Screening program for hepatitis c virus in an open population at a third-level healthcare center

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Introduction and Objective: Worldwide, there are 71 million people with chronic hepatitis C (HCV), and yearly 1,5 million become infected. In Mexico, it is estimated between 400,000 to 600,000 viremic. Among the WHO goals for 2030 is to detect >90% of people with HCV. This study aimed to describe the screening strategy carried out in the open population using two-step HCV screening tests at the Hospital General de México from January to December 2021.

Materials and Methods: Study in an open population that attended the General Hospital of Mexico for any reason, and agreed to take the risk factor questionnaire and underwent a rapid test for the detection of anti-HCV antibodies (RT), which were reactive, load viral (PCR to detect HCV-RNA). Descriptive statistics and the statistical package STATA v.14 were used.

Results: In 2021, 33,523 subjects were examined; 71.5% were women, mean age of 47±10 years. Reported at least one risk factor for HCV 53.5%. The most frequent risk factors were: Multiple sexual partners/history of sexually transmitted diseases (STDs) 36.2%, tattoos/piercings 26.7%, surgery before 1995 20.2%, transfusion before 1994 5.4 % and health workers after accidental puncture 4.2%. Of the 33,523, 0.7% were reactive in RT. Of the reagents in RP, the PCR was positive in 57.9% (prevalence of viremia= 0.4%). Of the viremic patients, the risk factors identified were blood transfusion before 1995 37%, multiple sexual partners/STDs 35%, surgery before 1995 30%, tattoos/piercings 30%, and injected drugs only 3.5%. All viraemic (100%) linked to treatment.

Conclusions: HCV prevalence was similar to that previously reported. Traditional risk factors such as transfusion or surgery remain highly prevalent. Timely diagnosis of HCV allows linkage to treatment.

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Use of glecaprevir and pibrentasvir as rescue therapy in patients with resistance to direct-acting antiviral agents

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Introduction and Objective: Hepatitis C virus infection is one of the main causes of chronic liver disease. Treatment with direct-acting antivirals (DAAs) has shown high efficacy in achieving sustained viral response with a low risk of relapse. There are no specific algorithms for treatment in patients with resistance to DAAs). Treatment with Sofosbuvir, velpatasvir and voxilaprevir is suggested for 12 weeks with a sustained viral response of 95%, except in moderate/severe liver disease. There is a combination of sofosbuvir plus NS3 protease inhibitor and an NS5A with favorable results.

Materials and Methods: 65-year-old female, positive smoker, occasional alcoholism. Car accident and transfusion in 1992. Surgeries: hysterectomy and cholecystectomy. Chronic: DM2, irritable bowel syndrome, hypothyroidism under treatment, anxiety disorder treated with venlafaxine and clonazepam. In 2010 Hepatitis C was detected, and he received peginterferon and ribavirin without response. Triple therapy (peginterferon, boceprevir and ribavirin) was used with partial response; he presented relapse. In 2015 she received daclastavir, sofosbuvir and ribavirin with no response. Viral load in 2017 and result of resistance Genotype 1a: polymorphism Q80K (resistance to Simeprevir), mutation V36M (resistance to Boceprevir, Simeprevir, telaprevir and possibly Asunaprevir, Grazoprevir and Paritaprevir), mutation L31V (resistance to Daclatasvir, Elbasvir, Ledipasvir, OmbitaSvir), received Sofosbuvir Velpatasvir 12 weeks post-treatment undetectable viral load, at 24 months detectable viral load, Glecaprevir biprentasvir was indicated for 16 weeks with a sustained viral response; elastography 6.8 kPa, discharge due to healing. The trial was approved by the research ethics committee, and informed consent was obtained.

Conclusions: According to the evidence, there are treatment schemes suggested internationally. However, their availability is not the same in our country, so according to the results obtained in this patient, this rescue scheme with Glecaprevir Biprentasvir is suggested for 18 weeks if there is no response to Sofosbuvir/velpatasvir, and no availability of other DAAs.

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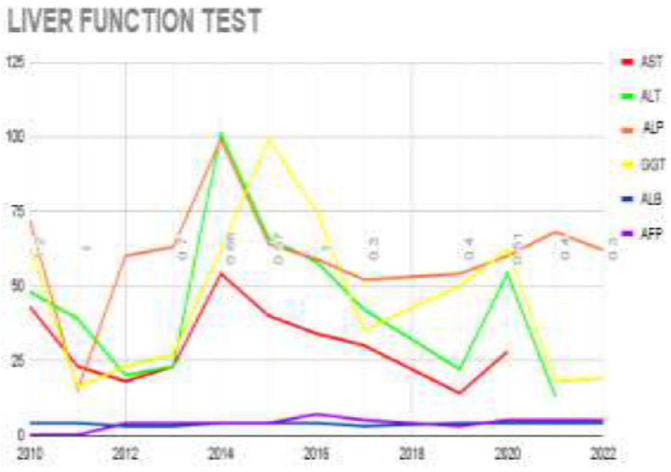

Fig. 1.

Fig. 2

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