

# Centers for Disease Control (CDC) Consulting Meeting on Prevention and Control of Viral Hepatitis in Prisons

## Part Two

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This is part two of an article on the March 2001 Centers for Disease Control (CDC) consulting meeting held in Atlanta, GA.

Part one <http://www.hcvadvocate.org/Articles/CDCPrisons.htm> discussed the data on hepatitis in prisons. This article will focus on some of the recommendations made by the consultants assembled at this meeting and some of my impressions of the meeting. It should be noted that the consultants were comprised of government officials doctors, CDC officials, lawyers, pharmaceutical representatives, and prisoner/patient advocates.

The discussions on recommendations for the control and prevention of viral hepatitis in prisons were held in working groups and unfortunately, prisoner / patient advocates were not allowed to sit "at the table" but were relegated to sitting in the back. We were allowed to discuss items only after the panel of "experts" gave their input. I was concerned after talking with a couple of doctors who work in prisons who said they did not believe significant clinical data existed to prove that treatment for HCV with interferon or interferon/ribavirin will alter disease progression. In fact, one doctor who works in prisons said he does not believe that anyone with HCV has symptoms such as fatigue and is convinced that most of the symptoms patients complain about are the direct result of depression and anxiety, not the disease itself. Thankfully, experts in the field of liver disease participated in the working groups and refuted the claims made by these prison doctors. But one does have to wonder of the level of care in prisons from doctors who hold these views.

### Hepatitis A (HAV)

As discussed in part one, HAV infection resolves itself and does not become chronic. Once infected with HAV, a person develops protective antibodies that will prevent future infection. An individuals who have not been previously exposed to HAV should be vaccinated if they are at risk. Since the prevalence rates in prison are unknown, testing for markers, that is evidence of prior exposure, is recommended. If a person does not have any evidence of exposure, vaccination should be considered. If an infection occurs in prison, it was recommended that prisoners and staff coming into direct contact with HAV infected individuals should be vaccinated. Additionally, it is recommended that any person in occupation that has the potential to pass the HAV such as food handlers, be vaccinated against HAV.

### Hepatitis B (HBV)

HBV guidelines are a little more complicated since HBV can lead to chronic infection. HBV is highly infectious by almost any bodily secretion. The potential for infection is high in prisons because of the close proximity of housing and physical interactions in prisons.

It was recommend by most that prisoners be tested for markers of prior infection or chronic active infection. Those who do not have antibodies should be vaccinated. It is especially important to vaccinate against HBV if a cellmate is HBV positive with acute or chronic infection. It was also generally agreed that screening and vaccination should be initiated upon arrival in prison so that the series of HBV vaccinations (3 doses over a 6 month period) can be completed before release. Even if a prisoner cannot complete three doses, most experts recommended they be given at least one dose to protect against future infection because one dose of vaccine can convey a high rate of protection against HBV. It was also recommended that a system be developed that allows the sharing of information between prisons and public health agencies for vaccine tracking which would eliminate the cost of unnecessary doses of vaccine.

Screening and treatment of HBV in prisons has not been well documented. However, it was recommended that screening and treatment guidelines be established.

## Hepatitis C (HCV)

Currently, there is not a vaccine against HCV. Vaccinations against HAV and HBV should be given to anyone with HCV because there is a potential for severe HAV and HBV disease for a person with HCV. The potential cost of HCV in prisons was a part of every discussion. The rate of transmission of HCV in prison is not well understood or documented, but we know the majority of transmissions occur outside of the prison environment. Therefore, in order to address the problem of HCV in prisons many believe the problem of HCV in prisons should be a shared responsibility between the state / national prison systems and the public health sector to properly deal with the crisis. It was also recommended that veterans in prisons be given access to their Veteran's medical benefits to help defray the prisons' burden of medical costs.

## Testing / Screening

The majority of working groups recommended testing for HCV. However, there was not a consensus on guidelines for testing. Some believed that due to the high incidence of HCV in prisons, screening should be routine and given to everyone. Others believed that screening should be tied to potential treatment (if available), risk factors or symptoms because of the potential expense of testing all prisoners. It was generally recommended that testing would require patient consent and would not be mandatory. The big problem is having services such as counseling, education, support, treatment and care available around the testing component. We have been all too familiar with testing without consent or pre- and post-testing counseling. Many prisoner advocacy organizations receive letters from prisoners who have been tested and not told they were tested or when told were not offered any type of education, counseling or care available after diagnosis. Most conference participants believed that there should be an HCV specialist in every prison.

## Treatment

In general, treatment guidelines were not part of the discussion. The CDC officials stated that the treatment guidelines would be taken from the National Institute of Health (NIH) Consensus Statement in 1999– [click here for the NIH Consensus statement](#) –

[http://odp.od.nih.gov/consensus/cons/105/105\\_statement.htm](http://odp.od.nih.gov/consensus/cons/105/105_statement.htm)

Unfortunately, most prisoner/patient advocates believe that these guidelines are out of date and will have a negative impact especially in prisons. It has been rumored that the National Institutes of Health will convene another HCV consensus conference in 2002 that will radically change the approach to HCV treatment in the general population and will be more favorable to treatment of special populations such as prisoners.

Most of the other recommendations were made after discussions in the working groups. Again, it should be noted that prisoner/patient advocates were pretty much excluded from these discussions.

The CDC will release the guidelines sometime this fall. It is hoped that these guidelines will enable prisons to establish a standard of care for prisoners that is available to the general population. This document will not solve all the complex problems of diagnosis, treatment and care of HCV, but will be an important first step.

Source: CDC Draft – Prevention and Control of Infections with Hepatitis Viruses Among Persons in Corrections Settings

Visit these websites for more information on hepatitis C:

National Hepatitis C in Prison Coalition: <http://www.hcvprisonnews.org>

HCV Advocate: <http://www.hcvadvocate.org>