untreated HCV in HIV/HCV-Coinfected US Population Despite an Abundance of Curative Therapies

Per AASLD-IDSA (www.hcvguidelines.org), treatment of hepatitis C should be prioritized in patients coinfected with HIV and HCV. This recommendation is based on a higher rate of HCV disease progression in this population, along with reported treatment responses comparable to HCV monoinfected patients. Despite the availability of highly effective, well-tolerated anti-HCV therapies, payers have created barriers to access in the HCV monoinfected population (J Viral Hepat 2016 23:447). However, in the HCV-HIV coinfected population, previous analyses suggest that payers do not influence access to DAAs, but rather lack of prescription accounts for most of the non-treated HCV (J Hep 2018 68: S261). Here we attempt to address the question of “How many patients remain untreated since the advent of curative DAA” by looking at coinfected populations from 2014 to 2018.

2. METHODS

EMR data for 3891 patients were collected from 10 large HCV treatment clinics in the US. HCV infection was defined as positive HIV antibody test result, at least 2 HIV viral loads ≥200 or 1 HIV viral load ≥500, HIV drug prescription and/or dispense, or HIV diagnosis (ICD9 0.42.x-0.44.x or ICD10 B20.x-B22.x, B24.x) and HCV infection was defined as (ICD-9 0.70-0.71, 0.70-0.74, 0.70-0.76, 0.70-0.77, 0.70-0.78, V02.62, IC2011 B171, B170, B171, B192, B109, B192, B190, B191, B182, B183), HIV viral load ≥500, HCV prescription or dispensation. Populations were assessed each year and for the entire time period and classified into one of the following groups: Treated or Cured (DAA prescription, dispense, or ≥2 HCV RNA undetectable ≤20 IU/ml). Lost to Follow Up (TUF), no evidence of treatment or cure, without evidence of being in care as of OCT 2018, or Not treated (no evidence of treatment or cure, patient in database with evidence of HCV coinfection as of OCT 2018, [FIGURE 1]). LTFU were assessed by Cochran-Armitage test for trend in proportions. Differences between groups were assessed using chi-square with subsequent comparisons by the Z test with Bonferroni correction. Population characteristics were limited for this dataset, which prevented analyses evaluating the impact of payer on treatment status.

3. RESULTS

By year, the percentage of patients with active HCV that received treatment increased from 17% in 2014 to 23% (p=0.003) in the last period [FIGURE 2]. At the end of the observation period, 82% (23%) patients remained untreated, 1.21 (31%) were LTFU, and 1.58 (49%) were treated; [FIGURE 3]. Age and gender were available for 76% (855/1166) patients. [TABLE 1] A significantly higher fraction of treated patients and lower fraction of LTFU were observed for males compared to females (p<0.001). The patient age group 50-64 had a higher fraction of treated patients and lower fraction of LTFU were observed for males compared to females (p=0.023), though all other age comparisons were not significant.

4. CONCLUSION

In this cohort of coinfected patients, 23% remained untreated and 31% were lost to follow up. The data suggest that females and <50 year old patients had lower treatment rates. Median time to treatment was 4 months longer than median time of last care for patients lost to follow up, suggesting that more timely treatment and/or improved patient engagement are critical in care of the coinfected population. Despite the availability of highly effective, well-tolerated DAAs [FIGURE 2], treatment of HCV in this population of coinfected patients was suboptimal.

REFERENCES

