A MODEL OF CARE TO MICRO-ELIMINATE HEPATITIS C IN PWID MANAGED AT A LOW-THRESHOLD PROGRAM IN SLOVENIA

CERNOSA J[1], MEGLIC VOLKAR J[1], VIDECNIK J[1], VIDMAR VOVKO D[1], PIRNAT Z[1], GREGORCIC S[1], KOTAR T[1], KLESNIK M[1], PRAH J[1], RAJTER M[1], POLJAK M[2], LAZARUS JV[3], and MATICIC M[1,4]

[1] Clinic for Infectious Diseases and Febrile Illnesses, University Medical Centre Ljubljana, Slovenia
[2] Institute of Microbiology and Immunology, Faculty of Medicine, University of Ljubljana, Slovenia
[3] Barcelona Institute for Global Health (ISGlobal), Hospital Clínic, University of Barcelona, Spain
[4] Faculty of Medicine, University of Ljubljana, Slovenia

BACKGROUND

Although therapy with direct-acting antivirals (DAAs) made elimination of hepatitis C possible, significant challenges remain in treating people who inject drugs (PWID) enrolled in low-threshold programs (LTP), where improvements in hepatitis C virus (HCV) screening, linkage-to-care, and treatment are needed. Our aim was to analyse a model-of-care (MoC) to achieve HCV micro-elimination in LTP in Slovenia, where HCV treatment is being centralized at six HCV centers.

DESCRIPTION OF A MODEL OF CARE

In 2017, SVIT Koper, a non-governmental organization (NGO) providing harm reduction-focused LTP for PWID with needle/syringe programmes, counseling, and assistance with social and medical issues, initiated cooperation with the Clinic for Infectious Diseases in Ljubljana, the nearest HCV center with a 100 km distance. The MoC addressed the barrier of distance by arranging regular transport of PWID to HCV center, where physician specifically assigned to MOC provides counseling on safe injection practices and ongoing HCV care: HCV RNA test, Fibroscan® examination, referral to abdominal ultrasound and to other specialists when needed, follow-up care. NGO staff is in direct contact with the physician and helps arrange all examinations needed, provides support during HCV treatment, and encourages participation in HCV follow-up care (Table 1).

EFFECTIVENESS

By December 2022, 51 were screened for HCV, 49/51 (96%) were anti-HCV positive, 41/49 (83.7%) were HCV RNA-positive. 8/49 (16.3%) spontaneously resolved HCV; however, one of them (1/8, 12.5%) had re-infection and died prior to DAA treatment. 36/41 (87.8%) chronically infected started DAAs, 3/41 (7.3 %) were lost to follow-up (LFU), 2/41 (4.9%) were prepared for DAAs. Of 36 treated, 32/36 (91.2%) completed treatment, one died during treatment (for non-HCV reason), one ended treatment prematurely and two were currently on DAAs. Overall, 5/32 (15.6%) were HCV RNA negative at treatment completion and LTF, whereas 28/32 (84.8%) achieved a sustained virological response at 12 weeks post treatment (SVR12). Of them, 3/28 (10.7%) died after SVR12 (for non-HCV reasons) and 6/28 (21.4%) had re-infection; of them, 2/6 (33.3%) already completed HCV re-treatment, 3/6 (33.3%) are currently receiving it, and 1/6 (20%) died before HCV re-treatment (Figures 2 and 3).

CONCLUSIONS

Although the presented MoC that focuses on PWID has been effective in achieving HCV micro-elimination in a LTP unit, regular HCV screening and follow-up are necessary for all PWID as the risk of reinfection remains high.

CONTACT INFORMATION

jasna.cernosa@kclj.si

Low-threshold program SVIT Koper

All PWID:
- Regularly organized transport in need of HCV screening or treatment

If HCV RNA positive:
- Assistance in arranging abdominal ultrasound examination and addiction specialist's opinion
- Help with obtaining DAA from pharmacy
- Providing motivation and help during treatment with DAA

Follow up:
- Motivation of treated PWID to take part in the follow-up care

Clinic for Infectious Diseases and Febrile Illnesses Ljubljana

If HCV status unknown:
- Anti-HCV screening
- Counselling about safe injection practices

If anti-HCV positive:
- HCV RNA testing
- Fibroscan
- Addiction specialist's opinion, if on OAT
- Pan-genotypic treatment

Follow-up:
- HCV RNA at the end of treatment
- SVR assesment (FU12)
- Reinfection monitoring every 6 months
- Abdominal ultrasound depending from stage of liver fibrosis

FIGURE 1: The model of care.

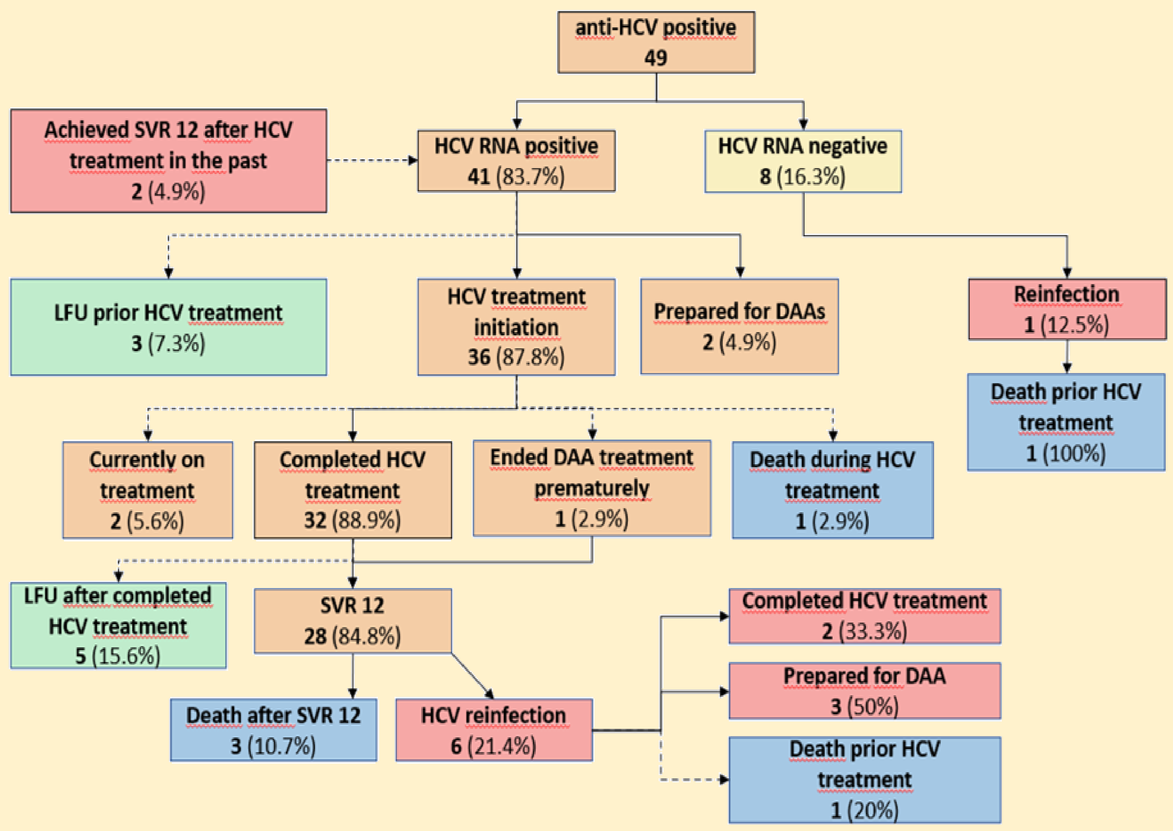

FIGURE 2: The study tree.

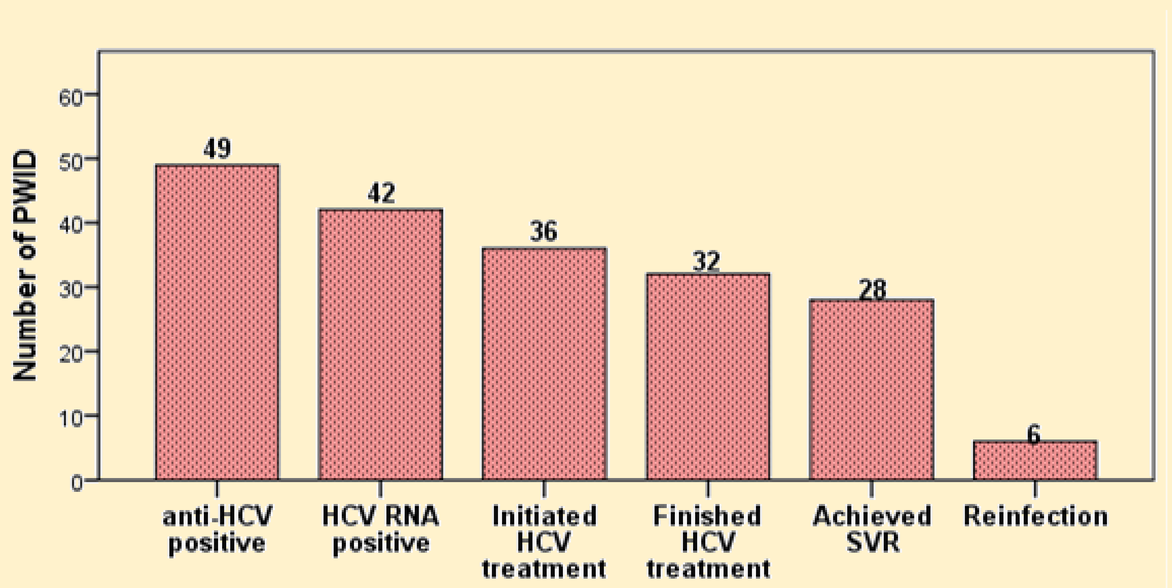

FIGURE 3: The cascade of care.