Article: Survival of patients with HCV cirrhosis and sustained virologic response is similar to the general population—S Bruno et al.

Source: Journal of Hepatology 2016 vol. 64 j 1217–1223

Study Aims and Results
The study looked at the overall survival of 181 patients with hepatitis C-related cirrhosis who were cured with interferon-based therapy. These patients were compared to hepatitis C patients who had decompensated cirrhosis, non-treated, and non-cured. The overall survival was calculated from the date at the start of interferon therapy to death.

The risk of death to the general population was also established by matching the results to the sex and age results of the general population.

Of the 181 people followed for a median of 9.6 years (range of 1 – 25 years) 28 people died. The 10-year survival was 91% and the 20-year survival was 63%.

The number of expected deaths in the group of people (HCV cured group vs healthy group) matched by sex and age to the general population was the same – 28 people.

There were a very small amount of people who were cured, but developed decompensated cirrhosis and liver cancer even after achieving a cure.

Editorial Comments
This is good news for people with hepatitis C. We need clinical studies with direct-acting antivirals to further understand the relationship between being cured and disease progression. This is even more important with direct-acting antiviral medications.

As mentioned above, there were some people who developed decompensated cirrhosis, liver cancer and died. It is critically important that people are followed after being cured.

Another study conducted by the Veteran’s Administration found that at the beginning of treatment the following factors could influence the further disease progression even after being cured:
- Cirrhosis
- 64 years old
- Genotype 3
- Diabetes.

It is important to know that the risk of these types of complications is low and the benefits of being cured are extremely high. Prevention and vigilance is the key to living well with hepatitis C even after being cured of it.

— Continued on Page 2
Article: Role of human papillomavirus in non-oropharyngeal head and neck cancers—JD Combes et al.


Study Aims and Results
The MD Anderson Cancer Center was the first cancer center established to treat HCV-infected cancer patients. The center physicians started to notice a large number of patients with head and neck cancers among their patients. As a result, they decided to study whether hepatitis C is associated with head and neck cancers.

The medical records at the center from 2004 through 2014 were analyzed for primary oropharyngeal or non oropharyngeal. The control group (non-hepatitis C) had smoking-associated cancers—lung, esophagus, or urinary bladder. The biopsy reports of the oropharyngeal cancers were tested for human papillomavirus (HPV) and reviewed. All of the patients with lymphoma were excluded.

A total of 34,545 cancer patients were tested for hepatitis C. Of those patients, 409 had head and neck cancers (164 oropharyngeal and 245 non oropharyngeal). The number of patients with oropharyngeal cancer with hepatitis C antibodies was 14% compared to 6.5% of those without hepatitis C antibodies. This was even higher in HPV-positive oropharyngeal cancer—16.9% vs. 6.5% and still higher in the non oropharyngeal group—20.0% vs. 6.5%. than in the control group.

The authors concluded that there needs to be further studies to understand the relationship between hepatitis C, HPV and other HPV-related cancers.

Editorial Comments
Hepatitis C is not just a liver disease. It is a systemic disease that affects every area of the body. The larger medical profession is finally catching up to what patients and some medical providers have known all along. More research is needed to understand the connection between hepatitis C and head and neck cancers.

There are well-known extrahepatic-manifestations that affect the mouth and salivary glands such as sialadenitis and Sjogren’s Syndrome. There are many extrahepatic conditions. Want to learn more? Check out our Extrahepatic Manifestation Glossary: http://hcvadvocate.org/resources/glossaries/exhtrahepaticglossary/

Human papillomavirus (HPV) is the most common sexually transmitted infection (STI). HPV is so common that nearly all sexually active men and women get it at some point in their lives. Some types of it can cause health problems including genital warts and cancers. But there are vaccines that can stop these health problems.

Lymphoma is a cancer that starts in the cells that are part of the body’s immune system.

Oropharyngeal cancers are cancers that begin in and around the throat.

Non oropharyngeal cancers are cancers that begin in and around the mouth.

An association is when two different attributes occur together either more or less often than expected by chance. In other words – the association between oropharyngeal and non orpharyngeal cancers doesn’t mean the hepatitis C causes them it means that there is a higher rate of HCV in people who have these types of head and neck cancers.
Facing Unique Hurdles in Pursuit of Healthcare

—By Matthew Zielske

Linkage to care is more than giving someone a positive hepatitis C (HCV) test result and sending them on their way. It is more than a pat on the back with a few pamphlets of health information and the reassurance, “you can call if you ever have any questions,” and it’s certainly more than telling HCV positive persons, “it [your liver] isn’t bad enough yet, come back in a few months and we will check on it again,” while not providing any social support or care.

I’ve heard similar experiences from many of the people living with HCV that I work with, and after each one I find myself more frustrated with the current state of HCV linkage to care services. Compared to HIV infection, HCV is lagging behind in overall treatment and health outcomes. Yes, we know how to cure HCV at rates of 95% or greater, something we can’t do with HIV, but effective treatments for HCV only matter if people can complete care. In my previous essay I mentioned Vanderburgh County ranks 77 of 92 counties in Indiana for overall health outcomes. Hearing that, it may come as a surprise Vanderburgh County ranks 9 of 92 counties in Indiana for clinical care. The county has comparably great health care options, services and providers, while also having a track record of those services not being highly accessed consistently for long term health care.

County health rankings, the source of the above data, uses various metrics to compile the overall health outcomes for U.S. counties. A few of the key metrics used include: quality of life, health behaviors (this includes statistics on, alcohol, STDs, teen pregnancy and chemical overdose deaths), clinical care (there are 1,039 people for every primary care physician, which is better than the national average) and social and economic factors (this includes statistics on high school and college graduation rates, poverty and insurance). The complex method of calculating each counties overall health outcomes means that no single social determinant of health is the cause for deficits in the health of a local population. More specifically, the issues of linkage to care experienced by HCV positive persons with substance use concerns cannot be significantly improved by only focusing on structural improvements. Such an approach would be missing the subtleties of patient frustration.

There are a few issues that seem to be arising more often. They include provider concerns of patient consumption of alcohol, and the view by some
providers that HCV reinfection is likely because of past substance use. What we are finding however, is that if these provider concerns are about the efficacy of HCV medication and treatment uptake, then they are nothing more than rhetoric being used to hide stigma. Research shows alcohol does not significantly affect the success of HCV medication (e.g. Harvoni, Sovaldi, Zepateir) at curing hepatitis C, nor is HCV reinfection among substance users as high as previously thought.

A research study published in the Journal of Hepatology followed a cohort of treatment successful participants over a seven-year span from Sweden. The study showed the reinfection rate of HCV was 11%, and linked primarily with the occurrence of relapse. This means reinfection can be addressed by focusing on relapse prevention. When given adequate funding syringe exchange sites and universal access to harm reduction education increases the overall health outcomes of HCV positive persons with substance use concerns.

The more social determinants of health a patient is affected by (low income and education, race/ethnicity, health literacy) the more challenging improving their health will be. These patients are faced with navigating more barriers than others, and are likely to be experiencing all of this with less help and higher levels of anxiety and uncertainty.

Although policy changes can improve the linkage to care services of affected populations, and their overall health outcomes, exclusively doing so will push marginalized groups further to the fringes of healthcare by ignoring their diversity of healthcare needs. HCV positive persons with substance use concerns operate within a delicate space when accessing health care. Successfully addressing the growing HCV epidemic means being acutely aware of this.

I am worried that an often reported problem HCV positive persons with substance use concerns experience in accessing health care is going unaddressed. Cultural sensitivity is hard to measure and improve because it is rooted not in broken policy, but in the opinions and perceptions of people. No matter how well we improve over health outcomes through policy change, until we collectively view HCV positive persons with substance use concerns as human beings who demand respect and are eager to improve their lives and health, instead of saying through body language and subtleties they are more work than they are worth, we will continue seeing increases in HCV incidence and poor health outcomes.

Matthew Zielske currently works as a HIV/HCV special populations prevention specialist at an HIV services organization. He utilizes a harm reduction model in his work with the substance use population focusing pointedly on persons who inject drugs. He is currently conducting research on Health Literacy and hepatitis C for his Master’s Thesis in Communications.
I read an article in the *New Yorker* that has been nagging at me for five years, “Top Athletes and Singers Have Coaches. Should You?” Written by one of my favorite writers, physician Atul Gawande argues forcibly that even when we are at our best, a coach can help us in many ways. Top tennis players and musicians use coaches throughout their careers. They are always striving to learn. Did I need a coach to help me be a better hepatitis C advocate? The essay stirred something in me, and I did what I often do when faced with potentially life-changing information, I filed it away. A year later, I discovered blogger Matt Starr, a health coach with hepatitis C. Matt used his experience with hep C, cirrhosis, multiple treatments, transplant, and post-surgical complications as opportunities for transformation. Instead of lying down and dying, he turned to yoga, meditation, and self-care. He coached himself to a wellness that transcends his physical maladies, and he lives in peace. At that time of my life, I was healthy, making decent choices, but there was room for improvement. However, I knew I could do better, and I wondered if I needed a coach to help me be a better hepatitis C advocate?

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At that time of my life, I was healthy, making decent choices, but there was room for improvement. However, I knew I could do better, and I wondered if I needed a coach to help me to be healthier. Matt inspired me, and I thought about asking him to coach me to a healthier lifestyle, but frankly, I wasn’t ready for yoga and gardening. I filed the notion away.

One thing about change is that it occurs when we are ready for it, and not a moment sooner. In my case, it took nearly five years from reading that New Yorker article to committing to working with a coach. But when I was ready, change happened easily.

Sometimes change may seem to happen accidentally, although when I write this, it clearly didn’t happen by chance. I discovered coach Toni Feldstein because of an essay she wrote in the *Huffington Post*. At that point, I had decided if I wasn’t going to use a coach, I could at least write about the value of coaching, so I contacted her. You can probably guess the next part; I ended up asking her to be my coach.

Toni and Matt understand what it is like to live with that ticking time bomb, hepatitis C. Both know fear, yet both learned how to live in peace. Toni felt that empowering herself was a better choice than living in fear. She was willing to take a risk to be as strong as possible. Matt was called by a desire to attend to a purpose beyond his own story, as if the bumps and challenges were ultimately part of a deep plan to illuminate and transform. Love figures prominently in both Matt and Toni’s journeys.

**What Does a Coach Do?**

There are many types of coaches, such as life, business, financial and health coaches. Matt and Toni are both life coaches who do health coaching. Clearly, their hepatitis C experiences were pivotal to their own decisions to become coaches. In my work with Toni, I cannot separate my health from my life choices; my health is the foundation that everything rests on.

Toni describes her role as a coach, “To assist clients to establish a grounded position, to design a plan, build momentum through action, and to maintain the motivation...”
and commitment needed to achieve their goals. If you are dealing with a chronic illness, I help you manage and cope with your illness and condition, as well as taking proactive actions to improve your sense of good health, wellness and state of mind.”

Coaching begins with an honest assessment of where you are in the moment. A coach asks the right questions, and in the process, encourages clients to see where they are and what they want. Matt puts it this way, “I teach clients how to use positive attitudes and actions to heal from within and love the life they live despite setbacks. You move beyond your limitations, and embrace what you want from life.”

Why Use A Coach?

I fought the idea of working with a coach. I was afraid and I made up stories. What if I learned that the only way I’d be happy is by living in a monastery? Or worse, if I had to take up running? What if coaching was time-consuming, or costly. Besides, couldn’t I just make some goals for myself and then make them materialize, despite the fact that this has never worked for me before?

It took me five years to decide to work with a coach. It felt like I did more work in my first week working with Toni than I did in those five years. The experience was profound and it was fun. Toni didn’t tell me to do yoga and plant kale. She helped me discover what I could do. The accountability and companionship of a wounded healer were enough for me to make genuine change. Now I can’t imagine not having a coach.

Choosing a Coach

• Look for a coach that fits your needs. If you want to learn how to be healthy with liver disease, then work with someone who understands that disease. Matt and Toni understand both. I choose Toni because she understands that people who no longer have hepatitis C still have health issues. “Treatment can sweep the virus away, but it doesn’t sweep away our habits and thinking,” she said.

• Work with a certified coach. There are varieties of certification programs. Spend a little time reading the credentials of the coach you are considering, and see if their style resonates with you.

• Ask for a free introductory session. Many coaches offer this; it’s a good way to explore if that coach is right for you, and if coaching is really what you need.

• Look for a coach who is focused and concrete. You should see results. Your coach should be helping you assess, plan, and reach your goals. If you aren’t getting anywhere, either you aren’t ready or you haven’t found the right coach. In either case, don’t waste your time and money.

If money stands between you and working with a coach, find out if there are any webinars, group sessions, or ways to work with your budget. I am famously frugal on most things, but when it comes to my health, it makes no sense to be pennywise, pound-foolish. If health is truly my foundation, then that foundation better be a solid one.

My only mistake was not doing this sooner. But as I said, we change when we are ready. Perhaps I would have gotten a coach earlier if I read these words by Toni, “We cannot wait until the conditions are right to reach for joy and happiness and to blossom into our very best selves. Life is here for the taking, for the grabbing with all of our might.”

 integral Bloom with Toni Feldstein
www.integralbloom.com

Starr Wellness Coaching with Matt Starr
www.starrwellnesscoaching.com

Lucinda K. Porter, RN, is a long-time contributor to the HCV Advocate and author of Free from Hepatitis C and Hepatitis C One Step at a Time. She blogs at www.LucindaPorterRN.com and HepMag.com
The current drugs to treat hepatitis C have high cure rates and minimal side effects (compared to the older therapies). This has created a dilemma for drug developers who must develop new drugs that somehow improve upon the current drugs. This is a difficult task, but not impossible. Probably the biggest achievement will be shorter treatment duration and lower cost. There is a percentage of patients who are the more difficult to treat, such as those with genotype 3 who have cirrhosis and have not achieved a cure with a previous course of therapy. The race is on for new, better and cheaper therapies—this is very good news for people living with chronic hepatitis C.

You will see below that the need for these new therapies has narrowed the pharmaceutical companies to a number that you can count on your fingers! As a result I have decided to rework our pipeline and list it by the pharmaceutical company. I am also just listing the major studies. This is also a new pipeline that will grow as information is released. The pipeline is a brief overview. More extensive information is listed in our newsletters and in our blog.

A brief overview of how this pipeline is laid out:

**Date:** The Pipeline will be updated on a monthly basis and will be included with the HCV Advocate Newsletter

**Genotype (s):** This lists the drugs or combination of drugs and the particular genotype or genotypes that the drug is active against.

**Comments:** This section will list the study results. Within this section, I will list the genotype(s) being studied and the phase of the study with a brief recap of the study.

You will note that many of the drugs or combinations of drugs are pan-genotypic—that is they work on many or most of the HCV genotypes. **Note:** Many of the drugs listed below have been updated with the latest information from the Liver Meeting 2015 and and the International Liver Congress 2016. More detailed information about drugs in development is available in our blog and reported in the HCV Advocate newsletters.
### AbbVie

**COMMENTS:**

**Genotype 1 – Phase 2 Study:** Information from the International Liver Congress 2016: AbbVie’s once-daily therapy of ABT-493 (protease inhibitor) and ABT-530 (NS5A inhibitor).

**Non-cirrhotic patients** Treatment period - 8 weeks:
- Genotype 1: 85% were treatment-naïve; 15% were pegylated interferon (PEG)/ ribavirin (RBV) experienced, cure rates—97% (33 of 34 patients)
- Genotype 2: 87% were treatment-naïve; 87% were PEG/RBV treatment experienced: cure rate—98% (53 of 54 pts)
- Genotype 3: 100% were treatment-naïve: cure rate—97% (28 of 29 pts)

**Treatment period 12 weeks:**
- Cirrhotic treatment-naïve patients, genotype 3 – cure rate —100% (24 of 24 patients)
- Non-cirrhotic treatment-naïve patients (85%), PEG/RBV (15%); genotype 4 (22 pts), genotype 5 (1 pt), genotype 6 (11 pts)—cure rate—100% (34 of 34 pts)

**Bottom line:** cure rates were 97% to 100%.

### Gilead

**COMMENTS:**

- **Genotype 1 – Phase 3:** Sofosbuvir plus velpatasvir (GS-5816) In Phase 3 clinical trials (ASTRAL-1-4), the cure rates in genotypes 1 through 6 ranged 97% to 100%. Gilead has applied for marketing approval to the Food and Drug Administration, (FDA) and approval is expected in 2016. The most common side effects were headache, fatigue, sore throat, runny nose, and nausea. In January 2016 the combination received priority review status and Gilead stated that FDA approval is expected by June 28, 2016. To view the Phase 3 data go here: [http://hcvadvocate.org/news/NewsUpdates_pdf/Advocate_2016/advocate0116_mid.pdf](http://hcvadvocate.org/news/NewsUpdates_pdf/Advocate_2016/advocate0116_mid.pdf)

- **Genotype 1 and 3 - Phase 2:** Information from ILC 2016: In the group of treatment-naïve patients treated for 6 weeks the cure rate was 79% (53 of 67 pts); the treatment-naïve group that was treated for 8 weeks the cure rate was 96% (95 of 99 pts)

In another study to treat people who are treatment experienced genotype 1 through 6 and who had been treated with a previous course treatment—prior NS5A-experienced (27%); non-NS5A-experienced (52%), direct-acting antiviral-experienced (DAA (52%), and 21% that failed an interferon-based therapy without a DAA. The cure rate was 99% (127 of 128 pts).

In yet another study GS-9857 with sofosbuvir/velpatasvir was tested to treat DAA experienced genotype 1 patients with cirrhosis. The treatment period was 12 weeks. The cure rate was 100% (24 of 24 pts).

**The bottom line:** the cure rates were in the 79% to 100% in people treated 6 to 12 weeks.

The combination of sofosbuvir, velpatasvir and GS-9857 is currently in phase 3 clinical trial (POLARIS 1,2,3 and 4). The Food and Drug Administration (FDA) has granted the combination as Breakthrough Therapy for those who have previously failed an NS5A Inhibitor-containing regimen.
### COMMENTS:

- **Genotype 1 – Phase 1:** In a small study of samatasvir, it was found to be safe and have antiviral properties against genotype 1, 2, 3 and 4. There is now a phase 2 study of samatasvir plus Olysio (simeprevir) in treatment-naïve patients with genotype 1b or 4.

- **Genotype 1:** Janssen (Alios Pharma) has initiated a phase 2a study of AL-335, odalasvir, and simeprevir to treat HCV genotype 1 treatment-naïve patients. There will be 60 patients divided into three treatment arms who are treated for 4, 6 or 8 weeks.

- **Genotype 1 – Phase 2 Study:** ACH-3422 and Odalasvir (ACH-3102) and Sovaprevir are in studies with various combinations. Recently, Johnson & Johnson Innovation – JJDC, INC (Janssen) made an investment in Achillion for co-development and distribution.

- **Genotype 1 – Phase 2 Study:** Odalasvir plus sofosbuvir (used as a proxy drug) to treat genotype 1 patients for 6 weeks achieved 100% (12 of 12 patients) cure rates. A proxy drug is a drug used to stand in for another drug. Sofosbuvir is a polymerase inhibitor so it is assumed that odalasvir plus a polymerase inhibitor that is being developed by Achillion will produce similar cure rates.

- **Genotypes 1 through 6 – Phase 2b Study:** Odalasvir, AL-335, and simeprevir in treatment-naïve and treatment-experienced patients with and without cirrhosis. The trial will enroll 400 patients for six or eight weeks. The study will include four arms with different combinations of drugs. The trial will begin in June 2016 and end in July 2017.

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**RX**

**DRUG**

**PIPELINE** — CONTINUED FROM PAGE 8

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### COMMENTS:

**Merck**

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- **Phase 2** - The study was to evaluate the safety and efficacy of an all-oral therapy. There were three different groups that included treatment-naïve, non-cirrhotic patients. The patient population included 93 genotype 1 patients, 61 genotype 2 patients, and 86 genotype 3 patients. The treatment duration was 8 weeks. All of the treatment groups received MK-3682 (300 mg or 450 mg) combined with grazoprevir/elbasvir or grazoprevir/MK-8408.

Twenty-four percent of genotype 1 patients had resistant associated variants (RAVs): 59% had NS3 (protease) RAVs and 21% had NS5B (polymerase) RAVs.

The overall cure rates were 91 to 100% in the genotype 1 groups; 60 to 94% in the genotype 2, and 86 to 91% in genotype 3. The drugs were well-tolerated with no treatment discontinuations.

Part B of C-CREST 1 and 2 will evaluate the most effective dose to treat prior treatment failures, cirrhotic patients and treatment in people with HIV/HCV coinfection.

**Bottom line:** The most effective dose was associated with cure rates in the 90 to 100%.

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### COMMENTS:

**Regulus**

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**Regulus Therapeutic Inc.**

The study included 79 treatment-naïve genotype 1 and 4 patients. RG-101 is a GalNAc-conjugated anti-miR targeting miR-122, a host factor for HCV infection. It is an injectable medication given at Day 1 and Day 29 plus 4 weeks of a once-a-day direct-acting antiviral medication –Harvoni (27 patients), Olysio (27 patients), Daklinza (25 patients). Sixty-four of the patients were evaluated through week 8 of follow-up, 41 reached 12 weeks post treatment.

The cure rate was 97% (40 of 41 pts).
WHAT’S UP!

WE HAVE REVIEWED AND UPDATED THE FOLLOWING GUIDE AND FACT SHEETS:


The following Easy C fact sheets

Easy C Fact Sheet: 
HCV and Hepatitis B Coinfection

Easy C Fact Sheet:
HIV and HCV Coinfection

Easy C Fact Sheet:
Methadone and HCV

Easy C Fact Sheet:
HCV and Transgender People

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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