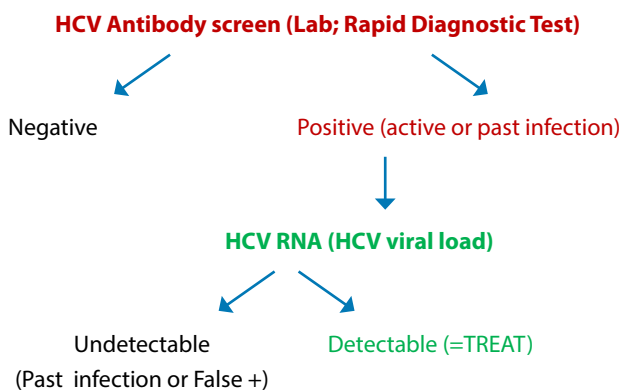


# A SIMPLIFIED APPROACH TO MANAGING PATIENTS WITH HEPATITIS C IN SOUTH AFRICA

## SCREENING:

- All adults (18 and above) screen at least once in their lifetime
  - routine screening in women as part of antenatal care;
  - haemodialysis patients and healthcare workers
- High risk or key populations must screen more frequently :
  1. People who inject or use drugs (PWID)
  2. Men who have sex with men – especially if HIV infected
  3. Commercial sex workers
  4. Incarcerated

## TESTING AND DIAGNOSIS



## TREATMENT

***Treat all - unless immediate life expectancy or prognosis is poor***

1. Pre-treatment - screen for HBV (**HBsAg and anti-HBc**) and HIV, vaccinate for Hep B (and Hep A) if negative.
2. If HBsAg positive start tenofovir - If HIV positive start ART – for both delay Hep C treatment for 3 months – unless pressing indication for Hep C treatment e.g. extra-hepatic HCV-related disease
3. Tabulate ALL current medication patient using and screen for drug-drug interactions. (<https://hep-druginteractions.org/checker>)
4. Basic blood tests: FBC; LFT; Renal function and AFP; and pregnancy test
5. Assess for severity (Fibrosis) of liver disease. Use **FIB-4** – if **FIB-4 > 3.25 prioritise treatment and retain in care post-treatment for HCC screening**
6. Start Sofosbuvir/Velpatasvir - 1 tablet a day for 12 weeks
7. Recheck HCV RNA 12 weeks after completing therapy
8. If HCV RNA (viral load) undetectable – regard as cured – can be discharged
9. Post cure – retain in care for HCC surveillance if advanced fibrosis/cirrhosis
10. PWID should be linked to OST and safe needle exchange programmes – key populations must have regular ongoing screening with HCV RNA (viral load) to exclude re-infection.

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