
Respect


Qualité


Solidarité


Innovatie


Engagement

National Hepatitis plan

Dr JP Mulkay

Clinic of Hepatology

Department of Hepato-Gastro-entrology

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National hepatitis Plan

- Hepatitis B: plan non-existent.
  - People's migration from endemic countries.
  - Reimbursement of treatment not adapted to the reality.
    - Cirrhotic patient with normal transaminases.
    - Prevention of Perinatal HBV Transmission (High viral load).
    - HBV reactivation on chemotherapy and immunosuppressive therapy
- Hepatitis C: plan available.
- Hepatitis Delta: plan non-existent
  - People's migration from east European countries.
  - Treatment not reimbursed.

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FEDERALE OVERHEIDSDIENST VOLKSGEZONDHEID, VEILIGHEID VAN DE VOEDSELKETEN EN LEEFMILIEU

[C − 2014/24267]

Protocolakkoord 'HCV-Plan'

SERVICE PUBLIC FEDERAL SANTE PUBLIQUE, SECURITE DE LA CHAINE ALIMENTAIRE ET ENVIRONNEMENT

[C − 2014/24267]

Protocole d'Accord 'Plan VHC'

- In June 2012, an inter-ministerial conference decided to adopt a plan of action against Hepatitis C.
- Published and brought out by the minister of Health on 8 August 2014.
- Developed through collaboration between government, hepatologists, HIV specialists, patients groups, Harm reduction groups, professional groups of gastro-enterologists.
- Goals of the plan:
  - Reduce transmission.
  - Increase the number of HCV+ patients aware of their diagnosis.
  - Enhance patients' care pathway and quality of live.

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Hepatitis C plan Belgium 2014-2019

6 strategic axis

1. Prevention
2. Testing
3. Linkage to care and Health care pathway
4. Hep A and Hep B vaccination
5. Scientific Research.
6. Epidemiologic follow-up.

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HCV plan (12/05/2014): 22 actions

- **Prevention**
- 1.Inform and sensibilize
- 2. Enforce the capacities of psychiological/medical/social actors
- 3. Develop prevention
- **Screening**
- 4. Develop a national HCV screening strategy
- 5. A HCV blood test in the hospital
- 6. Better inform GP's
- 7. Inform the population on risks and screening
- 8.Retest after cure with PCR in certain risk groups
- 9.Organise a follow up plan for detected cases
- **Healthcare pathway: linkage to care and treatment**
- 10. Develop a HCV expertise network
- 11. Reimbursement should not be dependent on a biopsy.
- 12. Minimalize the administrative burden for treatments.
- 13. Take into aocount the children.
- 14. Evaluation of fibrosis regarding international guidelines
- 15. Develop a national point for information
- 16. Enforce the capacities of phychologica/medical/social actors
- 17.Drugs delivery by hospital pharmacies
- 18.Speed up access to new HCV medication
- 19. More rationale on PCR testing
- **Vaccination**
- 20. Vaccination HAV en HBV
- **Clinical Research**
- 21. Support further research in HCV
- **Epidemiologic follow-up**
- 22. Database with HCV pos patients

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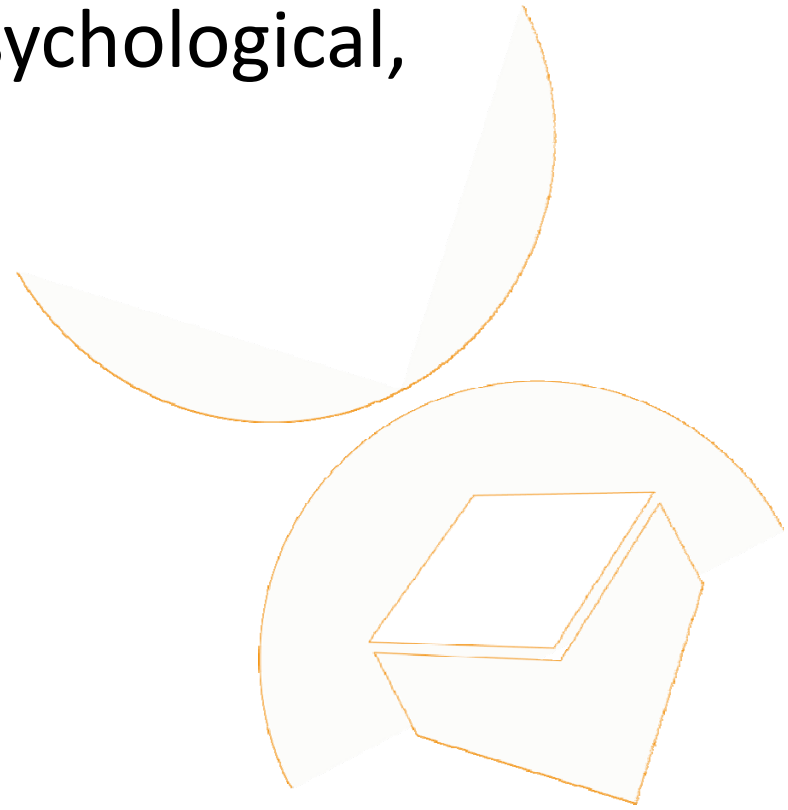
Prevention

1. Inform and raise awareness on prevention.
2. Enforce the capacities of psychological, medical and social actors.
3. Develop prevention.



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Prevention

- Lack of good prevalence data by groups.
- Lack of government support to develop awareness campaigns.
- HCV not regarded as a priority for education programs for physicians.
- Awareness levels of general population, high prevalence groups and GP's are not measured.
- Low GP's awareness about current treatment effectiveness.

✓ Strong harm-reduction programs.

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Prevention

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Screening

4. Develop a national HCV screening strategy.
5. Offer a HCV blood test in the hospital (free and anonymous).
   - Helpcenter Antwerpen, Elisa Bruxelles, CHU de Lìege.
6. Better inform GP's.
7. Inform the population on risks and screening.
8. Retest after cure with PCR in certain risk groups.
9. Organize a follow up plan for detected cases.

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Screening

Linkage to care and Health care pathway

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Linkage to care and Health care pathway

10. Develop a HCV expertise network.
    - HCV Working group meetings to plan the future of HepC care between nov/14 and April/15.

The Disease Burden of Hepatitis C in Belgium : An update of a realistic disease control strategy

P. Stärkel[1], D. Vandijck[2,3], W. Laleman[4], P. Van Damme[5], C. Moreno[6], S. Blach[7], H. Razavi[7], H. Van Vlierberghe[8]

(1) Cliniques Universitaires Saint-Luc, Université Catholique de Louvain (UCL), Brussel, Belgium ; (2) Ghent University, Ghent, Belgium ; (3) Hasselt University, Dept. of Health Economics & Patient Safety, Diepenbeek, Belgium ; (4) University Hospitals Leuven, KU Leuven, Leuven, Belgium ; (5) Universiteit Antwerpen, Antwerpen, Belgium ; (6) Erasme University Hospital, Université Libre de Bruxelles, Brussels, Belgium ; (7) Center for Disease Analysis (CDA), Louisville, Colorado, USA ; (8) Ghent University Hospital, Ghent, Belgium.

Achieving WHO recommendations for Hepatitis C Virus Elimination in Belgium

Stefan Bourgeois[1], Sarah Blach[2], Christian Brixko[3], Wim Laleman[4], Catharina Matheï[5], Jean-Pierre Mulkay[6], Homie Razavi[2], Geert Robaeys[7,8,9], Peter Stärkel[10], Pierre Van Damme[11], Hans Van Vlierberghe[12], Dominique Vandijck[13,14], Christophe Moreno[15]

(1) ZNA Campus Stuivenberg, Antwerp, Belgium ; (2) Center for Disease Analysis, Louisville, CO, USA ; (3) Department of Gastroenterology and Digestive Oncology, CHR Citadelle, Liege, Belgium ; (4) University Hospitals Leuven, KU Leuven, Leuven, Belgium ; (5) Department of Public Health and Primary Care, University Hospitals Leuven, KU Leuven, Leuven, Belgium ; (6) Hepato-gastroenterology, CHU Saint-Pierre, Brussels, Belgium ; (7) Department of Gastroenterology and Hepatology, Ziekenhuis Oost-Limburg, Genk, Belgium ; (8) Faculty of Medicine and Life Sciences, Hasselt University, Diepenbeek, Belgium ; (9) Department of Hepatology, UZ Leuven, Leuven, Belgium ; (10) Cliniques Universitaires Saint-Luc, Université Catholique de Louvain (UCL), Brussels, Belgium ; (11) Universiteit Antwerpen, Antwerpen, Belgium ; (12) Ghent University Hospital, Ghent, Belgium ; (13) Ghent University, Ghent, Belgium ; (14) Hasselt University, Dept. of Health Economics & Patient Safety, Diepenbeek, Belgium ; (15) CUB Hôpital Erasme, Université Libre de Bruxelles, Brussels, Belgium.

Mitigating the burden of hepatitis C virus among people who inject drugs in Belgium

Catharina Matheï[1], Stefan Bourgeois[2], Sarah Blach[3], Christian Brixko[4], Jean-Pierre Mulkay[5], Homie Razavi[3], Geert Robaeys[6,7,8]

(1) Department of Public Health and Primary Care, University Hospitals Leuven, KU Leuven, Leuven, Belgium ; (2) ZNA Campus Stuivenberg, Antwerp, Belgium ; (3) Center for Disease Analysis, Louisville, CO, USA ; (4) Department of Gastroenterology and Digestive Oncology, CHR Citadelle, Liege, Belgium ; (5) Hepato-gastroenterology, CHU Saint-Pierre, Brussels, Belgium ; (6) Department of Gastroenterology and Hepatology, Ziekenhuis Oost-Limburg, Genk, Belgium ; (7) Faculty of Medicine and Life Sciences, Hasselt University, Diepenbeek, Belgium ; (8) Department of Hepatology, UZ Leuven, Leuven, Belgium.

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Linkage to care and Health care pathway

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19. More rationale on PCR testing.

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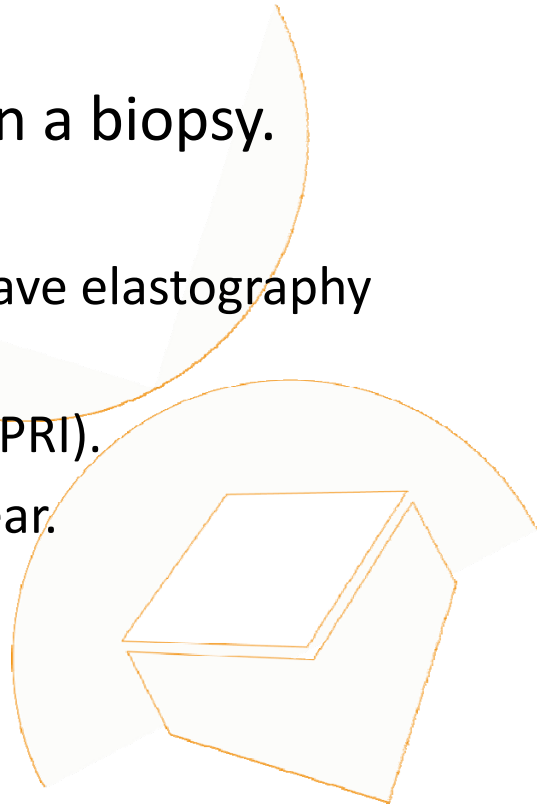
Linkage to care and Health care pathway

10. Develop a HCV expertise network
11. Reimbursement should not be dependent on a biopsy.
    - Either a liver biopsy, or
    - Either one elastography test (Fibroscan, Shear wave elastography or ARFI).

      + one biological fibrosis score (Fibrotest, FIB-4, APRI).
    - Maximum age of elastography and lab values: 1 year.
    - Results to be kept in file of patient.



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19. More rationale on PCR testing (labeled centers).

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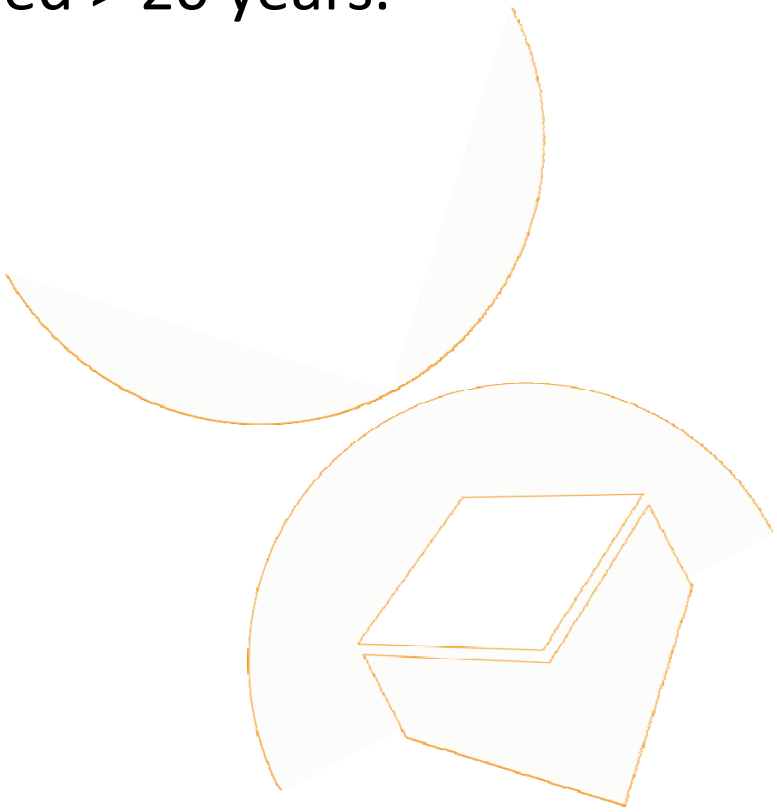
Linkage to care and Health care pathway

Vaccination

20. Vaccination HAV and HBV.
    - Implemented and recommended > 20 years.
    - Specific populations.
        - Infants and children.
        - Hemophiliacs.
        - Hemodialysis patients.
        - Candidates for organ transplants.
        - Family members
        - Unvaccinated teenagers.
        - Mentally handicapped.
    - Health workers.
    - PWID ??



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Vaccination

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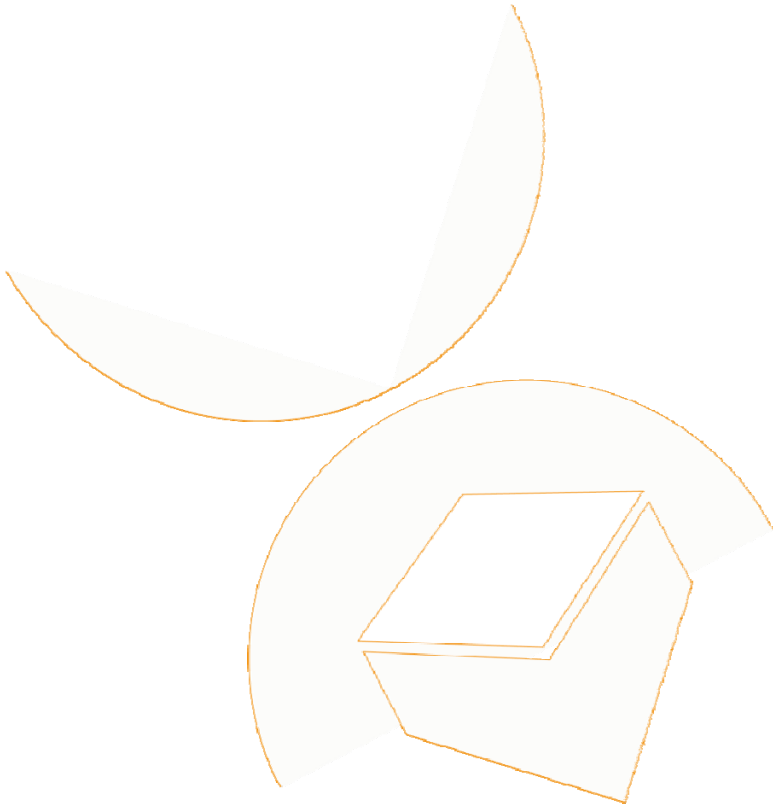
Clinical research

21. Support further research in HCV



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Clinical research

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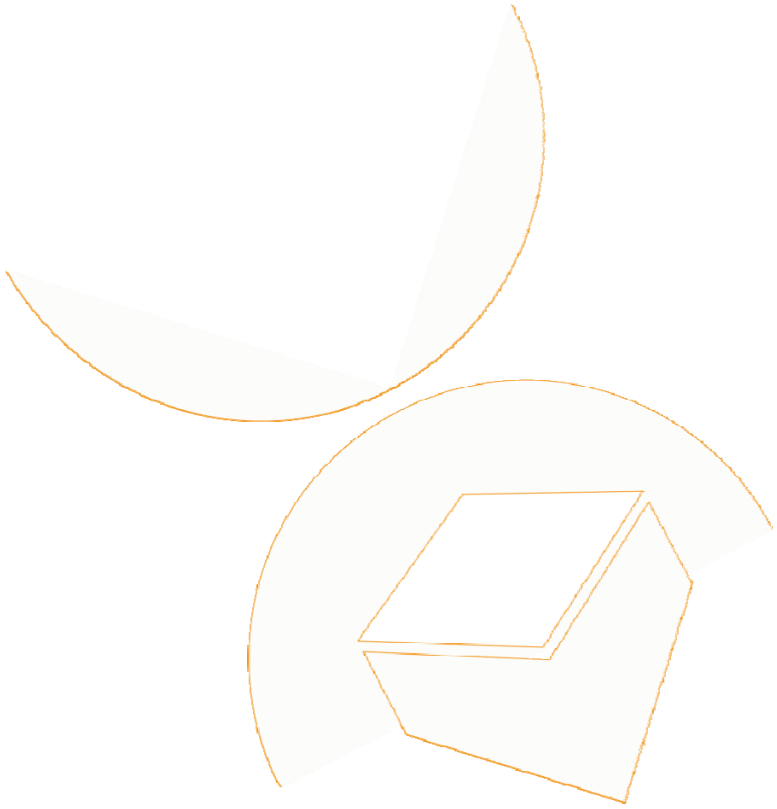
Epidemiological follow-up

22. Database with HCV positive patients.



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Epidemiological follow-up

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HCV plan (12/05/2014): 22 actions

- **Prevention**

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3. Develop prevention

- **Screening**

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18. Speed up access to new HCV medication
19. More rationale on PCR testing

Vaccination

20. Vaccination HAV en HBV

- **Clinical Research**

21. Support further research in HCV

- **Epidemiologic follow-up**

22. Database with HCV pos patients

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Hepatitis C plan: 2017

6/22 27%

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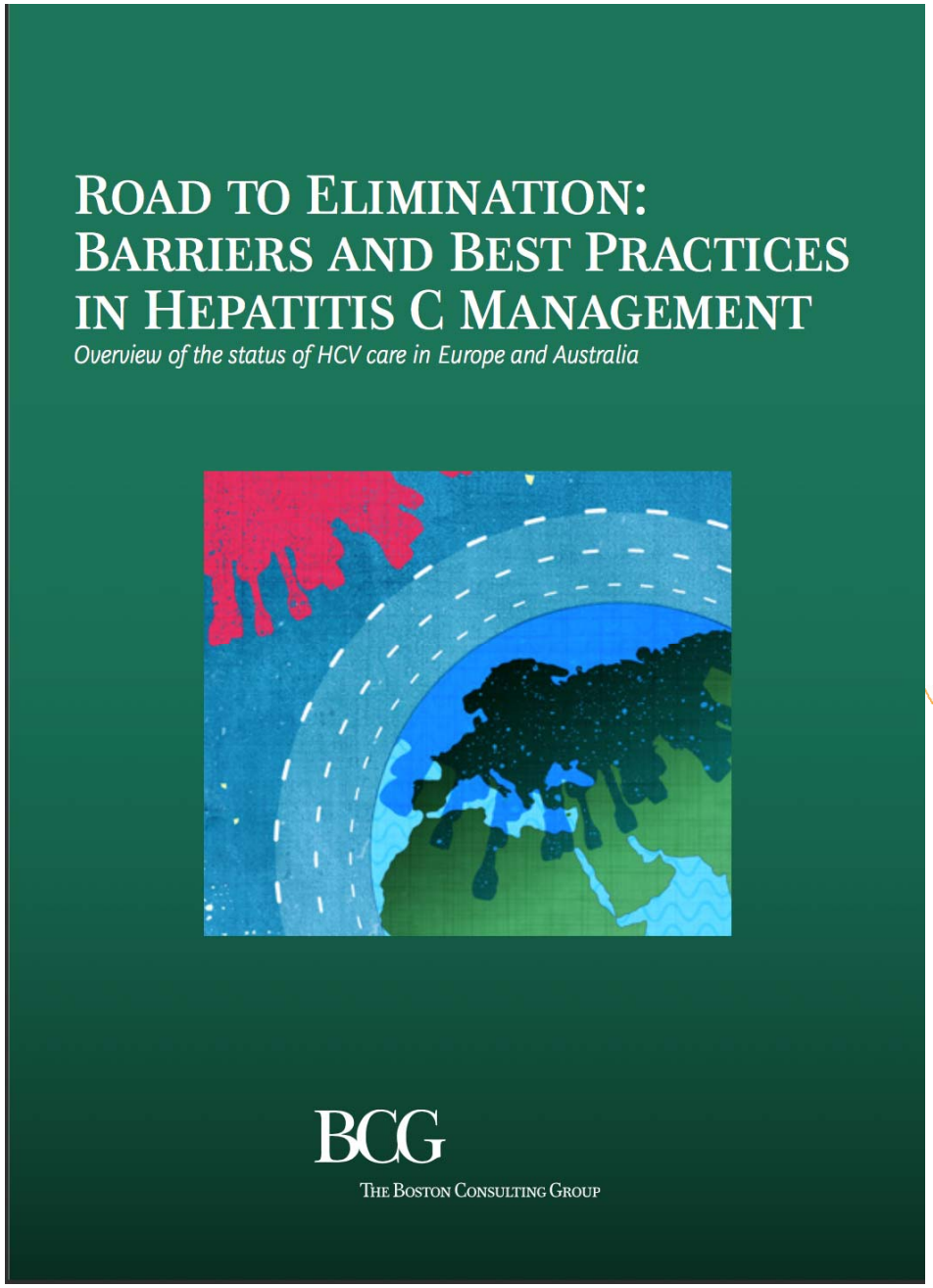

Boston
Consulting Group

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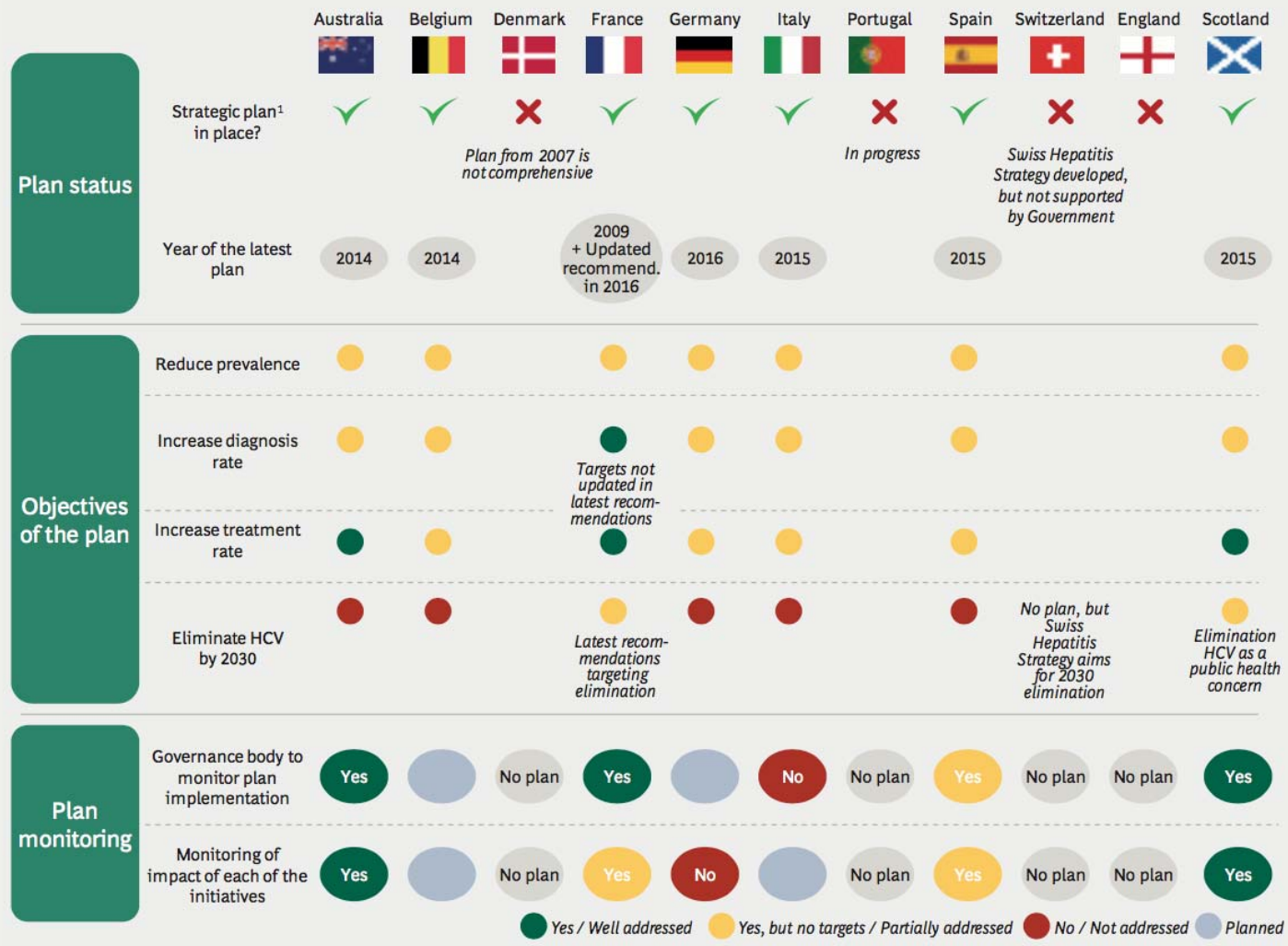
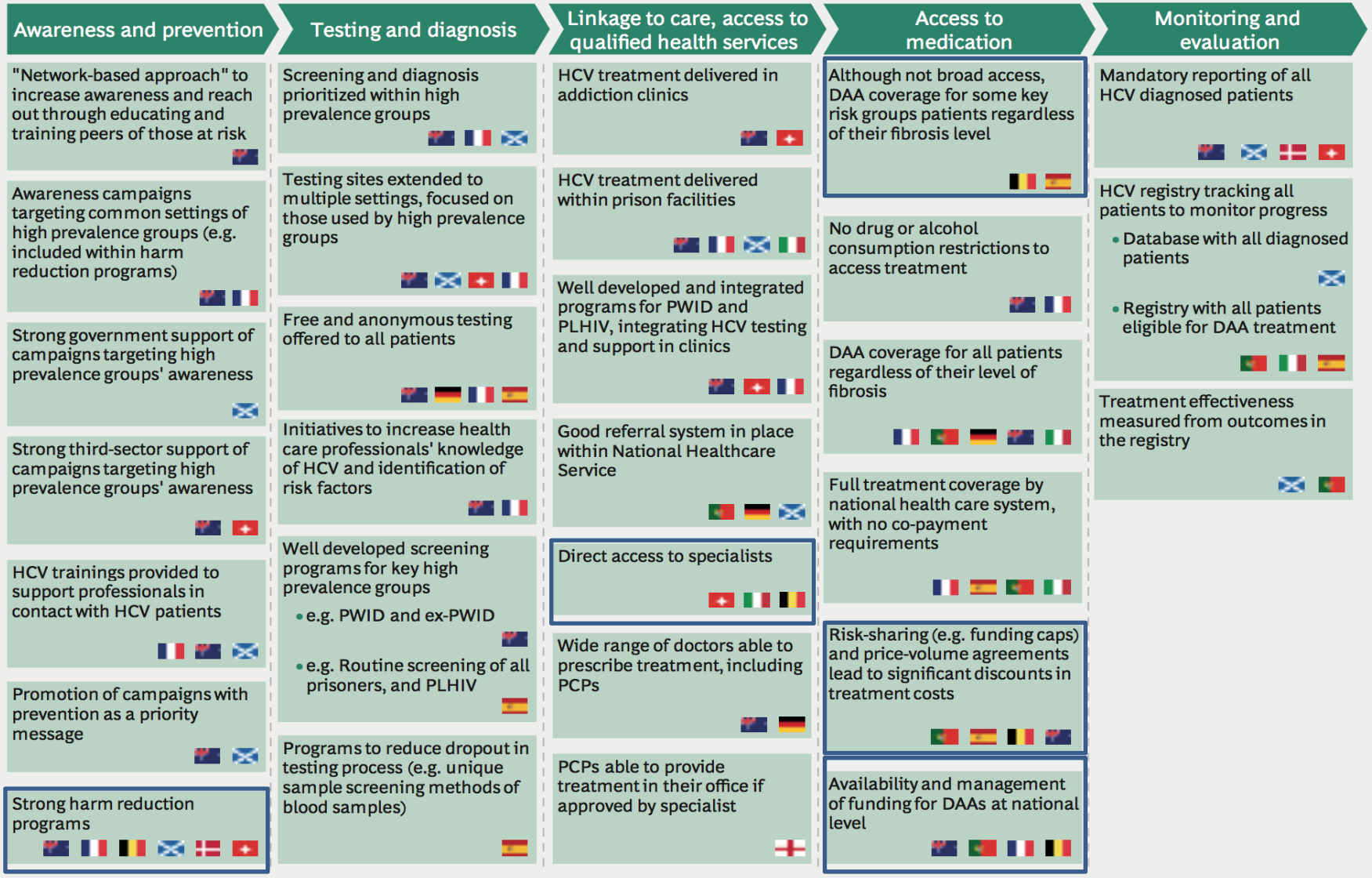
Figure 4 | Description of the availability of HCV elimination plans, objectives, and implementation in the selected countries



1. Strategic plan refers to government supported strategies to tackle HCV

Flags are examples of representative countries



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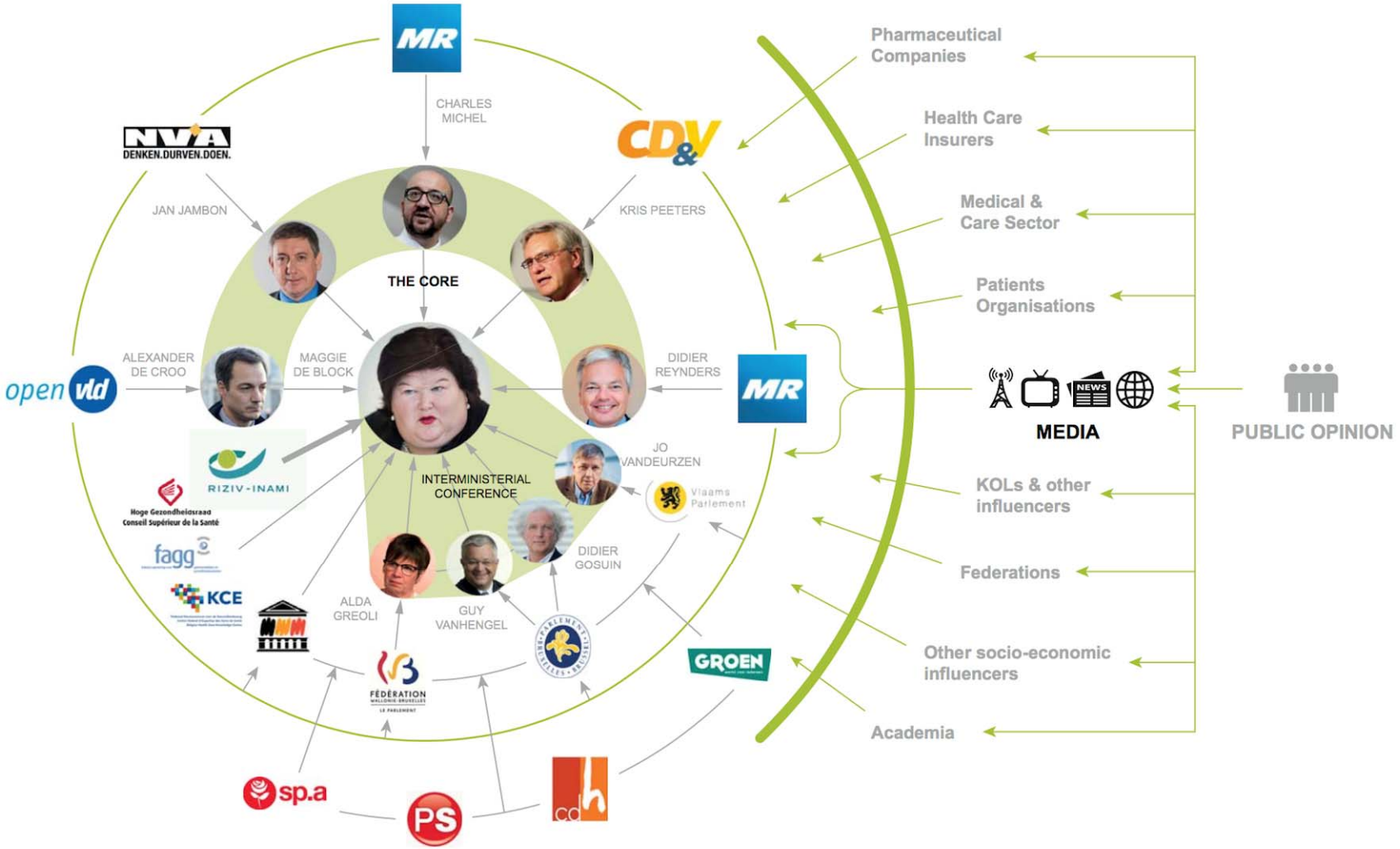

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Belgian health care system

- In Belgium, responsibilities for health policy are shared between the federal level and the federated entities (regions and communities).
- The federal level is responsible
  - for the regulation and financing of compulsory health insurance;
  - the determination of accreditation criteria (that is, minimum standards for the running of hospital services);
  - the financing of hospital budgets and heavy medical equipment (e.g. CT and MRI scanners);
  - legislation covering different professional qualifications;
  - **the registration of pharmaceuticals and their price control.**
- The level of federated entities (regions and communities) governments are responsible
  - **for health promotion and prevention**;
  - maternity and child health services;
  - different aspects of elderly care, home care,
  - Coordination and collaboration in primary health care and palliative care;
  - the implementation of accreditation standards and the determination of additional accreditation criteria
  - the financing of hospital investment.

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Conclusions

- National plan is a good project.
- It is essential for actions
  - To be well-defined
  - To include clear accountabilities, timelines, budgets, and key performance indicators.
- Wake-up authorities particularly federated entities.

Treatment without prevention and screening

It makes no sense !!!

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Clinical Practice Guidelines

CrossMark

EASL JOURNAL OF HEPATOLOGY

EASL 2017 Clinical Practice Guidelines on the management of hepatitis B virus infection☆

European Association for the Study of the Liver*

Cirrhosis

Compensated	Treat regardless of ALT, especially if HBV DNA >2000 UI/ml.
Decompensated	Treat regardless of ALT and HBV DNA.

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Clinical Practice Guidelines

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EASL JOURNAL OF HEPATOLOGY

EASL 2017 Clinical Practice Guidelines on the management of hepatitis B virus infection☆

European Association for the Study of the Liver*

- All candidates for chemotherapy and immunosuppressive therapy should be tested for HBV markers prior to immunosuppression (Evidence level I, grade of recommendation 1).
- All HBsAg-positive patients should receive ETV or TDF or TAF as treatment or prophylaxis (Evidence level II-2, grade of recommendation 1).
- HBsAg-negative, anti-HBc positive subjects should receive anti-HBV prophylaxis if they are at high risk of HBV reactivation (Evidence level II-2, grade of recommendation 1).

EASL, AASLD and APASL Guidelines

Guidelines	HBeAg Positive			HBeAg Negative		
	HBV DNA, IU/mL	ALT	Liver Biopsy Results	HBV DNA, IU/mL	ALT	Liver Biopsy Results
AASLD 2016[3]	> 20,000	≥ 2 x ULN	N/A	> 2000	≥ 2 x ULN	N/A
APASL 2016[10]	> 20,000	> 2 x ULN	N/A	> 2000	> 2 x ULN	N/A
EASL 2017[4]*	> 2000	> ULN*	At least moderate necroinflammation and/or fibrosis*	> 2000	> ULN*	At least moderate necroinflammation and/or fibrosis*
	> 20,000	> 2 x ULN	N/A	> 20,000	> 2 x ULN	N/A

N/A, not applicable.
*In patients with HBV DNA > 2000 IU/mL, treatment indicated if ALT > ULN and/or at least moderate fibrosis.

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