THE MAJORITY OF PATIENTS WITH HEPATITIS C NOT ACHIEVING SVR CAN BE SUCCESSFULLY RETREATED WITH FIRST-LINE REGIMENS: RESULTS FROM A MULTIDISCIPLINARY TEAM APPROACH TO GUIDE TREATMENT DECISIONS

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Background:
Amongst people who inject drugs, SVR bloods may not always be available. Subsequent positive RNA tests may represent treatment failure, or reinfection. We discuss such cases in a Multidisciplinary Team (MDT) setting, with testing for NS5A resistance (RAVs), assessment of reinfection risk factors and compliance, to judge the necessity for first or second-line antiviral regimens. We report outcomes from this approach.

Methods:
From an HCV database, patients were identified who received two DAA regimens with no SVR from the initial treatment. Patients with a genotype switch were excluded. Treatment completion, time between treatments, reinfection risk factors, NS5A resistance testing, second treatment (first vs second-line) were recorded, along with second treatment outcome.

Results:
185 patients were identified. 7/185 (3.8%) were excluded due to genotype switch. 55/178 (30.9%) had incomplete treatment. 42 (23.5%) had end of treatment response (EOTR) with positive RNA at SVR, 65 (36.5%) had EOTR then positive RNA at a delayed interval. 16 (9.0%) were non responders. The median time between treatments was 13 months (IQR 15). 48 (27.0%) had documented risk factors for reinfection. 120 (67.4%) had RAV testing, 53 (44.2%) of which were positive. 103 (57.9%) were retreated with first-line regimens. Intention to treat SVR was 154/178 (86.51%), with 87/103 (84.5%) first-line vs 67/75 (89.3%) second-line (p=0.88). 9 patients (6 confirmed EOTR) lacked SVR bloods. 7 patients (4 first-line, 3 second-line) prematurely terminated treatment and remained viraemic. 8 patients (6 first-line, 2 second-line) experienced treatment failure. Thus, per protocol SVR was 154/162 (95.1%), with 87/93 (93.5%) first-line vs 67/69 (97%) second-line (p=.30).

Conclusion:
An MDT approach to treatment failure, combined with resistance testing where available, allows for the majority of patients to be retreated with a first-line DAA regimen, with comparable rates of SVR to those treated with second-line regimens.

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