HCV ECHO Case Recommendations

Session 3: February 10, 2025

Case Recommendations and Considerations:

CATEGORY	RECOMMENDATIONS	Relevant Presentation Question or Concern	REFERENCES/ RESOURCE LINKS
History	• Efforts must be made to obtain information from the primary source. For example, a records request for the full report of a patient's imaging study may be invaluable in providing guidance to the treatment team on how best to move forward with a patient's care.	1. How do you obtain more information on incidental findings written on patient's discharge summary that necessitate close follow-up?	
Physical Exam	•		
Diagnostic evaluation	• Obtain an AFP level for all patients with liver nodules. One should not be overly re-assured that a negative AFP indicates no malignancy, especially if your pre-test probability is higher. AFP may be falsely negative in patients with liver malignancy. In addition, review the patient's imaging report and consider repeat imaging. The echogenicity of a liver nodule may provide clues to the likelihood of malignancy. Sub-centimeter nodules tend to be less worrisome, especially if stable over time. For a sub-centimeter nodule, biopsies are unreliable because sampling errors can occur. • Take caution when interpreting low platelet counts for patients with risk factors for chronic liver disease. Also consider a hematologic etiology. Review other	1. For patients with liver nodules found on imaging, what other tests should you order? 2. Does a low platelet count always refer to liver disease in a patient with a history or exam suggestive of increased risk? 3. Is ultrasound enough to evaluate a liver nodule in a patient with chronic liver disease?	

	parameters of the patient's complete blood count as a decrease in other cell lines—red blood cell count, white blood cell count—may indicate a different etiology for a patient's low platelet count. If imaging is available, checking the spleen size may also help. ● In patients with advanced chronic liver disease, ultrasound may not be sufficient in the evaluation of liver lesions. Advanced imaging with a CT scan, especially a triple phase CT, or MRI would provide more information.		
Medication Therapy & Adjustments	● Yes. All patients found to have chronic hepatitis C infection should be treated. Patients with complicated social histories and ongoing risk factors in the community may have to be engaged differently. Strategies such as motivational interviewing and leveraging available community resources and timing (e.g. patient's motivation for change) can be used.	1. For patients with complicated social histories and risk factors who are incidentally found to have hepatitis C through screening programs on the field, do they warrant treatment?	
Vaccination	● Your approach to asking a patient about vaccination can greatly affect your success rate. Don't ask patients if they "want" the vaccine. Typically, the answer would be no. Explain that the vaccine can prevent infection and is recommended, then ask "*May I give it to you today?*". If a patient has risk factors or has chronic liver disease and is not otherwise already immune, then vaccination protecting against hepatitis A and B is beneficial.	1. How do you improve your vaccination rates? Is it beneficial even if a patient has "aged-out" a vaccine?	
Social Determinants	●		

of Health (SDOH)			
Behavioral Health	•		
Screening	•		
Risk Reduction	•		
Other	•		

Didactic Q&A:

1. Is HCV Genotype 3 more difficult to treat and associated with worse liver disease?

HCV Genotype 3 was historically easier to treat than genotype 1, but was and is still associated with worse disease. Current treatment regimens are pan-genotypic, meaning they are effective for all genotypes. Evidence exists that even advanced liver disease, like cirrhosis, when associated with HCV can improve with treatment.

2. How do we adjust treatment regimens or medications for patients on acid blockers?

Try to find out the reasons or the indications for the patient being on an acid blocker. If a patient has stronger indications requiring continued use of an acid blocker, like Barrett's esophagitis or high risk for UGI bleed, then glecaprevir/pibrentasvir (Mavyret) may be the more appropriate HCV regimen as it does not require gastric acidity for absorption. The NS5A component of sofosbuvir/velpatasvir (Epclusa) is dependent on gastric acid for absorption. If taken with a gastric acid blocker, the efficacy may be decreased. If a patient has to be on an acid blocker and also needs to take sofosbuvir/velpatasvir for HCV treatment, their interaction can be minimized by more widely separating the timing of intake between the two.

One should be careful of sudden discontinuation of proton pump inhibitors (PPI), especially for patients who have been on these medications for a long time. Rebound reflux can occur. If there is no strong indication for continued PPI use, tapering the PPI can be an effective strategy for discontinuation. An example would be one pill every other day for a period and then one pill every third day for a period and then discontinue. A trial can be done prior to complete discontinuation of the PPI.