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# HCV ADVOCATE

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## Latinos and Hepatitis C



Alan Franciscus, Editor-in-Chief

There are an estimated 40 million Latinos living in the United States. By the year 2050, it is estimated that Latinos will comprise 25% of the U.S. population, which makes Latinos the largest and fastest growing minority group in the U.S. The prevalence of hepatitis C (HCV) among Latinos is estimated at 2.1% which is significantly higher than the estimated prevalence of 1.8% in the general population, and the 1.5% of the non-Hispanic Caucasian population.

Information regarding differences in HCV disease progression and treatment outcomes in Latinos compared to other races or ethnic groups is sparse and the data that does exist is conflicting. This is in large part due to the lack of large prospective clinical trials.

In the *American Journal of Gastroenterology*, results from a clinical trial by R.C. Cheung and colleagues were reported that may shed some light on the differences between Latinos and non-Hispanic Caucasians.

In this study conducted in 24 Veteran Administration (VA) medical centers across the United States a total of 421 treatment naïve HCV positive Latinos and 2,510 Caucasians were enrolled in a prospective clinical study from December 1999 to December 2000. The aim of the study was to compare the natural history or disease progres-

sion of chronic hepatitis C, and the response of Latinos and Caucasians to HCV treatment.

The characteristics of Latinos and non-Hispanic Caucasians in the trial were similar in age, socioeconomic factors, duration of HCV infection, alcohol consumption and sex (male). However, Latinos were more likely to have a previous exposure to hepatitis A (39.9% vs 26.4%) and HIV coinfection (20.4% vs 3.9%). Risk factor information and race/ethnicity was determined by patient self-reporting. Injection drug use was the most common risk factor in both groups, but was seen slightly more often in Latinos than in Caucasians (63.9% vs. 59.0%). Risk factors reported as seen less often in Latinos included sexual contact with injection drug users and other forms of blood contact (combat, needle stick, surgery).

Liver biopsy was performed in 30% of the patients enrolled in the study and it was found that inflammation was similar in the two groups. However, in the Latino patients, cirrhosis was found to be less common (11% vs. 15.6%), but steatosis was found to be more common (54.7% vs. 43.2%).

### TREATED GROUP

Treatment eligibility criteria were defined by the VA's February

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25, 1999 HCV Treatment Guidelines, which were consistent with those of the 1997 National Institutes of Health (NIH) consensus statement. Study participants who had not been previously treated with HCV medications and who had compensated liver disease were eligible participants. Interestingly, more Latinos (43% vs. 37.8%) were likely to meet all treatment criteria, but fewer Latinos actually started treatment.

There were 88 Latinos and 481 Caucasians treated according to treatment guidelines. The characteristics between the two groups were similar except the Latino group had a higher number of genotype 1 patients, higher viral load, but lower baseline absolute neutrophil count. Only 3.5% of the Latinos had cirrhosis compared to 16.8% of Caucasians (defined as stage 4 fibrosis). However, the percentage of patients with advanced

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fibrosis and mean grade and stage on pretreatment liver biopsy were similar.

Treatment consisted of interferon (alfa-2b) 3 million units three times per week plus ribavirin (1,000mg for people < 75 kg weight and 1,200 mg for people > 75kg weight) per day. Genotype 1 and 4 patients were treated for 48 weeks and genotype 2 and 3 patients were treated for 24 weeks. Treatment was discontinued if genotype 1 and 4 patients remained HCV RNA (viral load) positive after 24 weeks of treatment. Standard guidelines for dose reduction and treatment discontinuation were followed. The results were analyzed on an intention-to-treat basis (all patients counted in final results) See table below.

Sustained virological response (SVR) was defined as undetectable HCV RNA (< 100 copies/mL) 24 weeks after completion of therapy.

Interestingly, in this study there was a minor difference in the SVR between the two genotype 1 groups, but a much lower SVR for Latinos with a genotype other than 1. The authors offered several explanations for this discrepancy including the higher prevalence of genotype 1, higher viral load, and a higher rate of treatment discontinuation among the Latino group.

The authors concluded that based on their study “Latinos were

infected younger, more frequently HIV coinfecting, more likely to meet criteria for antiviral therapy yet less likely to initiate treatment and had a trend toward lower SVR rates than Caucasians, but not in severity of liver disease. Latino ethnicity was associated with early discontinuation but not as an independent predictor of SVR.”

It is also important to remember that in this clinical trial non-pegylated interferon was used. As we have seen with other populations, the SVR rates are dramatically higher in clinical trials that use pegylated interferon plus ribavirin. Currently, a new clinical trial to evaluate the efficacy and safety of PEGASYS® plus ribavirin in treatment-naïve Latino patients versus non-Latino Caucasian patients with chronic hepatitis C - genotype 1 is underway. The anticipated time on the study treatment is 3-12 months and the study population to be recruited is 500+ patients. For more information about this study go to our clinical trials page <http://www.hcvadvocate.org/community/trials.asp> or to [www.clinicaltrials.gov](http://www.clinicaltrials.gov).

### Reference

Cheung, R.C. et al Chronic Hepatitis C In Latinos: Natural History, Treatment Eligibility, Acceptance, and Outcomes American Journal of Gastroenterology 2186-2193, 2005

## HEALTH ALERT FOR THOSE LIVING IN THE GULF COAST AREA

Although hurricane season is almost over, there are still some health threats to those living or assisting others in the Gulf Coast area. High on the list are infectious diseases, particularly Influenza. Another is *Vibrio vulnificus*, bacteria that live in brackish salty water.

*Vibrio vulnificus* can cause very serious health problems and is of a particular concern for those with liver disease. To prevent infection, try not to expose cuts, burns, sores, or other breaks in your skin to marine waters. Also, do not drink marine water or eat raw or undercooked shellfish, such as oysters, clams, and mussels.

*Vibrio vulnificus* can cause wound infections, blood poisoning and gastrointestinal problems. Symptoms of wound infections include redness, swelling, pain in a wound. Fluid-filled blisters may develop. If not treated early, amputation or death may occur. The symptoms of blood poisoning or *septicemia*, are chills, fever, nausea, vomiting, and diarrhea. Skin lesions may appear. If not treated early, death may occur.

A little bit of good news, *Vibrio vulnificus* is less prevalent in the winter and spring. However, if you are a resident or relief worker in the Gulf Coast area and think you may have been exposed to this organism, seek help immediately. Early intervention is essential.

For more information on *Vibrio* see the article on Seafood Safety in the July 2005 *HCV Advocate* newsletter.

	Latino (n=88)	Caucasian (n=481)	p value
End of treatment	27.5%	37.0%	0.079
<b>SVR (overall)</b>	<b>14.8%</b>	<b>22.5%</b>	<b>0.11</b>
Genotype 1	10.2%	14.6%	0.14
Non-genotype 1	17.7%	38.4%	0.055
Early discontinuation	39.8%	28.9%	0.043

# HealthWise:

## *Smoking and Hepatitis C*



Lucinda K. Porter, RN, CCRC

*There is an important event on the third Thursday of every November. No, I am not talking about the U.S. holiday, Thanksgiving. That is on the fourth Thursday. The third Thursday is the American Cancer Society's (ACS) Great American Smokeout. Since 1977, the ACS has waged a campaign encouraging smokers to refrain from smoking for one day. The ACS hopes that one day of abstinence from smoking will lead to a lifetime of freedom.*

Freedom describes precisely one of the benefits gained after quitting smoking. Freedom from a life dependent on managing a habit that the majority of smokers wish they did not have. I know the feeling. I was a one to two pack a day smoker starting in my adolescence and quitting in my early thirties. Quitting smoking was the single hardest thing I ever did. As far as challenges are concerned, it tops my list of accomplishments, ahead of having and raising a child, nursing school, a year of HCV treatment, and a solo climb of Mount Whitney.

When I quit smoking, I vowed I would not become a villainous reformed smoker. I believe I have kept my promise. I am sympathetic to the hideous and all-encompassing nature of this addiction. However, compassion does not mean silence and if there are any smokers still with me at this point, I hope you will consider quitting.

I doubt I need to mention that smoking and health do not mix. Smoking leads to the death of one in ten people worldwide. There is evidence that smoking may lead to more HCV-related inflammation. Nearly a half a million people die annually in the U.S. because of smoking. That is a half a million preventable deaths. Compare that to 8,000 to 12,000 HCV-related deaths and it is clear why tobacco dependence is such a problem. More people die from secondhand smoke (35,000) than from HCV.

Freedom and health are only two of the rewards gained after quitting smoking. There are economic gains as well as the chance to be a positive role

model for our children. The guilt from harming the lungs of our loved ones with our secondhand smoke is a burden that is lifted after quitting. Ostracism and standing out in the cold in order to smoke is another incentive for quitting.

In spite of all the reasons to quit, people continue to smoke. That is because it is hard to quit. Withdrawal is very unpleasant. Some claim that smoking is a way to cope with stress. Some have had trouble quitting in the past. Smokers are afraid to gain weight. There are arguments showing the flaws in these reasons. For instance, the average weight gain is less than ten pounds. Are yellow teeth and premature aging more attractive than a temporary weight gain? There are ways to avoid or minimize weight gain. Besides, a well-nourished alive body seems so much better than a thin but dead skeleton.

Just like drugs and alcohol, there is help for tobacco dependence. There are many free resources for help in quitting (see Resources). Medicare offers smoking cessation coverage for some individuals. Many health insurance companies cover treatment for it. There are books, groups, telephone services, and online support. Acupuncture, acupressure, hypnosis, biofeedback, massage, and stress reduction may also help.

Experts agree that success is most likely to occur with the use of simultaneous tools. These include prescription and non-prescription interventions, counseling and support. Studies show that people who seek outside help are more likely to quit smoking permanently than those who try to quit on their own.

People can and do quit on their own. Whether you do this alone or with support is your choice, with "choice" being the important word here. Has the addictive nature of tobacco robbed you of the freedom to choose health over smoking? If you are ready to reclaim your freedom from cigarettes, I

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## SMOKING

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suggest you make a plan. The resources at the end of this article can help you formulate a plan. It has been said, “failing to plan is planning to fail.” Make a plan, stick to it and you increase your chances of success. If the plan does not work, make a new plan. Never give up. The average smoker has five to seven attempts to quit before doing so permanently.

Seven minutes of life is lost with each cigarette that is smoked. You do the math. Life is short enough. Mark your calendars. The next Great American Smokeout is November 17.

## RESOURCES

For more resources and information, look in the HCV and Wellness Fact Sheet section - [www.hcvadvocate.org](http://www.hcvadvocate.org)

American Cancer Society (ACS) - [www.cancer.org](http://www.cancer.org) Toll free: 1-800-227-2345; A practical and user-friendly web site for those wanting help with tobacco addiction. A good place to begin is to type “guide to quitting smoking” in the search box.

American Lung Association (ALA) - [www.lungusa.org](http://www.lungusa.org) Toll free 1-800-586-4872; Click on “tobacco control” for information about tobacco. ALA has an online tobacco cessation program called “Freedom from Smoking” along with lots of useful tools and information.

National Institutes of Health’s (NIH) MedlinePlus - [www.nlm.nih.gov/medlineplus/smokingcessation.html](http://www.nlm.nih.gov/medlineplus/smokingcessation.html) and [www.nlm.nih.gov/medlineplus/](http://www.nlm.nih.gov/medlineplus/)

[smoking.html](http://smoking.html). Toll call 1-301-496-4000; Medline is a service of the NIH and the National Library of Medicine (NLM). These web addresses link to an enormous amount of information about tobacco and smoking, much of it focused on quitting. Also from the NIH - [www.quitsmoking.com/clearingair.htm](http://www.quitsmoking.com/clearingair.htm)

SmokeFree.Gov - [www.smokefree.gov](http://www.smokefree.gov) National Network of Tobacco Cessation Quitlines Toll free 1-800-QUITNOW (1-800-784-8669) TTY 1-800-332-8615; A national network of U.S. government agencies offering phone and instant messaging assistance for tobacco dependence. Ask for your state or Canada’s toll free number for help quitting smoking.

Access to a free booklet Clearing the Air: Quit Smoking Today ([www.smokefree.gov/pubs/clearing\\_the\\_air.pdf](http://www.smokefree.gov/pubs/clearing_the_air.pdf))

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# Hepatitis C in U.S. Veterans

■■■  
Liz Highleyman

*Hepatitis C is more common among veterans, especially those who served during the Vietnam era, than in the population as a whole. In fact, Veterans Affairs Medical Centers (VAMCs) care for more people with hepatitis C than any other healthcare system in the U.S.*

In the past, many veterans were excluded from hepatitis C treatment due to co-existing psychiatric conditions or substance use. Today, multidisciplinary care, better HCV therapies, and appropriate side effect management allows many such patients to be treated successfully.

## HCV PREVALENCE

The exact prevalence of hepatitis C virus (HCV) infection among veterans is not precisely known. Some early VA surveys found rates around 8-10% – about five times higher than the 1.8% rate for the general population in the National Health and Nutrition Examination Survey (NHANES).

Analysis of data from the VA's National Hepatitis C Surveillance Day in March 1999 during which all blood samples taken at all VA medical facilities (representing more than 26,000 patients) were tested for HCV revealed a seroprevalence rate of 6.6% (Roselle

2002). In a recent VA Cooperative Study of nearly 1,300 patients at 20 VAMCs, the HCV prevalence rate was 5.4% (Dominitz 2005).

Looking only at VAMC patients skews the numbers, however, since medical centers serve sick people and the VA sees a disproportionate number of low-income and unin-

lower: just 1.7% in NHANES. The HCV prevalence among current service members is estimated at less than 1%.

But not all veterans are alike. HCV prevalence rates vary by region – as high as 35% at the VAMC in Palo Alto, CA (Cheung 2000). Some 40% of homeless veterans are HCV positive (Cheung 2002), and among HIV positive veterans, an estimated 40% are coinfecting with HCV.

Hepatitis C rates also differ dramatically based on the period of military service. In Dominitz's study, the HCV rate among veterans who served during the Vietnam War era was 11.5% – about twice the overall rate. Several studies have found that 60-70% of all HCV positive veterans served during the Vietnam years (compared with 4-8% during the Korean War, and less for other periods). Much of this difference is a function of age: some 40-60% of HCV positive veterans are between the ages of 40 and 50. Along with a great risk of infection, veterans in this age cohort are now presenting with symptoms due to liver disease progression over time.

## RISK FACTORS

Several factors contribute to the higher HCV prevalence among veterans. Under combat conditions, blood exposure and blood transfusions are common. Use of medical equipment for more than one person (such as jet air guns used for mass vaccination) can potentially transmit the virus. Until

*The VA recommends HCV screening for veterans with the following risk factors, as well as for anyone who wishes to be tested:*

- *Vietnam era service*
- *Blood transfusion before 1992*
- *History of injection drug use*
- *History of nasal cocaine use*
- *Blood exposure of skin or membranes*
- *History of multiple sex partners*
- *History of kidney dialysis*
- *Tattoos or piercings*
- *Heavy alcohol use*
- *Unexplained liver disease*
- *Unexplained ALT elevation*

sured veterans. The true hepatitis C rate for all individuals who have served in the military is much

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## VETERANS

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1992, blood was not tested for HCV, and universal precautions were not widely adopted until the advent of AIDS.

Military life also lends itself to more traditional risk factors. Members of the military may share personal items such as razors; many have tattoos and some visit prostitutes. Popular wisdom holds that hard drug use was rampant among soldiers serving in Vietnam. In one survey from the early 1970s, 10-15% of servicemen reported using heroin in Vietnam, but only 5-10% reported injecting (the rest smoked it). In Dominitz's study, 78% of HCV positive veterans reported either injection drug use or a blood transfusion. After adjusting for drug use, having a tattoo and incarceration were also associated with increased risk. In another study, injection drug use, transfusions, tattoos, combat medic work, incarceration, multiple opposite sex partners, and sex with a prostitute were independently associated with HCV infection (Briggs 2001).

Although Briggs found that combat medics were at higher risk for infection, most studies indicate that combat- or specifically military-related risk factors are not strongly linked to hepatitis C. In Dominitz's study, for example, military-related exposures were not associated with HCV infection after adjusting for demographic and "lifestyle" factors, leading the authors to conclude that the higher rate among veterans likely reflects "more exposure to traditional risk factors."

Route of infection is an important issue for veterans because the VA usually does not cover treatment for conditions it does not consider "service connected." Since it is dif-

ficult to prove how one got infected, activists have urged the VA to grant the presumption of service connection to all HCV positive veterans.

### BARRIERS TO TREATMENT

Liver disease tends to be more severe among HCV infected veterans, in part because they are more likely to be older than the HCV positive population as a whole. One study found that nearly half of HCV positive veterans biopsied at the St. Louis VAMC had advanced (stage 3-4) fibrosis or cirrhosis (Cawthorne 2002). Veterans as a group also do not seem to respond as well to HCV treatment, in part because they are disproportionately male, African-American, older, and infected longer – all factors associated with poorer response.

In addition to the biological factors that can render interferon-based therapy less effective, psychiatric conditions and drug or alcohol use may also present barriers. Various studies have shown that veterans have higher rates of substance use, depression, and other psychiatric illnesses; in particular, combat veterans may suffer from post-traumatic stress disorder (PTSD). What's more, careful mental health screening may turn up psychiatric problems that are not documented in patients' medical records (Lehman and Cheung 2002).

A retrospective analysis of more than 33,800 HCV positive veterans hospitalised between 1992 and 1999 revealed that 86.4% had at least one psychiatric or substance use disorder: depression (45.6%), PTSD (26.4%), psychosis (22.3%), bipolar disorder (15.5%), and anxiety disorder (44.6%). After adjusting for alcohol use (72.9%) and hard drug use (64.1%), however, the researchers found that psychiatric disorders were not independently associated with HCV, leading them to conclude

that the apparently high rates of psychiatric illness among HCV positive veterans is "mostly explained by their higher frequency of drug and alcohol use" (El-Serag 2002).

### OVERCOMING BARRIERS

Patients with psychiatric conditions and substance users have traditionally been excluded from HCV clinical trials and treatment. In a recent study of more than 4,000 HCV patients enrolled at 24 VAMCs, for example, 60-70% were considered ineligible due to factors including ongoing substance use, psychiatric illness, and co-existing medical problems (Bini 2005).

But recent research suggests that many such patients can benefit from HCV therapy. For example, some small studies show that injection drug users (IDUs) on methadone maintenance – and even those who relapse to drug use occasionally – can achieve acceptable response rates. For this reason, the latest National Institutes of Health (NIH) consensus guidelines (2002) recommend that all HCV patients should be considered for treatment on a case-by-case basis, with no groups automatically excluded.

Management of side effects is crucial in helping patients succeed on hepatitis C therapy. Many patients taking interferon develop depression, while others experience anxiety or insomnia; those with pre-existing psychiatric illness or substance use are at greater risk. In one small study, 68% of patients with pre-existing psychiatric diagnoses developed "major adverse events requiring intervention or discontinuation of therapy," compared with 29% of those without previous known psychiatric illness (Ho 2001). But this need not be an insurmountable barrier: recent research shows

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that antidepressant medications (usually SSRIs) can alleviate depression during interferon therapy – and even prevent it if started before HCV treatment begins.

The key to a successful hepatitis C treatment is comprehensive screening before starting therapy and ongoing monitoring once it has begun. Whenever possible, veterans with HCV should have their care managed by an interdisciplinary team that includes hepatologists, mental health professionals, and substance use specialists. This collaborative approach allows providers to rapidly deal with problems as they arise, thereby helping patients achieve the best possible treatment outcome.

### Medical Writers Circle Articles:

Hepatitis C in the Veteran Population (Ramsey Cheung): <http://www.hcvadvocate.org/hcsp/articles/cheung-1.html>

Managing the HCV Veteran (Samuel Ho): <http://www.hcvadvocate.org/hcsp/articles/Ho-1.html>

Hepatitis C in Vietnam Era Veterans (Bradford Waters): <http://www.hcvadvocate.org/hcsp/articles/vietvet.html>

### Resources:

Department of Veterans Affairs: Health Benefits & Services: [http://www.va.gov/health\\_benefits](http://www.va.gov/health_benefits)

Veterans Affairs National Hepatitis C Program: <http://hepatitis.va.gov>

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Veterans Health Administration. Management of Psychiatric and Substance Use Disorders in Patients With Hepatitis C: A Reference for Hepatitis C Care Providers. 2005. <http://hepatitis.va.gov/vahep?page=tp03-gd-01>

## HCSP GUIDES

The Hepatitis C Support Project has published various publications in our "Guide" series. The Guides are available on our Web site [www.hcvadvocate.org](http://www.hcvadvocate.org)

### ***A Guide to Understanding HCV***

– this Guide provides a simple but comprehensive overview of hepatitis C including transmission/prevention, disease progression, symptoms, diagnostic tools, disease management and information about HCV treatments. (Available in English and Spanish.)

### ***Management of Hepatitis C by the Primary Care Provider: Monitoring Guidelines.***

This Guide provides the medical provider with the necessary information to help identify and manage hepatitis C positive individuals. (Available in English and Spanish.)

### ***A Guide to Hepatitis and Disability***

is one of the most comprehensive documents available on how to prepare and file for social security disability. There is additional information on commercial disability insurance, and health insurance.

### ***A Guide to Hepatitis C Treatment Side Effect Management***

provides information on treatment related side effects and simple tips on how to manage the sides of HCV therapy.

The Guides are downloadable in copy-ready format. Permission to be reprinted is granted and encouraged with credit to the hepatitis C Support Project.



# Extrahepatic Manifestations: *Lichen Planus*



Alan Franciscus, Editor-in-Chief

**L**ichen planus is fairly common skin disorder that may last for months to years and affects about 1 or 2% of the U.S. population. Lichen planus usually affects people between the age of 30 yo and 70 yo and is slightly more prevalent in women than in men. The exact cause of Lichen planus is unknown, but it seems to be triggered by stress, genetics, allergic reactions to medicines, and by viral infections such as hepatitis C. There have been studies that have found a prevalence of HCV in people with Lichen planus from 3.5% to 60%. For this reason, it has been recommended that people with Lichen planus (especially with elevated liver enzymes) should be tested for HCV.

Lichen planus typically affects

the skin, nails, vulva, penis, and mucous membranes including the mouth. The symptoms appear as purple or plaque like shiny flat-topped itchy bumps. There is no cure for Lichen planus but treatment is affective in alleviating the symptoms (itching of the skin lesions) and improves the appearance of the rashes.

## SKIN

Lichen planus most commonly affects the skin. The bumps can appear on any skin surface, but are most often found on the inside of the wrists and ankles, the lower legs, back, and genital regions. In severe cases, the bumps can be extremely itchy and painful. When the lesions heal the skin may become discolored. The skin discoloration may fade over time. Treatment consists of topical steroids and antihistamines used to relieve the itching.

Severe cases may require the use of oral corticosteroids such as cortisone or prednisone. Extreme cases may require photo chemotherapy light treatment and prescription drugs to help control and alleviate the symptoms. Other strategies to reduce the symptoms include the use of oatmeal baths (Aveeno), and anti-itch topical creams.

## MOUTH

Lichen planus of the mouth usually affects the gums, tongue and inner cheeks of the mouth. It appears as white, interconnecting lines which resemble and are named after the lichen plant, but Lichen planus is not related in any way to the plant. Severe cases may involve painful sores and ulcers of the mouth. Very severe cases of Lichen planus of the mouth can slightly increase the risk of oral cancer. For this reason it is important to control the disease with medications and good oral hygiene.

Lichen planus that affects the mouth is generally found by a den-

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## ORGAN DONOR REGISTRY: TEXAS

There is an organ shortage in the United States, especially among minorities. Organ donation rates are lower among minorities while the need for organs is higher. Organ transplantation relies on genetic matching, so people who share ethnic backgrounds are more likely to match each other. This means that, proportionately, minorities have longer waiting times for organ transplantation, are sicker at the time of transplantation and are more likely to die during this wait.

Did you know that non-resident aliens are eligible to give and receive organs? The Anatomical Gift Educational Program (AGEP) is a statewide program maintained by the Texas Department of State Health Services. The guidelines in Texas are similar to those in other states. The most important detail is to tell your close relatives and loved ones about your wishes. Tell your medical providers you wish to be an organ donor. The state of Texas provides a donor card and you can apply a donor sticker to your driver's license. The web address for the Texas registry is [www.dshs.state.tx.us/agep](http://www.dshs.state.tx.us/agep)

For further information, contact:  
Anatomical Gift Educational Program  
Texas Department of State Health Services  
1100 West 49th Street  
Mail Code 1938; Department ID G31000  
Austin, Texas 78756  
Phone: (512) 458-7150  
1-800-222-3986 Toll Free

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tist or dental hygienist. The diagnosis may be confirmed by a biopsy. Yeast infections are commonly found in association with Lichen planus or can be triggered by topical steroids used to treat it. The treatment of the yeast infection sometimes improve the symptoms of oral Lichen planus.

Alcohol, tobacco, spicy foods, peppermint, cinnamon, citrus type foods and stressful situations trigger the symptoms and should be avoided if possible. Treatment of oral Lichen planus includes the use of topical steroids as well as controlling the triggers. Regular dental exams are recommended to look for any tissue changes. Teeth cleaning and good personal oral hygiene will improve the symptoms.

### HAIR

Lichen planus can also occur on the scalp and can cause permanent scarring and inflammation of hair follicles leading to permanent hair loss. To prevent permanent damage, oral steroids, plus topical steroids as well as prescribed oral medications should be taken as soon as possible to prevent permanent damage.

### NAILS

Lichen planus can also affect the nails leading to damage of the nail root. Symptoms include grooving, splitting, nail thinning as well as nail loss. In severe cases the nail loss can result in permanent nail root damage.

#### For more information on the Web:

The Texas A & M University System—Baylor College of Dentistry  
<http://www.tambcd.edu/lichen/>

## HCSP FOREIGN LANGUAGE GUIDES

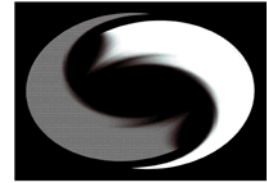
The Hepatitis C Support Project's website [www.hcvadvocate.org](http://www.hcvadvocate.org) offers educational materials in a variety of languages in an effort to serve all of the communities affected by hepatitis C.

We currently offer materials in Spanish, Russian, German, French, Tagalog, Vietnamese, and Chinese.

**\*\*Spanish:** Our fact sheets, as well as the monthly HCV Advocate newsletter are available on a special web page devoted entirely to the Spanish speaking community. Web page: <http://www.hcvadvocate.org/espanol.asp>

**\*\*A Guide to Understanding HCV** is available in Spanish, Russian, French, Vietnamese, and Chinese. HCSP's Easy C Guide to Hepatitis C is available in Spanish and Russian. Web page: [http://www.hcvadvocate.org/hepatitis/hepatitis\\_C.asp](http://www.hcvadvocate.org/hepatitis/hepatitis_C.asp)

**\*\*Fact Sheets** in Russian, French, German, Spanish, and our recently added Vietnamese are available. Web page: <http://www.hcvadvocate.org/hepatitis/factsheets.asp>



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SUPPORT PROJECT

#### Executive Director Editor-in-Chief, HCSP Publications

Alan Franciscus  
[alanfranciscus@hcvadvocate.org](mailto:alanfranciscus@hcvadvocate.org)

#### Managing Editor, Webmaster

C.D. Mazoff, PhD  
[cdmazoff@hcvadvocate.org](mailto:cdmazoff@hcvadvocate.org)

#### Contributing Authors

Liz Highleyman  
Lucinda K. Porter, RN, CCRC

#### Design and Production

Paula Fener  
Blue Kangaroo Design  
[blueroodesign@aol.com](mailto:blueroodesign@aol.com)

#### Contact information:

Hepatitis C Support Project  
PO Box 427037  
San Francisco, CA 94142-7037

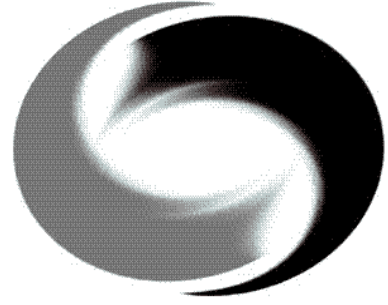
The HCV Advocate offers information about various forms of intervention in order to serve our community. By providing information about any form of medication, treatment, therapy or diet we are neither promoting nor recommending use, but simply offering information in the belief that the best decision is an educated one.

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**HCSP**

P.O. Box 427037  
San Francisco, CA  
94142-7037