



THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

Role of GPs in HCV

The Role of GPs in Relation to Hepatitis C Virus (HCV) Infection

Adopted by Council 42/1, 30/31 October 1999

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Issue

The role of GPs in relation to hepatitis C virus (HCV) infection.

Aim

To assist GPs play a central case management role in the care of their HCV Ab positive patients.

Principles

- HCV positive patients, including injecting drug users, have rights of access to all health services and to be treated without discrimination.
- The principles of prevention and harm reduction are the key approach to managing HCV and health issues related to alcohol and other drugs.
- The principles of confidentiality in management of information relating to diagnosis and test results and of obtaining informed consent prior to testing are crucial.

Background

- HCV was first identified in 1989. A serological (antibody) assay first became available in February 1990. Most cases of (pre-1990) non-A/non-B hepatitis were found to be HCV.¹
- HCV infection is characterised by:
 - high undetected prevalence, due to frequent asymptomatic acute infection
 - high incidence amongst injecting drug users
 - uncertain natural history, including the incidence of cirrhosis, liver cancer and liver failure
 - variable effectiveness of current drug treatments, available through accredited liver clinics.
- HCV infection is self limiting in 15% of cases. Approximately 85% of those with HCV infection fail to clear the virus by six months and develop chronic hepatitis²
- A total of over 110,000 diagnoses had been made to the end of 1997. Approximately 80% of those diagnosed were infected through injecting drug use, 5-10% through receipt of blood/blood products and 10-15% through other routes, such as needlestick injury or tattoos³
- The prevalence of HCV infection in 1997 was estimated to be around 190,000.³ Prevalence is higher in the following groups:
 - Injecting drug users - an estimated 50-70% are infected with HCV³
 - Haemophiliacs - an estimated 85-90% of people with are infected with HCV¹
 - Migrants from countries with a high prevalence of HCV.^{1,4}
- The incidence of new HCV infections in 1997 was estimated at 11,000, 91% of these resulted from exposure through injecting drug use³
- The RACGP has responded to the issue of hepatitis C by conducting a project with the Gastroenterological Society of Australia to ensure that appropriate guidance is provided to GPs. The RACGP also revised the curriculum of the Training Program to include hepatitis C core competencies.

Key Management Issues

Prevention and harm reduction

In the absence of any reliable treatment/cure, preventive strategies remain the primary public health response including information/education and needle and syringe programs.

Infection control

It is essential that infection control procedures be maintained at all times, irrespective of the known/perceived hepatitis C serological-status of patients. The Appendix summarises the universal infection control procedures and the NH&MRC recommendations in relation to occupational exposure and health care workers.

Testing

Given the high undetected prevalence of HCV, Ab testing should be offered to patients with a recognised risk factor for HCV infection. Testing should be preceded by pre-test counselling and only performed with the patient's informed consent. Patients should be informed that HCV is a notifiable disease. Any further disclosure of confidential test results should only occur with the patient's consent.

Current therapy

Interferon alpha monotherapy and interferon alpha in combination with ribavirin are currently approved for the treatment of chronic hepatitis C and available to patients who meet the S100 assessment criteria through approved liver clinics. A sustained response rate of normalisation of ALT at 6 months post IFN treatment is experienced by approximately 20-25% of patients. Although research findings are unclear, predictors of a sustained response include: genotype 2 or 3, female gender, younger age, absence of cirrhosis and low HCV RNA levels.²

The trials of interferon alpha taken in combination with ribavirin are providing higher sustained response-rates.^{1,2}

S100 drug prescribing

Interferon alpha and ribavirin are drugs currently available on the S100 list of the Pharmaceutical Benefits Scheme which are prescribed by specialists within accredited centres, ensuring adequate patient support and monitoring. A joint Commonwealth/State funded trial of GP prescribing of interferon is currently underway.

Complementary therapies

Many patients, especially in the absence of proven treatment, wish to explore complementary therapies. Such therapies require rigorous testing within properly conducted trials.

A patient's wish to explore complementary therapies should not, however, be dismissed. Patients may be referred to the Hepatitis C Council for further information. All patients should be encouraged to inform their GP of all substances/medications taken that may affect their on-going care.

Position of the RACGP

The RACGP considers that:

- GPs play a crucial role in detecting and diagnosing the high levels of undetected HCV infection and in providing education to assist prevention of further transmission

- many cases of uncomplicated hepatitis C may be managed by GPs without the need for specialist referral. GPs are best placed to play the central role in the shared-care management of their HCV Ab positive patients, liaising with specialists as required, for example, during treatment with interferon
- The RACGP supports the NH&MRC position on screening for hepatitis C and has endorsed Hepatitis C: A Management Guide for General Practitioners
- The RACGP supports the trial of appropriately trained GPs, linked to accredited treatment centres, prescribing S100 drugs. The RACGP will assess the outcome
- The RACGP supports the conduct of further research to monitor and evaluate changes in GP practice with respect to management of hepatitis C.

Recommended Role for Individual GPs

The RACGP recommends that:

- GPs familiarise themselves with Hepatitis C: A Management Guide for General Practitioners
- GPs equip themselves with the skills required to carry out the essential roles in relation to hepatitis C through the RACGP QA and CE Program
- All GPs be able to:
 - effectively detect patients at risk of HCV infection;
 - diagnose hepatitis C
 - counsel patients and provide preventive information, with sensitivity
 - complete appropriate clinical investigations prior to any specialist referral
 - participate in the shared care management of their HCV positive patients to the extent to which they are confident
 - refer, as appropriate, to a specialist, another GP or other health care worker with relevant expertise
 - refer patients to other counselling and support services related to alcohol and other drugs and psychosocial issues as required.
- GPs should follow any State or Territory legal requirements or guides on issues such as infection control and disability discrimination.

Strategies

The RACGP will:

- Review and update the:
 - RACGP/ANCARD Hepatitis C Algorithms and Support Resources
 - National Directory of Hepatitis C Education/ Information and Support for GPs
 - HCV-related content within the Vocational Training Program.
- Support the formation of an HCV special-interest group within the College

- Monitor the trial of GPs prescribing S100 drugs, including interferon alpha and ribavirin
- Maintain a working partnership with the Gastroenterological Society of Australia (GESA) and the Australian Liver Association of the GESA, NCETA (National Centre for Education and Training on Addictions), the Australian Divisions of General Practice and State Health Departments
- Promote the concept of GP management within 'shared-care' in relation to hepatitis C and encourage GP-specialist-alcohol and other drugs service links
- Promote 'harm reduction' strategies through State Faculty alcohol and other drugs committees.

Appendices

Universal infection control precautions^{4,5}

Standard infection control precautions include:

- Adequate hand washing and drying before and after patient contact
- Correct sterilisation/disinfection procedures
- The use of protective barriers which may include gloves, masks, eye shields, gowns
- Safe disposal of needles and other sharp instruments
- Appropriate handling and disposal of infectious waste
- The use of aseptic techniques.

Standard precautions apply when handling blood and all other body fluids (excluding sweat), non intact skin, mucous membranes and dried blood.

NH&MRC recommendations in relation to screening

It is recommended that:

- Routine screening of health-care workers is not warranted and infection control procedures should be in place at all times
- In the case of health-care worker exposure to body fluids from an HCV Ab positive source, follow-up testing should occur
- Any health-care worker who performs exposure prone procedures should know their HCV sero-status
- GPs who are HCV Ab positive but have no evidence of active infection should seek advice from 'advisory panel/professional board'
- HCV Ab positive GPs with evidence of active infection should not perform exposure prone procedures^{3,4}
- Where State/Territory occupational exposure guidelines and infected health-care worker policies exist, these should be followed.

References

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2. Vakil D, McCaughan G. Update on the Management of Hepatitis C. Aust Fam Physician 27(9) 780-786 1998.
3. Australian National Council on AIDS and Related Diseases Hepatitis C Sub-Committee, Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Epidemic in Australia, August 1998
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5. The Royal Australian College of General Practitioners Practice Management Committee of Council Sterilisation/Disinfection Guidelines for General Practice, 1994.

Publication Date: 13 October 1999

Authorised By: Office of the CEO