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## اإرشادات aasld hcv 2019 pdf

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The AASLD/IDSA guidance on hepatitis C addresses management issues ranging from testing and linkage to care, the crucial first steps toward improving health outcomes for HCV-infected persons, to the optimal treatment regimen in particular patient situations. Recommendations are evidence based and rapidly updated as new data from peer-reviewed research become available. For each treatment option, recommendations reflect the best possible management for a given patient and a given point of disease progression. Recommendations are rated with regard to the level of the evidence and strength of the recommendation. The AASLD/IDSA guidance on hepatitis C is supported by the membership-based societies and not by pharmaceutical companies or other commercial interests. The governing boards of AASLD and IDSA have appointed an oversight committee of 4 co-chairs and selected panel members from the societies. This guidance should be considered a living document in that the recommendations are updated frequently as new information and treatments become available. Please listen to Dr Ray Chung discuss the most recent AASLD/IDSA HCV guideline update.1 Articles from Clinical Liver Disease are provided here courtesy of American Association for the Study of Liver Diseases AASLD develops evidence-based practice guidelines and practice guidances which are updated regularly by a multi-disciplinary panel of experts, including hepatologists, and include recommendations of preferred approaches to the diagnostic, therapeutic, and preventive aspects of care. AASLD develops evidence-based practice guidelines and practice guidances which are updated regularly by a multi-disciplinary panel of experts, including hepatologists, and include recommendations of preferred approaches to the diagnostic, therapeutic, and preventive aspects of care. Media Contacts: Caroline Laurin, (703) 299-9766 Lauren Martin, IDSA, (312) 558-1770 (December 3, 2019) HCVguidelines.org — a website developed by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America to provide up-to-date guidance on the management of hepatitis C — was recently revised to reflect important developments in the identification and management of chronic hepatitis C (HCV). Notably, the guidance includes an important new recommendation that all adults be screened for HCV. In addition to universal screening for hepatitis C, the guidance emphasizes universal treatment. To this end, the update includes: A simplified treatment algorithm for patients without cirrhosis or with compensated cirrhosis, who have never been treated for HCV, for use by primary care providers. New treatment recommendations for children ages 3-11. A recommendation that patients with acute HCV be treated without a waiting period. Updates to all treatment sections, including removal of less efficacious, complex, alternative regimens, and regimens no longer available in the US. The update also includes new information about management of hepatitis C in patients receiving transplantation of organs from HCV-infected donors, an emerging area of the field. "HCV has been called 'the silent killer' because of its ability to damage the liver while causing few or no symptoms. Identifying patients who don't know they are infected is key to stopping the spread of the disease. Our Panel has always recommended screening high-risk populations, but several studies now demonstrate that routine, one-time HCV testing among all adults in the U.S. would likely identify a substantial number of HCV cases that are currently being missed, and that doing so would be cost-effective. This is why we now recommend universal screening of adults," said HCV Guidance Co-Chairs, Drs. Marc G. Ghany, Kristen M. Marks, Timothy R. Morgan, and David L. Wyles. "The good news is that once new HCV cases are identified, there are safe and effective treatments that can cure more than 95% of people. We believe that the improved testing and treatment strategies described in the Guidance will bring us closer to achieving the World Health Organization's goal of eliminating HCV infection as a public health threat by 2030," they added. Visit HCVguidelines.org for more information about these recommendations and to view other sections of the HCV Guidance. About AASLD AASLD is the leading organization of clinicians and researchers committed to preventing and curing liver disease. The work of our members has laid the foundation for the development of drugs used to treat patients with viral hepatitis. Access to care and support of liver disease research are at the center of AASLD's advocacy efforts. Learn more about AASLD's evidence-based practice guidelines and guidances. About The Infectious Diseases Society of America (IDSA) is an organization of physicians, scientists, and other health care professionals dedicated to promoting health through excellence in infectious diseases research, education, prevention, and patient care. The Society, which has over 12,000 members, was founded in 1963 and is based in Arlington, Va. For more information, see www.idsociety.org. Acute Liver Failure, Management Acute-on-Chronic Liver Failure and the Management Alcohol-Associated Liver Disease Ascites, Spontaneous Bacterial Peritonitis and Hepatorenal Syndrome, Management Autoimmune Hepatitis, Management Drug, Herbal, and Dietary Supplement-induced Liver Injury Hemochromatosis, Management Hepatic Encephalopathy Hepatitis B, Chronic Hepatitis C, Guidance Hepatocellular Carcinoma, Management Liver Biopsy Liver Transplantation, Evaluation of the Adult Patient Liver Transplantation, Evaluation of the Pediatric Patient Long-Term Management of the Adult Liver Transplant AASLD strives to review and update its practice guidelines every five (5) years, as necessary. Users are cautioned that in the interim, scientific and medical developments may supersede or invalidate, in whole or in part, specific recommendations in any guideline. A guideline is considered to be "inactive" if it has not been updated by AASLD in at least five (5) years, and for this reason particular care must be exercised in placing reliance on an inactive guideline. AASLD commissions and provides financial support for the formulation and production of practice guidelines/guidances by volunteer experts. Financial support from commercial entities or the pharmaceutical industry is not accepted for the development of AASLD practice guidelines. As a library, NLM provides access to scientific literature. Inclusion in an NLM database does not imply endorsement of, or agreement with, the contents by NLM or the National Institutes of Health. Learn more: PMC Disclaimer | PMC Copyright Notice . Author manuscript; available in PMC: 2022 Nov 30. Published in final edited form as: Hepatology. 2020 Feb;71(2):686-721. doi: 10.1002/hep.31060 The American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) initiated the hepatitis C guidance project (hereafter HCV guidance) in 2013. The AASLD-IDSA HCV guidance website (www.HCVguidelines.org) disseminates up-to-date, peer-reviewed, unbiased, evidence-based recommendations to aid clinicians making decisions regarding the testing, management, and treatment of hepatitis C virus (HCV) infection. Utilizing a web-based system enables timely and nimble distribution of the HCV guidance, which is periodically updated in near real time as necessitated by emerging research data, recommendations from public health agencies, the availability of new therapeutic agents, or other significant developments affecting the rapidly evolving hepatitis C arena. The value and utility of the online HCV guidance to the community of hepatitis C care providers throughout the world is evidenced by the nearly 10 million pageviews by 1.5 million users originating from 228 countries and territories since the January 2014 launch of the website. A major update of the HCV guidance was released electronically in November 2019. This HCV guidance update summarizes and highlights key new or amended recommendations since the previous October 2018 print publication.(1) The advent of safe, well tolerated, and highly efficacious (>95% cure rate)(2) direct-acting antiviral (DAA) therapy for HCV infection has ushered in a new era in which elimination of hepatitis C is conceivable. In 2016, the World Health Organization (WHO) proposed a global health sector strategy to eliminate hepatitis C as a public health threat by 2030 and developed an action plan to facilitate this goal.(3) In response to the WHO action plan, the National Academies of Science, Engineering, and Medicine (NASEM) developed a U.S. strategy for the elimination of hepatitis C.(4) Key elements of the elimination plan include improved detection of undiagnosed cases, increased linkage and access to care for newly diagnosed persons, and expanded treatment access. Many of the recommendations included in the latest update to the HCV guidance and highlighted herein align with and support the goals of the NASEM and WHO strategies to move from control to eventual elimination of hepatitis C. Topics addressed include universal and risk-based hepatitis C screening; simplified treatment algorithms for treatment-naïve adults without cirrhosis or with compensated cirrhosis; hepatitis C management in the pediatric population; acute hepatitis C testing and management; and transplantation of organs from HCV-viremic donors into HCV-negative recipients. For detailed evidence reviews related to these topics and information addressing other aspects of HCV testing and management, see the online HCV guidance (www.HCVguidelines.org). The HCV guidance was developed and is updated by a volunteer panel (representing AASLD and IDSA) of hepatology and infectious diseases clinicians with hepatitis C expertise using an evidence-based review of available data, including information presented at scientific conferences and published in peer-reviewed journals. Based on scientific evidence and expert opinion, recommendations are rated by the level of evidence (I, II, or III) and the strength of the recommendation (A, B or C) using a system adapted from the American College of Cardiology and American Heart Association.(5, 6) See the original AASLD-IDSA hepatitis C guidance publication(7) or the HCV guidance website for additional details about the processes and methods employed. All recommendations are reviewed and approved by the governing boards of AASLD and IDSA. The HCV guidance panel classifies therapeutic regimens as recommended, alternative, or not recommended based on patient factors (i.e., treatment naïve versus experienced, cirrhosis status, and comorbidities) and viral characteristics (i.e., genotype, subtype, resistance-associated substitutions). Recommended regimens are considered equivalent; alternative regimens are effective but, compared to recommended regimens, have potential disadvantages, limitations for use in certain patient populations, or less supporting data. The identification of risk factors associated with contracting HCV infection served as the basis for the risk-based hepatitis C screening recommendations issued by the U.S. Centers for Disease Control and Prevention (CDC) in 1998.(8) Although sensitive for the identification of persons with chronic HCV infection, risk-based screening failed to identify the majority of individuals with HCV infection due to both clinician and patient barriers.(9-12) Analysis of the 2003-2010 National Health and Nutrition Examination Survey (NHANES) prevalence data demonstrated that approximately three fourths of individuals with chronic hepatitis C in the United States belonged to the 1945 through 1965 birth cohort.(13) Based on these data, both CDC and the U.S. Preventive Services Task Force (USPSTF) recommended one-time hepatitis C screening of all individuals in this birth cohort (1945 through 1965) regardless of risk factors.(14, 15) Since these recommendations were established in 2012, HCV epidemiology in the United States has changed. Hepatitis C infection incidence nearly quadrupled from 2010 to 2017, primarily driven by increased injection drug use related to the opioid epidemic.(16-19) CDC viral hepatitis surveillance data indicate progressively increasing acute HCV infection incidence each year from 2009 through 2017. Most of these new HCV infections occurred in persons born after 1965 with those aged 20-39 years accounting for the majority of cases. This ongoing trend has spurred interest in expanding HCV screening among the general U.S. population. Several modeling studies suggest the cost-effectiveness of such an approach.(20-23) Accordingly, the AASLD-IDSA guidance HCV screening and follow-up recommendations have been updated and include newly recommended universal HCV screening for all adults aged 18 years or older followed by periodic testing for persons with ongoing risk behaviors and/or exposures. 1)One-time, routine, opt out HCV screening is recommended for all individuals aged 18 years or older. (I, B) In light of the inadequacy of targeted HCV case finding using risk-based and birth cohort HCV screening,(24, 25) investigators have modeled the cost-effectiveness of one-time universal HCV screening for adults aged ≥18 years. Independent studies using different modeling techniques demonstrate that one-time universal screening for adults aged ≥18 years is cost-effective (2 g/d) and certain herbal supplements. Nephrotoxic drugs (e.g., nonsteroidal anti-inflammatory drugs) should also be avoided. Ongoing imaging surveillance for HCC and gastroesophageal varices is recommended for patients with cirrhosis.(78-80) Cirrhosis with portal hypertension portends a greater likelihood of developing future hepatic complications in untreated patients.(81, 82) Transient elastography provides point-of-care information regarding liver stiffness and can reliably distinguish patients with a high versus low likelihood of cirrhosis.(83-85) Screening for hepatitis B virus (HBV) with an FDA-approved hepatitis B surface antigen (HBsAg) assay and HIV with an FDA-approved HIV-antigen/antibody test is recommended because these coinfections are associated with a poorer HCV prognosis.(86-90) Persons who test positive for HBsAg require additional monitoring during HCV treatment due to HBV reactivation risk(91) Anti-HBV therapy is another consideration for these patients. For persons who test negative for hepatitis B core antibodies (with or without hepatitis B surface antibodies) have resolved HBV infection and no further workup or additional monitoring is needed.(92) Primary prevention measures for persons without coinfection include counseling about how to avoid contracting HIV and HBV, and immunization against HBV and hepatitis A virus (HAV) as needed. CDC also recommends pneumococcal vaccination for all persons with chronic liver disease.(93) Measures to Prevent HCV Transmission HCV-infected persons should be counseled to avoid sharing toothbrushes and dental or shaving equipment, and be cautioned to cover any bleeding wound to prevent the possibility of others coming into contact with their blood. Persons should be counseled to stop using illicit drugs and enter substance abuse treatment. Those who continue to inject drugs should be counseled to: • Avoid reusing or sharing syringes, needles, water, cotton, and other drug preparation equipment. • Use new sterile syringes and filters, and disinfected cookers. • Clean the injection site with a new alcohol swab. • Dispose of syringes and needles after 1 use in a safe, puncture-proof container. Persons with HCV infection should be advised not to donate blood and to discuss HCV serostatus prior to donation of body organs, other tissue, or semen. Persons with HIV/HCV coinfection and those with multiple sexual partners or sexually transmitted infections should be encouraged to use barrier precautions to prevent sexual transmission. Other persons with HCV infection should be counseled that the risk of sexual transmission is low and may not warrant barrier protection. Household surfaces and implements contaminated with visible blood from an HCV-infected person should be cleaned using a dilution of one part household bleach to nine parts water. Gloves should be worn when cleaning up blood spills. Noninvasive Tests to Assess Liver Disease Severity Liver-directed physical exam (normal in most patients) Routine blood tests (eg, ALT, AST, albumin, bilirubin, international normalized ratio [INR], and CBC with platelet count) Serum fibrosis marker panels Transient elastography Liver imaging (eg, ultrasound or CT scan) AST-to-platelet ratio index (APRI) FIB-4 score Chronic HCV infection is an important infectious cause of death in the United States and a major contributor to morbidity and mortality from viral hepatitis globally. The availability of safe, effective, well tolerated therapy substantially facilitates the goal of expanding HCV treatment as recommended in the HCV elimination strategies of WHO(3) and NASEM.(4) Overall, DAA regimens successfully cure HCV infection in >95% of treated persons.(2) Moreover, the development of reformulated, pan-genotypic regimens that require relatively short treatment durations has greatly simplified HCV antiviral therapy administration. Despite these remarkable therapeutic improvements, in 2015, only 7.4% of persons with diagnosed HCV had begun antiviral treatment.(94) Although more recent limited data indicate increased DAA access and uptake, this has been uneven geographically and across different patient populations.(95-97) Thus, only a minority of persons with HCV infection obtain the many health benefits of successful treatment. From a public health perspective, successful HCV treatment also supports primary prevention by decreasing the population of persons capable of transmitting the virus, thereby reducing the incidence of HCV infection. 18)Antiviral treatment is recommended for all adults with acute or chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV therapy, liver transplantation, or another directed therapy. (I, A) Eradicating hepatitis C infection results in numerous health benefits, including reduced rates of all-cause mortality, cirrhosis, hepatic decompensation, and HCC.(33, 37, 98-110) Successful treatment also confers improvement in extrahepatic manifestations of HCV disease, including cryoglobulinemic vasculitis(111-116) and HCV-related non-Hodgkin lymphoma and other lymphoproliferative disorders.(117-125) as well as improved productivity and quality of life.(34, 35, 126-131) Given these and other benefits associated with virologic cure, the HCV guidance panel strongly recommends antiviral treatment for all adults with acute or chronic HCV infection (except those with a short life expectancy that cannot be remediated). Importantly, this recommendation includes persons with ongoing substance use (alcohol or drugs). Several studies demonstrate that treatment-committed individuals in this disproportionately affected population achieve sustained virologic response (SVR) rates with DAA therapy comparable to those without known, current substance use.(73, 132-139) The universal treatment recommendation represents a principal tenet of the HCV guidance along with newly recommended universal hepatitis C screening of adults. The HCV guidance panel urges healthcare providers caring for adults to encourage hepatitis C screening and treatment (if positive) because DAA therapy is safe and cures HCV infection in most people.(2) One approach to improving access to curative HCV treatment is expanding the number of healthcare providers administering antiviral therapy. Data demonstrate that HCV treatment can be effectively provided by a broad range of healthcare professionals with differing expertise—including specialists, primary care physicians, nurse practitioners, clinical pharmacy specialists, physician assistants, and registered nurses—without compromising treatment efficacy or safety.(95, 140) Consequently, the HCV guidance panel developed simplified HCV treatment algorithms for treatment-naïve adults (without cirrhosis or with compensated cirrhosis), which align with the NASEM plan to eliminate HCV as a U.S. public health burden by 2030. These simplified treatment algorithms are designed to be used by any healthcare provider knowledgeable about HCV disease and treatment, including those without extensive experience who have timely access to a specialist. The simplified treatment algorithms provide concise, clear guidance on pretreatment assessment, on-treatment monitoring, assessment of response, and post-treatment management (see Figures 2 and 3). Recommended Simplified HCV Treatment Algorithm for Treatment-Naïve Adults Without Cirrhosis Recommended Simplified HCV Treatment Algorithm for Treatment-Naïve Adults With Compensated Cirrhosis The simplified HCV treatment algorithm for adults without cirrhosis (see Figure 2) applies to persons aged ≥18 years who have not been previously treated for their infection and do not have evidence of cirrhosis as defined by the noninvasive parameters specified in the HCV guidance. Evidence of cirrhosis includes a FIB-4 score >3.25 or any of the following findings from a previously performed test: transient elastography indicating cirrhosis (e.g., FibroScan [Echosens, Paris, France] stiffness >12.5 kPa); noninvasive serologic tests that exceed proprietary cutoffs (e.g., FibroSure [BioPredictive, Paris, France], Enhanced Liver Fibrosis Test [Siemens Healthcare, Erlangen, Germany], etc.); clinical evidence of cirrhosis (e.g., liver nodularity and/or splenomegaly on imaging, platelet count