

Madigan Army Medical Center

Referral Guidelines

Hepatitis C

Diagnosis/Definition

- The detection of antibodies to hepatitis C virus is the most practical means of diagnosing both past and present infection, however, there are some shortcomings: there is a false positive rate as high as 50% in "low risk" patients (i.e. no history of blood transfusions prior to 1992, no IVDA or intranasal cocaine use, and monogamous sexual partner).
- A positive anti-HCV test may indicate resolved past infection (patient has no viremia) in up to 15% of patients with past exposure to the virus.
- Anti-HCV confers no immunity to the patient. In patients with risk factors, the anti-HCV antibody has a 90% sensitivity to diagnose past or present infection. Eighty-five percent of patients infected with the virus will continue to express viremia. Patients with elevated ALT's should be considered for treatment, if there are no contraindications.
- Those with a positive antibody and a normal ALT may be infected, but treatment of these patients is not indicated unless a persistently abnormal ALT is found on follow-up. At least 2-3 LFT's within the first few months are usually needed to establish the average ALT level.

Initial Diagnosis and Management

- Lab: Full LFT's, CBC, PT/PTT, HBsAg, and a liver ultrasound should be done to exclude other coexistent diseases and assess liver function. An ANA, ASMA, TSH, and fasting glucose should be obtained in patients considering treatment (an ANA > 1:320, or ASMA > 1:160 could indicate coincident autoimmune hepatitis, and patients should be referred to GI. Lower values are non-specific and often seen).
- HCV RNA testing (confirmation of infection) is indicated when: HCV Ab is positive and: 1) there are no risk factors for infection (i.e., no IV drug use history or transfusion history), 2) patients are going to proceed with interferon therapy, or 3) when the ALT is normal.
- Liver biopsy: should be performed in those patients that desire treatment. This aids in prognosis and treatment. This can be performed by Interventional Radiology (request ultrasound guided biopsy).

Ongoing Management and Objectives

- Patients should be counseled to avoid alcohol, they should be vaccinated against hepatitis A&B, and their household contacts should be tested for hepatitis C.
- Those with multiple sexual partners should practice safe sex, including the use of condoms. No changes in sexual practices are recommended for those in long-term monogamous relationships (they should be counseled that transmission can occur, but at a very low rate).

- The sharing of razors and toothbrushes should be avoided, and covering of open wounds is recommended.
- In patients not electing treatment or in whom treatment is not indicated (active contraindications to treatment, decompensated cirrhosis), at least yearly LFT's and annual PT & CBC, should be obtained to monitor for changes suggesting progressive condition.
- Surveillance for hepatocellular carcinoma: Indicated in those with known or probable cirrhosis (by biopsy, clinical signs such as ascites or varices, or obvious laboratory signs such as a depressed albumin, elevated PT or bilirubin, and best accomplished with alpha-fetoprotein and ultrasound every six months. Suspected masses should be confirmed by CT and biopsied (biopsies are performed by radiology).
- Treatment: is offered to all patients with a positive HCV RNA and recommend in patients with stage 2 fibrosis or above.
- Patients under 18 or over 60 should be managed on an individual basis.
- Patients with decompensated cirrhosis should not be treated with interferon.
- Treatment with Interferon is contraindicated in patients with a history of major depressive illness, cytopenia, active alcohol use or illicit drug use, hyperthyroidism, renal transplantation, history of unstable ASCAD, unwillingness to use two forms of contraception, or autoimmune disease.
- Primary care physicians wishing to initiate treatment themselves: An initial consult to GI is encouraged for our evaluation and recommendation to proceed with therapy.
- Physicians should be familiar with the NIH consensus statement.

Indications for Specialty Care Referral

- ANA > 1:320, or ASMA > 1:160.
- Any patient wishing therapy with interferon (please accomplish above INITIAL DIAGNOSIS AND MANAGEMENT as far as possible).
- Patients with signs of decompensated cirrhosis that might be candidates for liver transplantation (i.e., < 70 y/o with encephalopathy, variceal bleeding, or ascites).

Criteria for Return to Primary Care

Completion of subspecialty evaluation or treatment with interferon.

References

NIH guidelines; [NIH Consensus Development Program AALSD guidelines and recommendations](#)

Last Review for this Guideline: **June 2011**
Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator