

Hepatitis C: abstinence-based treatments deserve a bigger role

The value of abstinence is often discounted when giving treatment options to those with Hepatitis C. Commissioning services should reconsider the value of these services, say Tim Leighton and Nick Barton from Clouds.

The Department of Health calls it 'the silent epidemic'. It is estimated that there are up to 500,000 people infected with Hepatitis C in the UK, with between 200,000-300,000 in England alone. About a fifth of these will probably develop cirrhosis of the liver after 20 or more years of infection. It is likely that a considerable number of these will require liver transplants to survive. Of the 50,000 or so that have been diagnosed, most are current or former drug users. People who used drugs in the 70s and 80s are considered to be at higher risk. Samples of current intravenous users show various rates of HCV infection; up to 52 per cent for London and 54 per cent for the North West. Rates in some areas such as Glasgow were much higher than this in the early 90s but appear to have reduced to around 60 per cent.

Early diagnosis and treatment are now considered essential in order to increase the chance of clearance and to reduce the progression to liver damage. The costs of combination therapy (Interferon alfa-2a pr2b with Ribavirin), is £6,000 for 24 weeks, doubling to £12,000 for 48 weeks. These costs can be put into perspective by the costs of a liver transplant, which are quoted as between £70,000 to £100,000. However, the total costs of the procedure, the anti-rejection drugs and long-term aftercare have been estimated as high as £250,000. Dr Torbjorn Sundkvist, consultant in communicable disease control at the Suffolk Health Protection Unit argues that the department of Health should make extra money available for the treatment of Hepatitis C, which is a chronic, or ongoing, illness.

There is a consensus that heavy

alcohol use of more than 7-8 units a day will be likely to accelerate the development of fibrosis and cirrhosis. There is mixed and inadequate evidence about the effects of lower level of consumption. There is probably a genetic vulnerability to alcohol-related liver disease progression, which means some people may be able to get away with considerable alcohol consumption without increasing the progression. Women with Hepatitis C may be at more risk of alcohol related liver damage.

The *National Treatment Outcome research Study* (NTORS) found that 33 per cent of drug misusers were drinking above safe weekly limits at the point of intake. The average daily consumption was 18 units in drug misusers entering residential treatment and 11 units in those entering community methadone programmes. NTORS also found that at one-year follow-up, a substantial proportion continued to drink above safe levels. An evaluation of the treatment outcomes of Clouds House tallied with the NTORS findings. It showed that people referred primarily for a drug problem reported an average daily consumption of 20 units of alcohol per day. This compared to 30 units a day for those referred primarily for alcohol dependence.

Much has been made since NTORS of the failure of drug treatment agencies to address alcohol consumption among drug misusers. This makes sense for general health reasons, but there is another angle to consider: the need to slow or halt the rates of progressive liver damage caused by Hepatitis C, which can eventually require very expensive and radical interventions. Such progressive damage can be arrested by abstinence from alcohol followed by

interferon treatment and possibly reversed, as there is evidence that fibrosis repairs itself after successful treatment. This would seem on the face of it to be a powerful motivation for former drug misusers to adopt an alcohol-free lifestyle also. Certainly those undergoing treatment for Hepatitis

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C should know that alcohol use is considered seriously to interfere with that treatment. It appears to reduce adherence to the treatment and, although more evidence is required, may actually make the drugs less effective.

In July 2004, the Department of Health published *Hepatitis C: Action Plan for England*. Although it indicates clearly that alcohol consumption is a factor associated with rapid progression of the disease, there is no mention in its 'ongoing' or 'future' actions of interventions to reduce or eliminate alcohol consumption among vulnerable drug users. The *Alcohol*

Harm Reduction Strategy for England is similarly deficient. The NTA's *Models of Care for Treatment of Adult Drug Misusers*, on the other hand, does make a recommendation of 'complete abstinence from alcohol... to prevent progression of liver disease'. It adds that, 'even small amounts of alcohol can for some be harmful'.

Despite the recommendations and the evident risks involved in ignoring them, the value of treatment options that include abstinence from alcohol for drug misusers have not been given sufficient recognition. It is time to bridge this gap. Public Health Authorities, PCTs, Drug Action Teams and anyone else commissioning or purchasing services for drug misuse and dependence need to take note.

Existing harm reduction strategies generally aim to minimise new infections and quite rightly so, but this doesn't help those who are already infected and in whom liver disease is progressing relentlessly, in many cases undiagnosed. For this we need a 'transitional' intervention that can help move people towards significant and comprehensive change. Under these circumstances, an effective treatment model that involves engagement with self-help programmes in a supportive fellowship of peers, such as those that draw on the 12-Step approach, offers two distinct advantages. It aims at helping people become abstinent and it routinely addresses the alcohol consumption of people who are considered primarily as drug users. In other words, this type of intervention has a significant role to play in extending the lives of individuals and reducing the nation's health costs where liver disease is concerned.