ENSURING APPROPRIATE FOLLOW-UP AND ACCESS TO SCREENING FOR PEOPLE AT ONGOING RISK FOR HCV RE-INFECTION POST-CLEARANCE; A NEGLECTED STEP IN THE HCV CASCADE OF CARE

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Background:
In today's hepatitis C (HCV) elimination efforts, much attention has been targeted at expanding the ease of access to direct acting antiviral (DAA) therapy among people who use substances (PWUS) and improving the proportion of individuals achieving HCV cure. Until such time as the prevalence of HCV is greatly diminished, careful attention needs to be paid to mechanisms for regular testing post-viral clearance for those with ongoing risk factors.

Methods:
A review of all known HCV cases living in southern New Brunswick, Canada was undertaken in early 2019 to optimize monitoring of HCV prevalence. Among those post-HCV treatment who remained local, medical records were reviewed for evidence suggesting ongoing risk factors post-treatment and if present, whether re-screening was performed to monitor for re-infection. Evidence of ongoing risk factors included ongoing positive urine drug screens and/or hospital and outpatient visit documentation of ongoing snorting and/or injection drug use.

Results:
As of December 2020, 206 (84.4%) of the 244 cases treated for HCV and available for follow-up were acquired through high-risk activities. Of those, 99 (40.6%) are suspected of having ongoing risk factors for re-infection with a mean age of 41.7 years and 69.7% being male. Only 35 (35.4%) have had follow-up re-screening with 9 (25.7%) found to be re-infected post-completion of HCV therapy. Of the 99, 63.9% reported having a primary care provider and 68.0% were on opioid agonist therapy (OAT).

Conclusion:
Following treatment of HCV and confirmation of SVR, individuals with ongoing risk factors should be re-screened. This is a critical factor in HCV elimination efforts, and HCV elimination programs need to plan and resource adequately for the ongoing preventative care and re-screening of high-risk individuals particularly where a primary care provider is lacking and/or the patient is not connected to regular OAT care. Failure to do so may impede elimination efforts.

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