honoraria, from Abbvie, Gilead and MSD.

References:

- 1 Keiser O, Giudici F, Müllhaupt B, Junker C, Dufour JF, Moradpour D, et al.; Swiss Hepatitis C Cohort Study and the Swiss National Cohort. Trends in hepatitis C-related mortality in Switzerland. *J Viral Hepat.* 2018;25(2):152–60. doi: <http://dx.doi.org/10.1111/jvh.12803>. PubMed.
- 2 Schüreh S, Fux C, Dehler S, Conen A, Knuchel J, Friedl A, et al. Management of hepatitis C in opioid agonist therapy patients of the Swiss canton Aargau within and outside the cohort study. *Swiss Med Wkly.* 2020.;150:w20317. doi: <http://dx.doi.org/10.4414/smw.2020.20317>. PubMed.
- 3 Beck T, Bruggmann P, Haemmig R, Caflisch C, Falciato L, Fink A, et al. Medizinische Empfehlungen für Opioidagonistentherapie (OAT) bei Opioidabhängigkeits-Syndrom 2020. Bern: SSAM; 2020.
- 4 Federal Office of Public Health Switzerland. Hepatitis C bei Drogenkonsumierenden. Richtlinien mit settingsspezifischen Factsheets. Bern: 2019. https://www.infodrog.ch/files/content/hepc_de/richtlinien-hepatitis-c-drogen-de-2019.pdf
- 5 Kind J, Maeschli B, Bruggmann P. Im Schatten von HIV: Das “Aschenbrödel” Hepatitis C. *Suchtmedizin.* 2019;21(3):103–10.
- 6 Müller D, Dittli J, Eder J, Ettlin E, Janiak C, Stöckli H. Motion 19.3743: Die Eliminierung von Hepatitis gehört in ein Nationales Programm sexuell und blutübertragbarer Infektionskrankheiten. In: EDI, editor. Bern: Die Bundesversammlung - das Schweizer Parlament; 2019.
- 7 Hepatitis Schweiz. The HepCare Project: Swiss Hepatitis; 2020: www.hepcare.ch.