Improving Outcomes in the Treatment of Opioid Dependence

16th Annual Meeting
15–16 May 2018, Madrid, Spain

ACHIEVING HCV ELIMINATION

Highlights report

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Achieving HCV elimination

Introduction

The 16th annual 'Improving Outcomes in the Treatment of Opioid Dependence' (IOTOD) conference took place at the Hilton Madrid Airport hotel on 15–16 May 2018. The two-day event succeeded in delivering what IOTOD is well known for: expert presentations and thought-provoking discussions on a range of key issues in the field of opioid dependence, from cutting-edge treatment research to the latest harm reduction trends.

For the third year in a row, the IOTOD conference dedicated an entire session to hepatitis C virus (HCV). The need for HCPs, especially those who work with people who use and inject drugs (PWUD/PWID), to be proactive about eliminating HCV was passionately emphasised throughout the session. In addition to this urgent call to action, the expert speakers provided the latest updates in the field and numerous evidence-based and pragmatic recommendations, demonstrating the feasibility and simplicity of curing HCV.

These nuanced and thought-provoking discussions earned the session, chaired by Professor Foster, overwhelmingly positive feedback, with many delegates committing to implement meaningful changes to their clinical practices. The IOTOD interactive technology showed an average of **87% committed to making a change that contributes to eliminating HCV.**

This report summarises the key educational messages and opportunities discussed during the IOTOD 2018 HCV session.

Commitments to change

Achieving HCV elimination

Following IOTOD 2018, I will...	Percentage of delegates
Screen every new patient for HCV	**95%**
Discuss different HCV therapy options with my opioid-dependent patients diagnosed with HCV	**84%**
Ensure HCV care is provided in my clinic	**76%**
Liaise with key stakeholders to optimise the HCV treatment journey for my opioid-dependent patients	**92%**

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Professor Graham Foster
Queen Mary University of London, UK

Why bother?

HCV elimination: an extraordinary opportunity

Professor Foster opened the much-anticipated HCV session with a clear message: 'We have an extraordinary opportunity with the new generation of HCV treatments. These treatments have, for the first time, engaged policy makers in seeing people with addiction as a group deserving of and needing treatment. **We must now take advantage of this extraordinary opportunity because it may not come again.**'

The urgency of acting now to eliminate HCV instantly set the tone of the session, and Professor Foster dedicated his talk to HCV care for PWID, a group at high risk of being infected. In response to the question 'why bother about HCV?' he provided robust evidence and lessons from his own experience to passionately convince the audience (and everyone in this field) that they really must bother. As Professor Foster argued, not bothering is simply inexcusable.

Key highlights

Kicking off his talk, Professor Foster delivered an uncomfortable but necessary reminder of what is at stake if HCV care is ignored: 'If you don't test and treat your patients, sooner or later, they will get cirrhosis, they will get cancer, and they will die.'

Letting HCV care slip is no joke, and Professor Foster drew on data from the US and Russia to prove this. Limiting or denying access to HCV treatment has resulted in a catastrophic HCV epidemic and a tremendous burden of disease that will haunt the countries in years to come. This is a tragic yet clear picture of what happens when stakeholders 'don't bother'.

And what happens when people do bother? Reflecting on the positives, Professor Foster commented on the astonishing benefits of treating PWUD. Evidence has found that just treating one PWUD leads to a dramatic reduction in HCV prevalence, as this prevents them from infecting others. In addition, recent findings suggest treating PWUD results in enormous cost savings to the healthcare system.

Opportunities to test PWUD for HCV every time they engage with services must be seized. Not only does screening contribute to sweeping HCV away, it also has tremendous benefits to PWUD: it engages people and offers them hope. As Professor Foster affirmed, 'HCV testing is a doorway to better care.' Increased testing is an area HCPs must improve on as **57% of the IOTOD delegates reported screening 100% of their last five substance-using patients.** While this is a significant step in the right direction, more work clearly needs to be done (figure 1).

Swiftly offering pragmatic solutions to existing barriers, Professor Foster highlighted the need for better education of the HCV treatment landscape among HCPs and PWUD. One specific myth that Professor Foster felt needed to be obliterated is the misconception that HCPs must prioritise their patients' opioid dependence and substance use before treating HCV. As he affirmed: **'We wouldn't tell a diabetic patient we're not going to treat their cardiac problems until they get their sugar levels under control.** We need to abolish these barriers

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and unnecessary hurdles. This is pure bias and we shouldn't allow our clients to be mistreated this way.' Peer support groups, a reduced care pathway and HCV awareness posters in clinic waiting rooms, were some of the additional solid recommendations Professor Foster urged the audience to act on.

Moving forward, Professor Foster commented on the consistent findings from studies that PWID adhere to their treatment and achieve high cure rates. With this data, and given the extraordinary individual and public health benefits and opportunities of HCV care, it is inexcusable for HCPs to believe HCV is not their problem. In actual fact, it is everyone's problem.

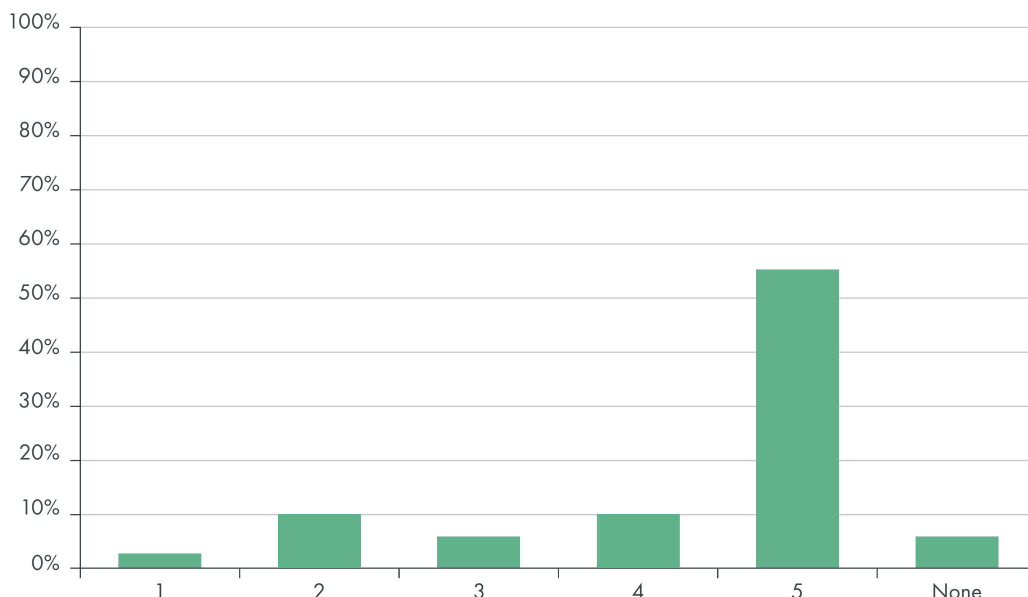
Ending his talk with a powerful call to action, Professor Foster summarised why HCPs should not disregard HCV care: 'We need to bother because it's *our* problem, *our* clients, *our* people who are going to die. It is our problem and we can fix it. **We have the tools, so let's get on with it and do it.**'

Delegate feedback

- Positive rating of the talk: **100%**
- Commitment to change clinical practice based on the talk: **95%**

'Made a lot of useful contacts of people who want to help with the HCV elimination plan in the UK'
IOTOD 2018 delegate

Figure 1. Outcomes of delegates' answers to the question: Of the last 5 patients you accepted into treatment for substance use, how many did you screen for hepatitis C? Please enter a number between 1 and 5 or select 'none'.



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Dr Marc Bourlière
Hôpital Saint Joseph, France

HCV treatment options

The many revolutions of HCV treatment

The HCV treatment landscape has progressed dramatically; in less than a decade, suboptimal medications with extremely unpleasant side effects have been replaced with a new generation of highly effective and well-tolerated direct-acting antiviral (DAA) treatments.

Keeping up with these speedy developments may seem challenging, yet Dr Bourlière wasted no time in reassuring the audience that the current landscape was overwhelmingly simple: in just three minutes, he summarised his entire talk before pretending to the leave the stage. He did, however, return and deliver his impressively comprehensive yet succinct account of HCV treatment and the story of its many revolutions.

Key highlights

After reiterating the extraordinary long-term health benefits of curing HCV, Dr Bourlière reflected on **'the fantastic history of treatment'**. It's the success story many have heard before: the largely ineffective and painful interferon-based treatments were once the only option for HCV, but breakthroughs in the field mean these have been replaced by DAAs, effective and well-tolerated treatments (figure 2).

The initial advances hugely benefited those with HCV genotype 1, the most common genotype in Western Europe. A further milestone was achieved by demonstrating the high efficacy of these medications in PWID, with outcomes similar to other populations. These findings were significant, as they meant injecting drug use should not be a criterion excluding people from treatment. However, curing HCV genotype 3 remained a challenge, and genotype testing itself involves a separate test that further lengthens the HCV care pathway.

Moving swiftly through the timeline of breakthroughs, Dr Bourlière introduced the solution to the genotype challenge: pangenotypic treatments. With overwhelmingly positive cure rates across all genotypes, even genotype 3, sofosbuvir/velpatasvir and glecaprevir/pibrentasvir further revolutionised the landscape. In addition, they are highly effective regardless of patients' cirrhotic status and treatment history.

With treatments boasting extraordinary cure rates of ~ 96–99%, Dr Bourlière posed a thought-provoking question: 'What about the ~ 3% patients who fail these regimens?' This issue cannot be ignored because current estimates show 47,000 individuals in Europe will have failed to achieve sustained virologic response (SVR) with these medications by 2020.

In the past year, innovation has struck yet again in the form of rescue therapies. Both sofosbuvir/velpatasvir/voxilaprevir and sofosbuvir+glecaprevir/pibrentasvir have achieved 96–98% SVRs for all patients, including those that had failed previous treatments. This has dramatically advanced the treatment landscape even further, since achieving SVR is no longer a challenge, and Dr Bourlière discussed recent guideline updates reflecting these new advancements.

Setting the scene for the next talk, Dr Bourlière urged the audience to remember these treatments

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will not automatically lead to elimination: efforts must be made to increase HCV screening and treatment uptake, and the IOTOD audience will play a key role in this.

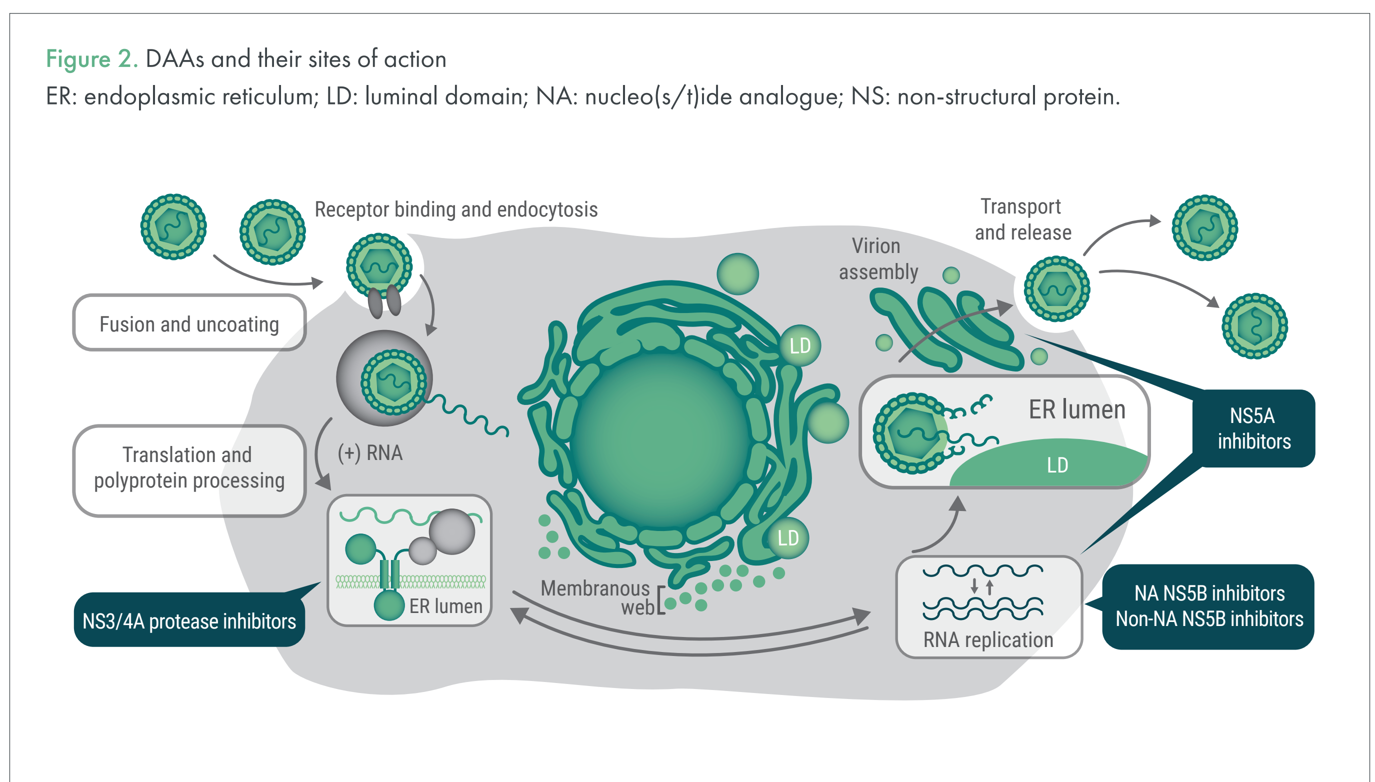
Finally, Dr Bourlière returned to the theme of his talk: simplicity. By summarising the current treatment landscape and conveying its simplicity, Dr Bourlière hoped **the audience would walk away not just knowing how to describe these medications, but with the competence to treat their patients diagnosed with HCV.**

Delegate feedback

- Positive rating of the talk: **99%**
- Commitment to change clinical practice based on the talk: **84%**

> 'Wonderful conference with relevant and clinically-based talks'
> IOTOD 2018 delegate

Figure 2. DAAs and their sites of action
ER: endoplasmic reticulum; LD: luminal domain; NA: nucleo(s/t)ide analogue; NS: non-structural protein.



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Professor Olav Dalgard
Akershus University, Norway

Optimising the patient pathway

Redefining tradition, optimising the HCV care pathway

Yes, highly effective treatments are now available. No, the healthcare community cannot pack their bags and leave the show; a lot of work remains to be done. This was Professor Dalgard's powerful yet simple take-home message; at present, treatment uptake is low among PWID and HCPs must work to increase it. This is imperative for achieving HCV elimination.

Having identified low HCV test rates in PWID and the standard lengthy HCV care pathway as significant barriers to treatment, Professor Dalgard swiftly moved on to equipping the audience with practical tools to engage with PWID and **redefine the traditional HCV pathway.**

Key highlights

Opening the final talk of the session, Professor Dalgard captured the current HCV landscape with some unsettling data: of the estimated 3,200,000 HCV-infected individuals in Europe, 1,180,000 are diagnosed and only 150,000 receive treatment. Given the unnecessarily lengthy HCV care pathway,

Figure 3. The standard HCV care pathway involves multiple referrals and week-long waits, leading to high drop-out rates. There is clearly a need to shorten the HCV care pathway, ideally to a same-day diagnosis and prescription of treatment.

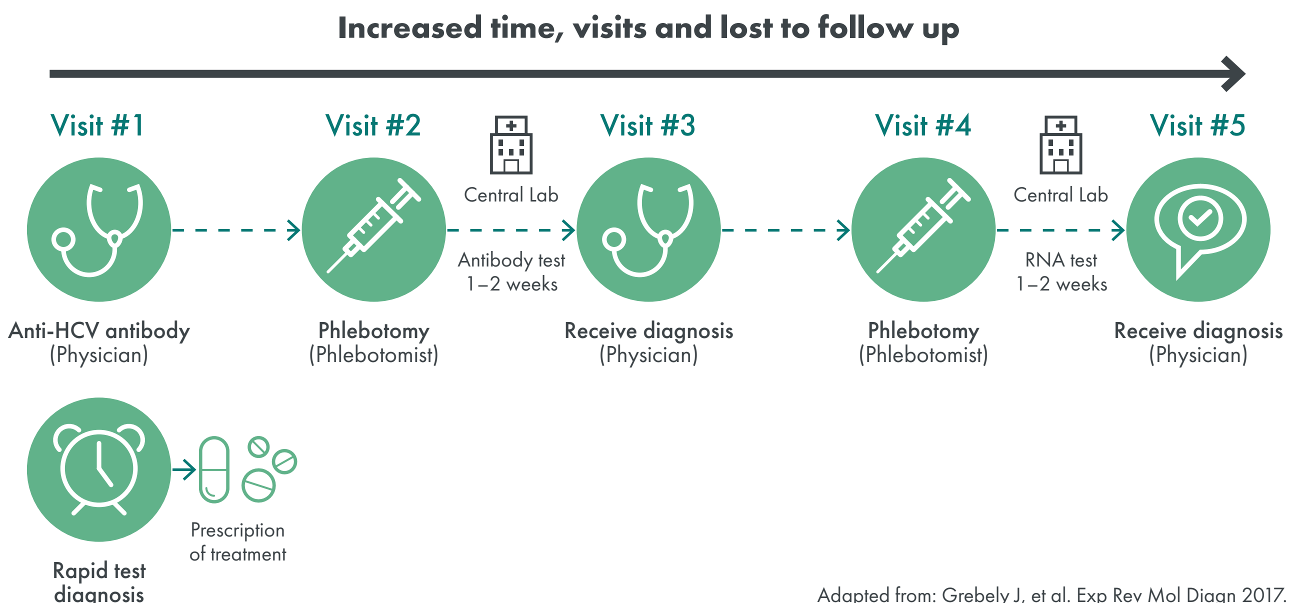

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Figure 4. Traditionally, receiving treatment has required referrals to specialised centres. Due to the high drop-out rates this results in, many HCPs are working to redefine tradition by bringing HCV care into the community.

Images courtesy of Jason Grebely.

in which even receiving a diagnosis involves week-long waits and multiple referrals, this is perhaps unsurprising (figure 3).

The reality of the problem has been further elucidated by studies showing low HCV diagnosis rates among HCV-infected PWID, highlighting the need to increase uptake of HCV testing in this population. As Professor Dalgard emphasised, this will not be achieved with the HCP community passively waiting for PWID to ask for testing – many are unaware of the consequences, will have other priorities and/or may be reluctant to engage with HCPs due to past discrimination faced in services. Citing several studies, Professor Dalgard showed how file-tagging at-risk patients, onsite shelter testing and dried-blood spot tests in drug clinics and prisons have successfully increased HCV diagnoses when compared with no interventions.

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Simplified and rapid diagnostics will be valuable tools and Professor Dalgard discussed the potentials of rapid antibody detection, dry blood spots and point-of-care testing. Although cost should be considered, their high sensitivity, specificity and short result waiting times make these tests a tremendous improvement from the previous week-long waits between tests and results.

However, as Professor Dalgard quickly pointed out, simplifying diagnoses solves only part of the problem as, traditionally, HCV care has been restricted to specialised centres. There is no doubt that referrals for treatment prescriptions, which are rarely same-day appointments and often require travel to inconveniently-located facilities, contribute to high drop-out rates. **'We must redefine the traditional HCV care pathway'**, urged Professor Dalgard. Now that highly effective treatments have been developed, it is imperative to bring them into the community, to PWID (figure 4) – an approach strongly supported by evidence and Professor Dalgard's wealth of experience working in both specialist and low-threshold clinics.

Moving on, Professor Dalgard discussed clinician-level barriers, including strong reluctance to treat PWID, which is partly fuelled by the widespread beliefs that PWID do not achieve SVRs and that treating this population will mean high reinfection rates. Addressing these misconceptions, Professor Dalgard drew on data showing 94% SVRs among PWID – similar rates to the non-injecting population. Regarding reinfection rates, Professor Dalgard argued that reinfection rates above those of the interferon era are a positive sign and actually indicate more people are being treated, including those not already engaged in services: 'I will not be happy until I see reinfection rates at about 10%'.

Optimal harm reduction coverage is also imperative: combining needle and syringe exchange programmes with opioid agonist treatment has resulted in a 74% reduction in HCV infection risks, and Professor Dalgard urged the audience to not forget harm reduction's role in HCV elimination.

Having addressed multi-level barriers and provided a range of evidence-based solutions, Professor Dalgard finished his nuanced talk with a simple reminder and call to action: 'a large proportion of people, especially PWID, are not accessing HCV care, so **let's optimise the patient pathway, improving uptake to testing and linkage to care.'** The IOTOD audience are, after all, now in a position to achieve this and ensure all their HCV-infected patients receive the cure they deserve.

Delegate feedback

- Positive rating of the talk: **98%**
- Commitment to change clinical practice based on the talk: **84%**

Discussion key highlights

During the Q&A and case study discussions, various topics were debated among the speakers and delegates. These included HCV in pregnancy, outreach in prisons and inpatient drug clinics, country-wide solutions mindful of healthcare infrastructures and point-of-care tests.

The notable distinctions between men who have sex with men (MSM) and PWUD were also described, with Professor Foster affirming: 'There is a very big divide between services provided to MSMs and services provided to PWUD. **I don't draw a distinction, everyone needs high-quality care regardless of their lifestyle.'**

Summarising the talks of the day, Dr Bourlière finished the session with a call to action: 'We have the tools and it's our task to cut this epidemic. **HCV care is a revolution, we've made it simple, the tools there, so let's do it.'**

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