World Hepatitis Day is July 28. Recent data published by the World Health Organization (WHO) estimates that there are 325 million people worldwide living with chronic hepatitis B virus (HBV) or hepatitis C virus (HCV) infection. According to the *WHO Global Hepatitis Report 2017*, a large majority of people with viral hepatitis lack access to testing and treatment. This puts millions at risk of chronic liver disease, cancer, and death. Vaccines and medicines can prevent this.

In 2015, approximately 1.34 million people died because of viral hepatitis. This mortality rate is comparable to the number of deaths caused by tuberculosis and HIV. A big difference between these diseases is that TB and HIV mortality rates are decreasing while hepatitis-related deaths are increasing. Only 11 percent of people living with HBV and/or HCV are aware of their status.

New HCV infections are increasing. In 2015, there were roughly 1.75 million new HCV infections. Globally, there are approximately 71 million people living with HCV. There is no vaccine against HCV, and access to treatment for it is low.

Routine vaccination has caused the rate of new HBV infections to decline. Approximately 84 percent of children born in 2015 were vaccinated against hep B. However, many people were born before the days of routine HBV immunization. Thus, 257 million people are living with chronic HBV infection; access to HBV treatment is low.

The goal of WHO’s Global Health Sector Strategy on viral hepatitis is to test 90 percent of the at-risk population.
population and treat 80 percent of people with HBV and HCV by 2030. To some, that may seem like a long time away. To me, this seems just around the corner. When I contracted HCV 30 years ago, the virus didn’t even have its own name yet, let alone a cure. The notion that HCV can be eliminated in my lifetime is a breathtaking goal. It makes me want to roll up my sleeves and get to work.

The best way to get a sense of how WHO is going to do this is to read the Global Hepatitis Report 2017. Here are some successes that show how elimination is possible:

- China, a country with high HBV and HCV infections rates, along with a high incidence of liver disease, has dramatically cut HBV prevalence rate in children under age 5 to less than 1 percent.
- Access to HBV and HCV treatment in Mongolia has dramatically risen; 98 percent of its population has coverage for treatment.
- Egypt, a country where the hepatitis C prevalence rate has been reported as high as 22 percent, has increased access to generic hepatitis C medicines. The price of drugs is dropping. Three months of HCV treatment costs about $200 (USD). In Pakistan, it costs as little as $100 (USD).
- The country of Georgia has a high prevalence of HCV. In 2015, Georgia committed to an elimination plan that included screening and treatment at no cost to those with HCV. Georgia’s goal is to reach HCV elimination by 2020.
- Australia has an ambitious plan to treat all Australians with HCV. It is on track to eliminate hepatitis C by 2026.
- WHO added sofosbuvir plus velpatasvir to its list of essential medicines, which are medications that should be available to everyone, everywhere. The list includes the first combination therapy to treat all six types of hepatitis C.
In 2016, four major global liver organizations issued a joint statement calling for the elimination of viral hepatitis. The organizations are the Latin American Association for the Study of the Liver, the European Association for the Study of the Liver, the Asian Pacific Association for the Study of the Liver, and the American Association for the Study of Liver Disease (AASLD). This year, the National Academies of Sciences, Engineering, and Medicine released their phase two report, “Eliminating the Public Health Problem of Hepatitis B and C in the United States.”

Eliminating hepatitis requires a little bit of help from everyone, which brings me back to World Hepatitis Day. This year’s theme is “Show Your Face” (#ShowYourFace). Drop by the site, upload your photo, add a message, and put a face on hepatitis. However, don’t stop there; get involved. Every action, no matter how small or how frequent, puts us a step closer to eliminating viral hepatitis. Click on World Hepatitis Day’s “get involved tab” for suggestions such as:

- Share your Show Your Face message.
- Plan or participate in an event. There are event toolkits on World Hepatitis Day’s web site.

People living with viral hepatitis live with it every day. One awareness day is not enough. But it’s a start. And what I said before, I will say again: Every action, no matter how small or how frequent, puts us a step closer to eliminating viral hepatitis.

Resources

American Association for the Study of Liver Disease www.aasld.org
Asian Pacific Association for the Study of the Liver http://apasl.info/
Centers for Disease Control and Prevention www.cdc.gov/hepatitis/hcv/index.htm
European Association for the Study of the Liver www.easl.eu
Latin American Association for the Study of the Liver http://aleh2016.wp/
World Health Organization www.who.int/hepatitis/en
World Hepatitis Alliance www.worldhepatitisalliance.org
World Hepatitis Day “Show Your Face” Campaign http://worldhepatitisday.org/showyourface

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 www.HepMag.com
In our final turn at covering European Association of Liver Disease (EASL)—International Liver Conference (ILC) Matthew and I will be writing our last HCV Advocate’s coverage of this important conference. The conference highlighted so many important studies that included many positive outcomes. It is important to know that the studies are a snapshot of clinical studies. I eagerly await the journal articles to review the more detailed information to learn more about these studies.

**SOURCE**

Abstract #FRI-234: Efficacy and safety of Epclusa (sofosbuvir plus velpatasvir) in people with chronic hepatitis C virus infection and recent injecting drug use: The SIMPLIFY study—J. Grebely et al.

**Study Aims and Results**

The study was an international study to evaluate the safety and effectiveness of sofosbuvir and velpatasvir in people infected with hepatitis C.

The people in the study included HCV Genotypes 1 (35%); 2 (5%); 3 (58%); 4 (2%), age <40yo 24%, female sex 28%, no opioid substitution therapy, but were injecting drugs 32%; opioid substitution and injecting drugs 42%, minimal/early fibrosis (F0-F1) 62% or early/severe fibrosis (F2-F3) 26%, cirrhosis (F-4) 9%.

The study recruited patients from 19 international sites. There were 114 people recruited for the study; 103 who started treatment. Three patients discontinued treatment who were lost to follow-up and there was one death. There was one case of relapse due to reinfection of hepatitis C. The cure rate was 94% (96 of 102 people).

**Conclusion**

There were very high cure rates and only one reinfection. The people in this trial will be followed for a period of three years.

**Editorial Comments**

The clinical trial validates that people who inject drugs who are on or off opioid substitution therapy can be successfully treated with direct-acting antiviral therapy. We need to treat people everyone with hepatitis C including injection drug users.

**SOURCE**

Abstract # THU 271: Improvement of glycemic state among responders to sofosbuvir-based DAAs—S. A Alem et. al.

**Study Aims and Results**

Egypt has the highest percentage of hepatitis C worldwide as HCV genotype 4 is the most common one in Egypt. The aim of the study was to understand the effect of sofosbuvir-based therapy on blood sugar levels.
Sixty patients—mostly male (70%); mean age 55yo; 48% cirrhotic; treatment naïve (70%) were treated with a variety of sofosbuvir-based therapies including simeprevir, ledipasvir or daclatasvir with and without ribavirin. The treatment period was 12 weeks. Thirty-six patients were on oral diabetic medications; 7 patients were on oral and insulin diabetic medications and one patient was on no diabetic medication. The fasting blood sugar levels (FBS) and hemoglobin A1C (HbA1c) were assessed at week 0 (baseline) and at 12-week post follow-up (SVR12-cure).

All of the patients in the study were cured of hepatitis C. There was a significant decline in the FBS and HbA1c between baseline and at the time of cure regardless of which drug was combined with sofosbuvir. The decline in FBS and HbA1c was more significant in the cirrhotic patients.

Conclusions
Treatment of hepatitis C in people with diabetes resulted in a significant decline in fasting FBS and HbA1c levels.

Editorial Comments
The link between diabetes and hepatitis C is a controversial issue. This study shows that there is an improvement in the levels of blood sugar numbers. Before drawing final conclusion I will need to read the journal article to support this study. As someone who is living with diabetes, I hope that this and other studies support the conclusion that being cured of hepatitis C improves the outlook of people with hepatitis C and diabetes.

*Fasting blood sugar levels (FBS) is a blood test—usually done in the morning before someone has eaten. The normal levels of fasting blood sugar levels are 70 to 100 mg/dl.

*Hemoglobin A1C (HbA1c) — sugar (glucose) substances becomes ‘stuck’ to hemoglobin—molecules in the blood. The test can measure how much of the sugar has become ‘stuck’ to hemoglobin over the previous three months. It is a test that is used to understand how well type 1 and type 2 diabetes is being controlled.

SOURCE
Abstract # THU-244 Treatment with direct-acting antiviral agents is associated with improvement of renal function in a cohort of hepatitis C virus infected patients with chronic kidney disease—C Masetti et.al.

Study Aims and Results
The hepatitis virus causes kidney disease through a complex process of an interaction with the immune system, the liver and the kidney.

The goal of the study was to understand the improvement in kidney function after being cured of hepatitis C.

The study included 42 HCV patients with kidney disease (38 pts stage III; 2 pts stage IV; 2 pts stage V). Note: Kidney disease is staged from Stage 1 to Stage 5 with Stage 1 mild kidney disease through Stage 5 kidney failure.

The results reported are end-of-treatment results. All patients were HCV RNA (viral load) negative. The cure rates are pending. Seventy-four percent had an improvement in kidney function. The increase in
Editorial Comments

This is good news for people with hepatitis C and kidney disease. I want to see more information about the slight worsening of kidney functioning. I also want to understand if the results are different once the cure rates are known and if the kidney function has recovered once significant time has elapsed.

Alan Franciscus is the Executive Director of the Hepatitis C Support Project and the Editor-in-Chief of the HCV Advocate Website.

More Highlights from the International Liver Conference – Part 3

SOURCE

Abstract #THU-439 interferon-free therapy is effective and safe for hepatitis C recurrence in liver transplant hepatitis C virus/human immunodeficiency virus coinfected recipients: a case-control study- M.-C. Londoño, et al.

Study Aims and Results: Current studies show interferon-free treatments are successful and safe for monoinfected liver transplant recipients with hepatitis C. There are fewer examples looking at how successful direct acting antivirals are in HCV/HIV co-infected liver transplant recipients. This study focused on looking at the success and side effects of interferon-free treatment in a national cohort of HCV/HIV coinfected participants who had HCV return after transplantation. There were 38 HCV/HIV coinfected and 133 HCV monoinfected liver transplant participants enrolled in the study. The two groups were fairly similar in gender, age, genotype, viral load, fibrosis stage and the amount of time from transplantation to treatment at 38 and 47 months. All coinfected participants were on HIV treatment; 84% had a RNA viral load of less than 50 copies/ml (undetectable) and a median white blood cell count of 367 cells/uL. For comparison, 1100-1400 white blood cells/ul is the range of someone who is not immunocompromised. The top three direct acting antiviral treatments that were used are as follows: ledipasvir + sofosbuvir ± ribavirin (RBV) (33%), simeprevir+ sofosbuvir ± RBV (31%), daclatasvir + sofosbuvir ± RBV (28%), simeprevir+daclatasvir ± RBV (5%), and AbbVie’s 3D...
(3%). More than half of each cohort received RBV. The treatment success was also close among the cohorts, with 92% of the coinfected group having a sustained virologic response 12 weeks post treatment (cure), and 96% of the monoinfected group. There were no serious side effects of treatment or differences in success related to genotype and advanced fibrosis.

**Conclusion:** This study was able to show interferon free treatments for HIV positive people who have had hepatitis C return are successful with few side effects. As important, this study showed that the success rates of interferon free treatment were similar to hepatitis C monoinfected participants.

**Editorial Comments:** Tackling the issue of treatment for people who receive a liver transplant and have hepatitis C return is crucial to any elimination plan. This is important not only among monoinfected people but those who are coinfected with compromised immune systems. The closer we can get to a treatment that is effective on both cohorts and has fewer side effects, the more likely we are to eliminate hepatitis C and save lives. Most importantly, this study shows that even after liver transplants people can be treated.

**SOURCE**
Abstract #THU-457 Favourable virological and clinical outcomes at 1 year after liver transplantation in hepatitis C virus-positive patients who received direct-acting antivirals on the waiting list-S. Martini, et al.

**Study Aims and Results:** The return of hepatitis C is very common for people who are viremic when receiving a liver transplant. Significant liver stiffness was highly linked with the transplantation failure one year post treatment. This study looked at what effects treatment of hepatitis C with direct acting antivirals (DAAs) pre-transplant had on health outcomes 1 year after transplantation. From July 2014 and October 2016 there were 64 hepatitis C positive people treated with direct acting antivirals + ribavirin while on the wait list who underwent a transplantation. Of those, 16 participants made the transition from pre- to post-transplant and remained hepatitis C negative. The median age of recipients was 57 years old; 84% were male. The median donor was 66 years old. The amount of time participants who were hepatitis C negative prior to liver transplant was 94 days. Of the 55 participants who reached SVR12 post-transplant, 54 of them were hepatitis C negative. The median number of days for follow up post-transplant was 377.

**Conclusion:** This study was able to show that using DAAs pre-, and close to, transplantation resulted in 98% of the participants being hepatitis C negative. Treating before transplant also led to fewer post-transplantation liver complications and rejections. Even though many of the transplantation donors were elderly, 75% of the participants showed absent/mild liver scarring 1 year after transplantation.

**Editorial Comments:** Liver transplantation is expensive, scary and comes with a risk of failure. This study showed that curing someone of hepatitis C before they receive a transplant can significantly reduce the poor outcomes that have been shown among those who don’t receive similar treatment. Being able to reduce liver scarring and the risk of transplant being rejected is encouraging. This gives hope to those seeking a transplant and confidence for all involved that it will work and they can remain cured.

“The closer we can get to a treatment that is effective on both cohorts and has fewer side effects, the more likely we are to eliminate hepatitis C and save lives.”
HCV Advocate
Monthly Pipeline Update

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:** There is more detailed information about the drugs in development in our newsletter (http://hcvadvocate.org/publications/newsletter/) and our blog (http://hepatitisc.hcvadvocate.org/) and in the HCV Advocate Hepatitis C Drug Pipeline & Conference Coverage Site hcvdrugs.com

For EASL coverage see www.hcvdrugs.com

If you are interested in finding out about clinical trials visit HCV Advocate Clinical Trial Reference Guide (http://hcvclinical.hcvadvocate.org/) for a list of trials that are currently recruiting patients.

### AbbVie

| Genotype(s): 1, 2, 3, 4, 5, 6 (Pan-genotypic) |  |

**COMMENTS:**
The combination of glecaprevir (ABT-493) plus pibrentasvir (ABT-530) to treat genotype 1, 3, 4, 5, 6 for a treatment duration of 8 weeks. The sustained virological results (SVR12/cure) released on 11/12/2016 are listed below:

<table>
<thead>
<tr>
<th>Study Name</th>
<th>Patient Population</th>
<th>Treatment Duration</th>
<th>Treatment Regimen</th>
<th>SVR&lt;sub&gt;12&lt;/sub&gt; Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENDURANCE-1</td>
<td>GT1 without cirrhosis, new to treatment or not cured with previous IFN-based treatments (pegIFN +/- RBV or SOF/RBV +/- pegIFN), and patients co-infected with HIV-1</td>
<td>8 week</td>
<td>G/P</td>
<td>99% (348 of 351 pts)</td>
</tr>
<tr>
<td>ENDURANCE-3</td>
<td>GT3 without cirrhosis, new to treatment</td>
<td>8 week</td>
<td>G/P</td>
<td>95% (149 of 157 pts)</td>
</tr>
<tr>
<td>SURVEYOR-2 (Part 4)</td>
<td>GT2, 4, 5, or 6 without cirrhosis, new to treatment or not cured with previous IFN-based treatments (pegIFN, SOF/RBV or pegIFN/SOF)</td>
<td>8 week</td>
<td>G/P</td>
<td>97% (196 of 203 pts)</td>
</tr>
</tbody>
</table>

*pegINF = pegylated interferon; RBV = ribavirin; SOF = sofosbuvir;
This combination was granted Breakthrough Therapy designation by the Food and Drug Administration (FDA) for those with HCV genotype 1 who had failed a previous course of therapy that contained a NS5A inhibitor.

In December 2016 AbbVie applied to the FDA to market and treat all HCV genotypes with the combination listed above. On February 02, 2017 the FDA granted AbbVie Priority review for this combination.
**COMMENTS:**

Gilead released the results of four phase 3 studies (POLARIS) of the triple combination of sofosbuvir (polymerase inhibitor), velpatasvir (NS5A inhibitor), and voxilaprevir (protease inhibitor). The study included 1,056 patients who received the triple combination (sofosbuvir (SOF), velpatasvir (VEL), plus voxilaprevir (VOX)—611 were treatment naïve and 455 were treatment experienced.

Nota: I am only listing the results from the triple therapy below — you will note that the percentage and numbers include all the patients treated. For a complete breakdown of all treatment regimens see November 2016 newsletter: http://hcvadvocate.org/news/NewsUpdates_pdf/Advocate_2016/advocate1116.pdf

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Genotype</th>
<th>Treatment</th>
<th>Duration</th>
<th>SVR12 Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLARIS-1</td>
<td>NS5A inhibitor-experienced 41 percent (172/415) had cirrhosis</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>SOF/VEL/VOX</td>
<td>12 Weeks</td>
<td>96% (253/263)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Placebo</td>
<td>12 Weeks</td>
<td>0% (0/152)</td>
</tr>
<tr>
<td>POLARIS-4</td>
<td>DAA-experienced (No NS5A inhibitor) 46 percent (153/333) had cirrhosis</td>
<td>1, 2, 3, 4</td>
<td>SOF/VEL/VOX</td>
<td>12 Weeks</td>
<td>97% (177/182)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SOF/VEL</td>
<td>12 Weeks</td>
<td>90% (136/151)</td>
</tr>
<tr>
<td>POLARIS-2</td>
<td>DAA-naïve 18 percent (174/941) had cirrhosis</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>SOF/VEL/VOX</td>
<td>8 Weeks</td>
<td>95% (476/501)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SOF/VEL</td>
<td>12 Weeks</td>
<td>98% (432/440)</td>
</tr>
<tr>
<td>POLARIS-3</td>
<td>DAA-naïve All had cirrhosis</td>
<td>3</td>
<td>SOF/VEL/VOX</td>
<td>8 Weeks</td>
<td>96% (106/110)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SOF/VEL</td>
<td>12 Weeks</td>
<td>96% (105/109)</td>
</tr>
</tbody>
</table>

The side effects were similar between the placebo (sugar pills) group, sofosbuvir plus velpatasvir, and the sofosbuvir, velpatasvir plus voxilaprevir groups. The most common side effects were headache, fatigue, diarrhea and nausea. Only one patient in the entire study discontinued therapy due to side effects.

This combination was granted Breakthrough Therapy designation by the Food and Drug Administration (FDA) for those with HCV genotype 1 who had failed a previous course of therapy that contained a NS5A inhibitor.

In December 2016 Gilead applied to the FDA to market and treat all HCV genotypes with the combination listed above—combined into one pill taken once-a-day.
EASL 2017: The results of the phase 2 study results of JNJ-4178 are included in the table below:

<table>
<thead>
<tr>
<th>AL-335 (mg QD)</th>
<th>ODV (mg)</th>
<th>SMV (mg QD)</th>
<th>HCV Genotype</th>
<th>Dosing Duration (weeks)</th>
<th>Number (%) with undetectable HCV RNA at SVR24*</th>
</tr>
</thead>
<tbody>
<tr>
<td>400</td>
<td>50 QD</td>
<td>100</td>
<td>1</td>
<td>8</td>
<td>20/20 (100%)</td>
</tr>
<tr>
<td>800</td>
<td>50 QOD</td>
<td>75</td>
<td>1</td>
<td>8</td>
<td>20/20 (100%)</td>
</tr>
<tr>
<td>800</td>
<td>50 QOD</td>
<td>75</td>
<td>1</td>
<td>6</td>
<td>20/20 (100%)</td>
</tr>
<tr>
<td>800</td>
<td>50 QOD</td>
<td>—</td>
<td>1</td>
<td>8</td>
<td>21/25 (84%)</td>
</tr>
<tr>
<td>800</td>
<td>50 QOD</td>
<td>—</td>
<td>1</td>
<td>12</td>
<td>7/8 (88%)</td>
</tr>
<tr>
<td>800</td>
<td>50 QOD</td>
<td>75</td>
<td>3</td>
<td>8</td>
<td>0/5 (0%)</td>
</tr>
<tr>
<td>800</td>
<td>50 QOD</td>
<td>75</td>
<td>3</td>
<td>12</td>
<td>10/13 (77%)</td>
</tr>
</tbody>
</table>

QD: every day; QOD: every other day; RNA: ribonucleic acid; SVR: sustained virologic response. *All results SVR24, with the exception of genotype 3 which is SVR12 **One patient did not attend SVR12 follow-up.

Note: The two drug combination of odalasvir and AL-335 for a treatment duration of 8 weeks will not proceed into phase 3 clinical trials. Clinical trial development of the combinations to treat HCV genotype 3 will also not move forward.

The combinations were generally safe and well-tolerated.

The next phase of development is to study these combinations in phase 2B studies.
**Merck**

<table>
<thead>
<tr>
<th>Genotype(s)</th>
<th>1, 2, 3, 4, 5, 6 (Pan-genotypic)</th>
</tr>
</thead>
</table>

**COMMENTS:**

- **Phase 2 - AASLD 2016:**

  **C-Crest:** The trial was a phase 2 study of a 3-drug co-formulation of MK-3682 (polymerase inhibitor), grazoprevir (protease inhibitor) plus ruzasvir (NS5A inhibitor) with and without ribavirin to treat HCV genotypes 1, 2 and 3. The treatment period was 8, 12 or 16 weeks. In the people who were previously treated with pegylated interferon plus ribavirin the SVR12/cure rates were 95% to 100% in genotype 1a, 1b and 3. In people with genotype 2 the cure rate was 87% in the 8-week group and a 100% rate in the 12-week group and 96% to 98% in the 16-week groups. There was very little difference in cure rates between the groups who had cirrhosis, and who did/did not receive ribavirin.

  **C-Surge:** An on-going phase 2 study to treat people with genotype 1 who had failed a previous course of a direct-acting antiviral therapy (Harvoni or Zepatier) using MK-3682, grazoprevir and ruzasvir with and without ribavirin. In the group that received ribavirin the treatment duration was 16 weeks; in the group that did not receive ribavirin the treatment duration was 24 weeks. The cure rates were 98% (43 of 44 pts) in the 16 week group that received ribavirin and 100% (49 of 49 pts) in the 24 week group that did not receive ribavirin.

**Regulus**

<table>
<thead>
<tr>
<th>Genotype(s)</th>
<th>1, 2, 3, 4, 6</th>
</tr>
</thead>
</table>

**COMMENTS:**

Regulus Therapeutic Inc.

The study included 79 treatment-naive 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). Regulus issued a press release on June 7, 2016 that reported through 24 weeks of follow-up an additional 4 patients relapsed.

<table>
<thead>
<tr>
<th>Time Since Treatment Completion</th>
<th>RG-101 + Harvoni</th>
<th>RG-101 + Olysio</th>
<th>RG-101 + Daklinza</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 12</td>
<td>27/27 pts (100%)</td>
<td>26/27 pts (96.3%)</td>
<td>22/24 pts (91.7%)*</td>
</tr>
<tr>
<td>Week 16</td>
<td>21/21 pts (100%)</td>
<td>19/20 pts (95.0%)</td>
<td>20/22 pts (90.9%)</td>
</tr>
<tr>
<td>Week 20</td>
<td>14/14 pts (100%)</td>
<td>13/15 pts (86.7%)</td>
<td>13/13 pts (100%)</td>
</tr>
<tr>
<td>Week 24</td>
<td>10/10 pts (100%)</td>
<td>8/10 pts (80.0%)</td>
<td>8/9 pts (88.9%)</td>
</tr>
</tbody>
</table>

*One patient missed the Week 12 visit. Viral load results for this patient at week 8 and 16 were collected and indicate that the patient was a responder at both time points.*
How to take care of your veins and when to know if you hit a vein or artery.

Techniques on safe injecting.

What is it and how to use it?

What are they and how they work?

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