→ Dr Hyde

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GSL/JCA

27 September 1993

Dr S Horsley
Chief Medical Officer
North West Regional Health Authority
Gateway House
MANCHESTER

Dear Dr Horsley

Chronic Hepatitis C Infection in Haemophiliacs

I thought I should write to you to flag out a health issue which relates to the past treatment of Haemophilia. This is a potential litigation issue and (almost inevitably) the treatment involved is expensive.

As a result of treatment with non-heat treated blood products prior to 1985, many Haemophiliacs developed clinical jaundice or deranged liver function tests, not associated with serological evidence of hepatitis A or hepatitis B ("non-A, non-A hepatitis"). Recent technological advances have identified a new virus, hepatitis C, for which serological screening tests are available. We have been screening our Haemophilia population and I can give you a break-down of our results so far.

Hepatitis C antibody positive 113/162 (70%)

of the Hepatitis C + ve patients:

35 (31%) have deranged liver function tests

48 (42%) are also HIV positive

NB "Abnormal liver function tests" signifies most recent serum transaminases greater than one and a half times the laboratory upper limit of normal. It should also noted that the results are as yet incomplete and the percentages may change slightly.

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To summarise the problem, therefore, approximately 70% of Haemophiliacs are hepatitis C antibody positive, as a result of hepatitis C infection transmitted by blood products before 1985. Approximately a third have deranged liver function (biochemically). Anecdotally, I should mention that one patient has received a liver transplant, and 2 others (both HIV positive) died of liver failure (with advanced AIDS).

There is genuine uncertainty about the natural history of hepatitis C infection and its best management.

Long-term studies appear to suggest that the probability of developing clinical liver failure among those who survive for 15 years after hepatitis C infection is about 20%. The experience of colleagues (any my own experience) suggests that this risk is considerably higher where there is concomitant HIV infection.

There is considerable uncertainty about the best management of patients with hepatitis C infection. I enclose a copy of a recent editorial in the Drug and Therapeutics Bulletin. As a take-home message, this can be read as advocating 6-12 months treatment with Interferon for hepatitis C antibody positive patients with histological evidence of liver damage. This editorial, however, makes it clear that the long-term benefits of such treatment with Alpha Interferon remains unproven.

I would also point out that many Centres advocate liver biopsies prior to treatment with Interferon and as a follow-up after such treatment. A severe haemophiliac will typically require 20,000 units of Factor VIII to cover a liver biopsy. The cost of diagnostic assessment, treatment with Interferon, and subsequent reassessment would therefore be approximately £10,500. (£4,000 to cover the Factor VIII for each liver biopsy and £2,500 to cover 12 months treatment with Interferon).

This is a new and evolving field, and at least one large British centre does not do liver biopsies on haemophiliacs before treating with Alpha Interferon. These are also blood tests becoming available which may be helpful predictions of active and continuing Hepatitis C injection.

From discrete sounding out of the Haemophilia Society, I think it is very likely that they will start to campaign in the relatively near future for compensation for hepatitis C infection and also for its active treatment.

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In view of this, I feel that it is vital that the problem is actively managed. I would find it extremely valuable if a Regional Policy or consensus statement could be formulated, enabling me, for example, to approach purchasers for the not-inconsiderable costs.

I would very much welcome your thoughts on how the Region should approach this issue.

Best wishes.

Yours sincerely

GRO-C

Dr G S Lucas
Acting Haemophilia Director

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