Introduction of combined Hepatology/ addictions advanced fibrosis clinic leads to high attendance rates amongst a cohort with a history of failure to engage with service

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Introduction

Direct acting anti-virals (DAA's) make treatment for Hepatitis C (HCV) in community settings easier.

In our institution patients with a Fibroscan reading of F0-2 disease may be treated by nurses following multi-disciplinary team (MDT) discussion. However, those with F3/4 disease or eligible only for an interferon containing regime (F0-2 Genotype 3 patients) require consultant review.

Hospital out-patient attendance rates are historically poor.

Aims

We initiated a pilot community addictions advanced fibrosis clinic with a view to:

* Engaging difficult to reach patients with advanced fibrosis in specialist care.

* Treating such patients in a community setting.

Methods

Patients with known F3/4 fibrosis from previous investigations /partial assessment, or requiring assessment for interferon, were offered transfer of their opiate replacement therapy (ORT) to a dedicated combined clinic.

Initial assessment by Liver Nurse Specialist (LNS);

* Education
* Blood tests
* Fibroscan
* Ultrasound referral

Then Hepatology review at monthly consultant clinic.

Following consultant clinic if patient suitable they would be referred back to LNS for initiation of HCV treatment.

Appointments were arranged so that LNS clinic, Consultant clinic and addictions reviews coincided with ORT prescriptions.

Support and encouragement to attend for necessary hospital based appointments (endoscopy/ultrasound) was given by all staff involved.

To help facilitate attendance bus passes were provided for patients with transport difficulties.

Results

Attendance:

Between November 2016 and July 2017 – 36 patients attended for LNS assessment, of whom 32/36 (89%) attended for consultant appointment. These patients had a history of failing to attend for hospital based appointments, with 145 (66 consultant, 79 nurse) previous missed appointments for HCV assessment/care.

Patient characteristics:

All patients were either GT1a (11, 34%) or GT3 (21, 66%).

18 (56%) had advanced (F3/4) fibrosis. 4 (12%) of those patients had decompensated liver disease (3 Child's B, 1 Child's C) and had failed to engage with hospital based services.

The patient with Childs Pugh C died in hospital prior to commencing treatment.

8 (25%) had a history of concomitant alcohol misuse

24 (75%) reported active drug use (9, 38% were both injecting and non-injecting, while 22, 92% were non-injecting).

Treatment:

To date none of the 5 patients eligible only for an interferon containing regimen have initiated treatment.

Of those eligible for a DAA regimen 18 (66%) have initiated treatment (8, 44% Grazoprevir/Elbasvir, 10, 56% Sofosbuvir/Velpatasvir), of whom 8 (44%) have completed treatment.

DAA's were prescribed as directly observed therapy, given alongside daily supervised methadone dispensed in community pharmacy. Appointments for bloods were again co-ordinated with appointments for ORT prescriptions.

No patients have terminated treatment prematurely. SVR data is pending.

Conclusion

A community hepatology/addictions advanced fibrosis outreach clinic proved an effective way of providing HCV care to patients with a history of failing to attend hospital services.

Significant numbers of patients with advanced liver disease were able to be identified, engaged in specialist care and initiated on to treatment.

Initial results indicate good compliance with therapy.

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