HV Epidemiology and Burden in Chelyabinsk Region

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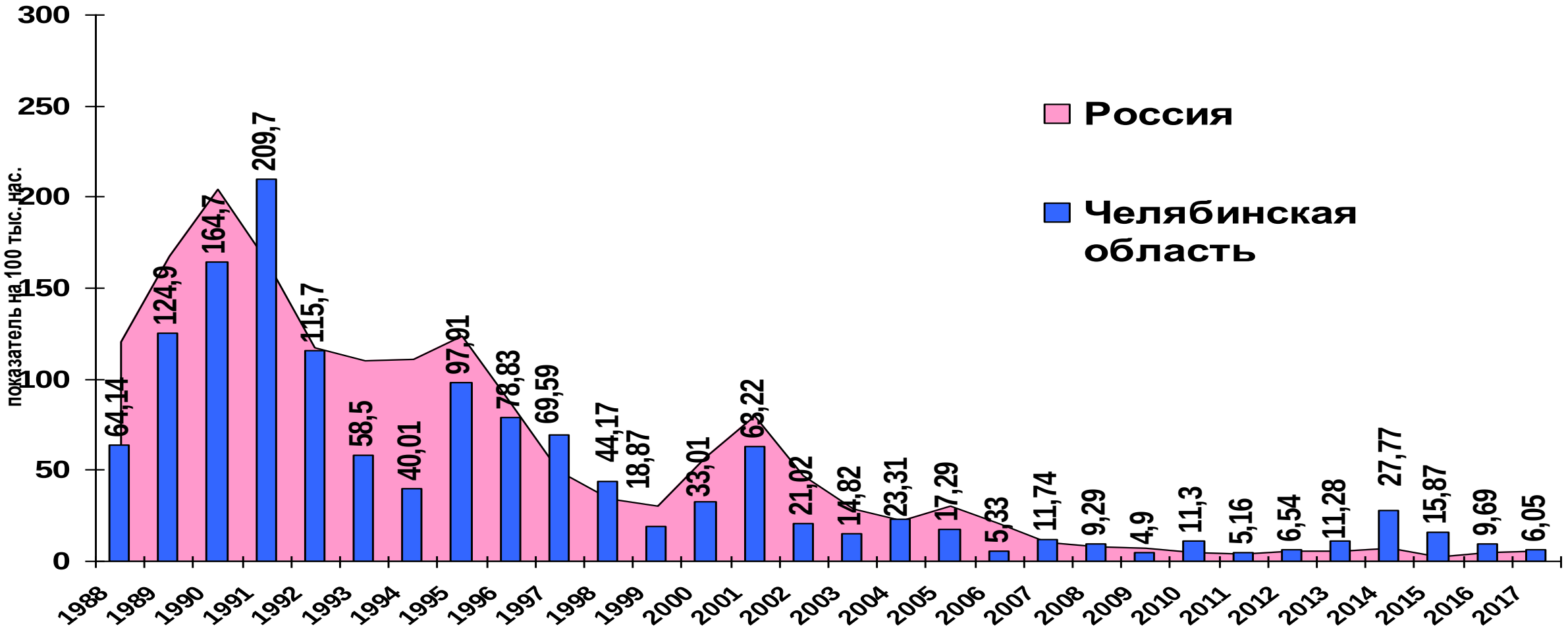
October 25, 2018

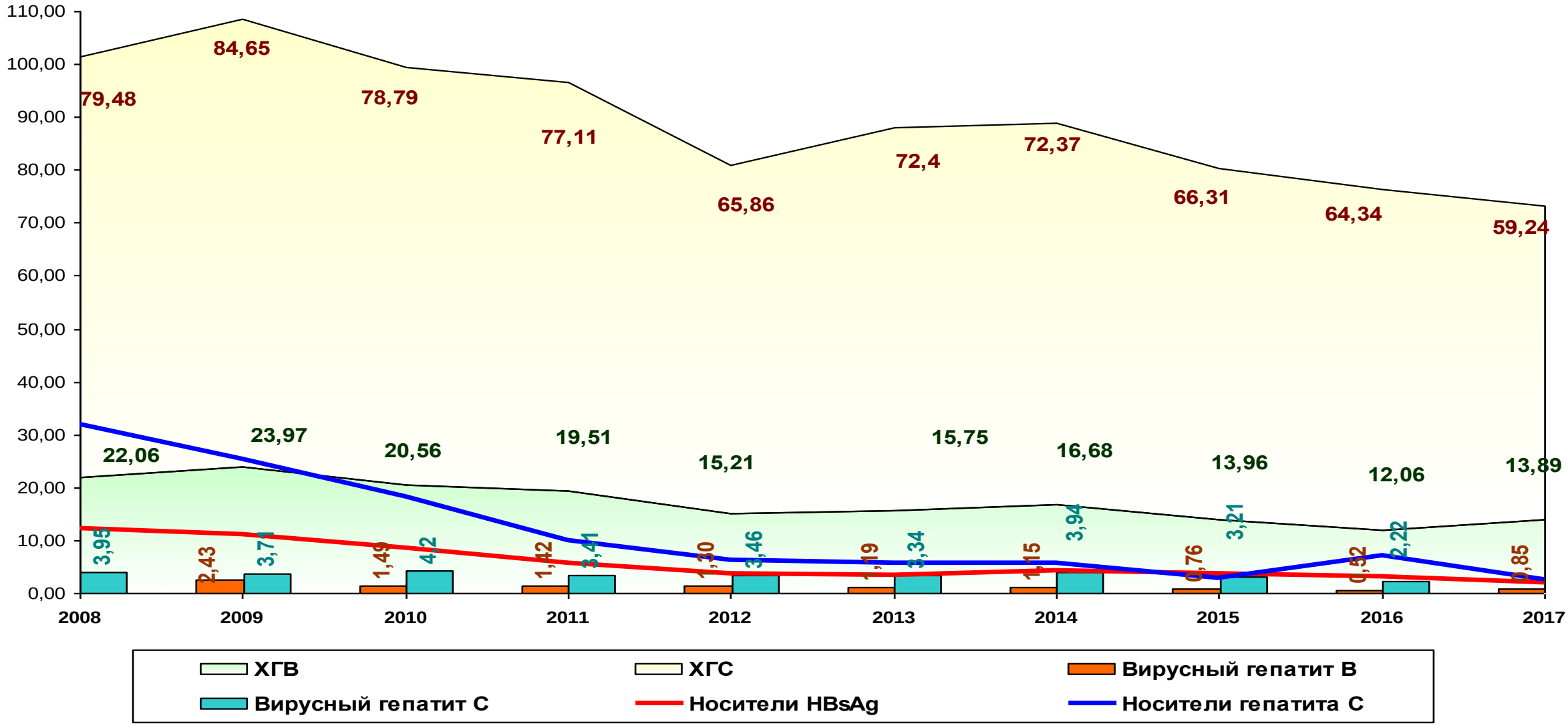
HAV incidence/100 000 in ChR

ChR population as of October 31,2017 –
3,5 MM, including cities (82,6%), versus Russia



Данные Управления Роспотребнадзора по Челябинской области

Acute and chronic HBV and HCV (incl. chHBV and chHCV)

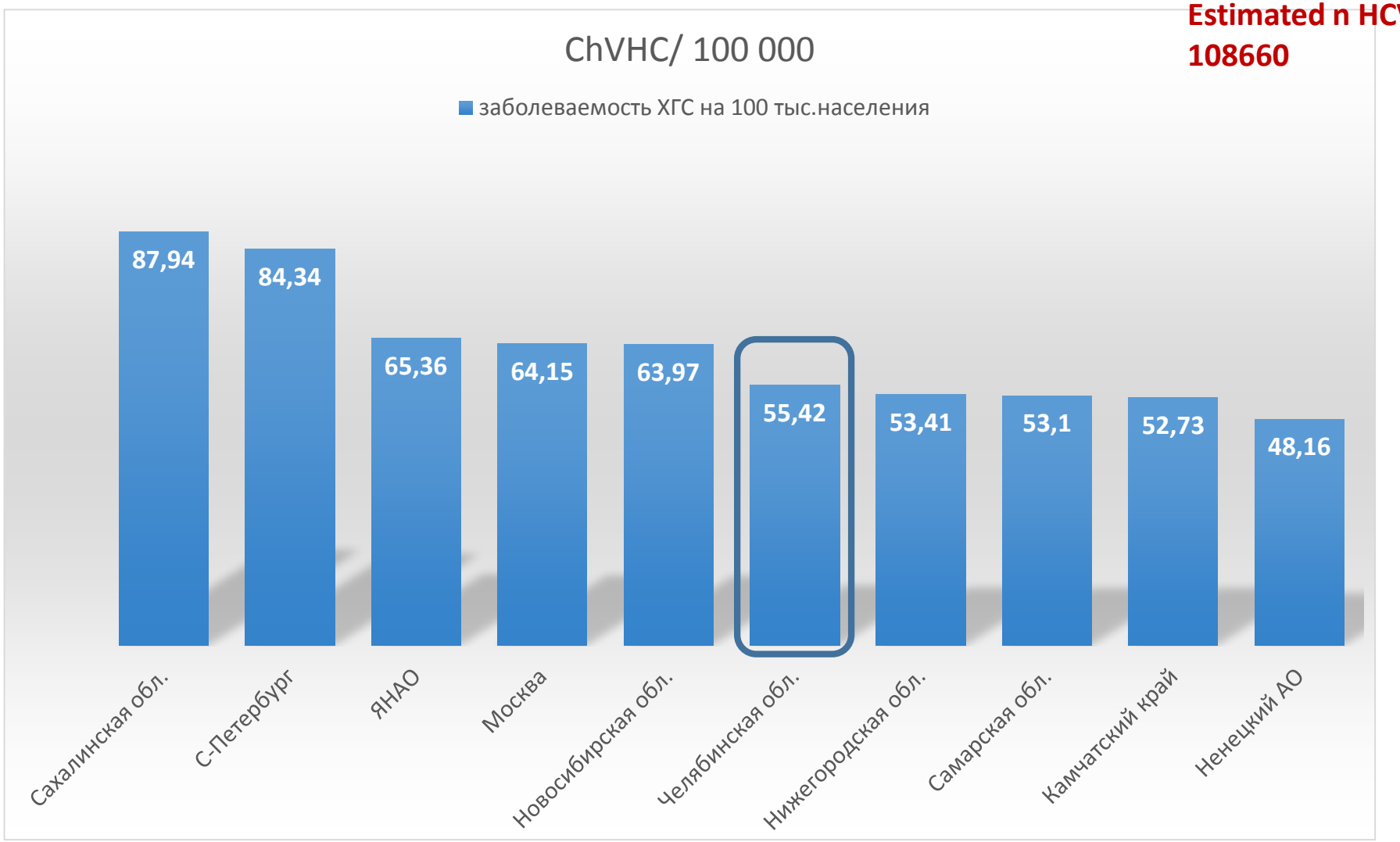


Данные Управления Роспотребнадзора по Челябинской области

Unpublished data compiled by Center for Disease Analysis and register holder

Chronic HCA prevalence in TOP10 regions RF in 2017

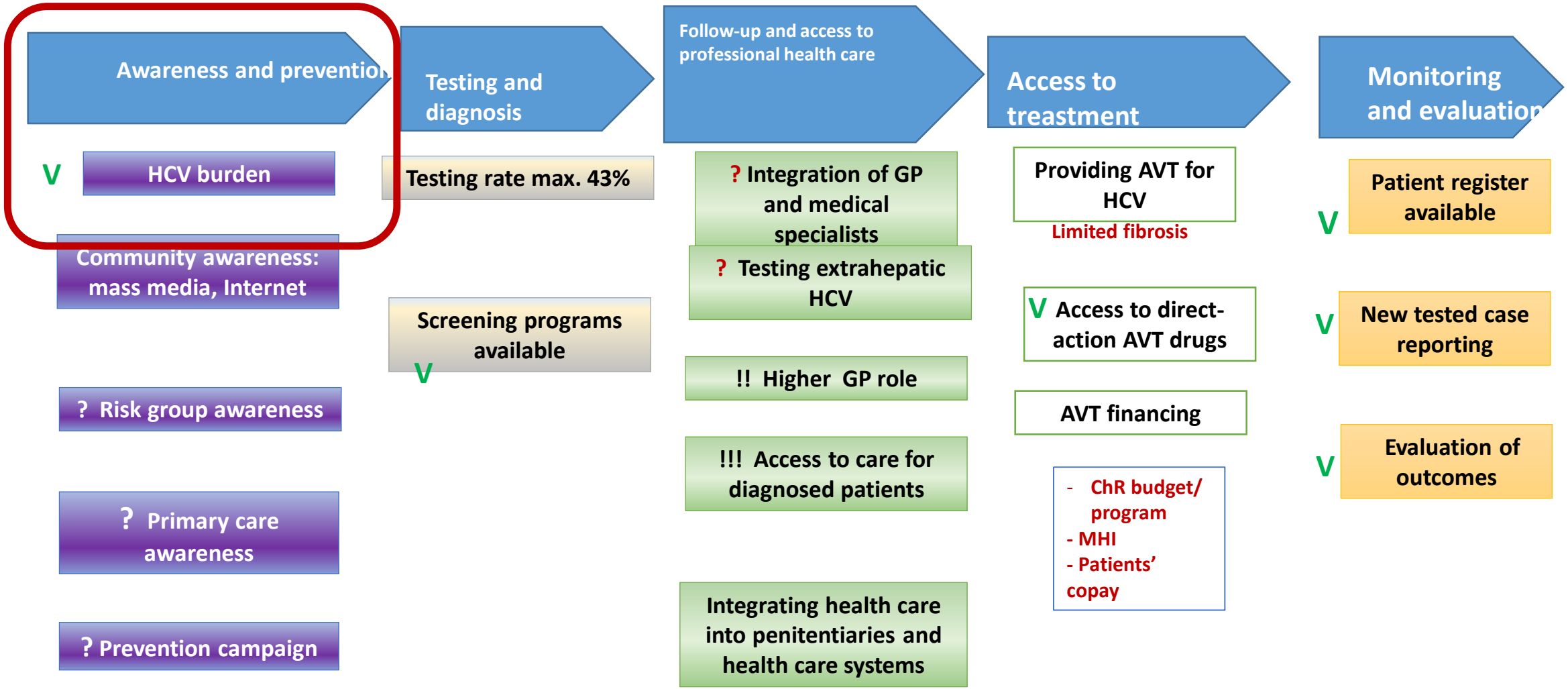
Estimated n HCV patients in ChR – 108660



Форма 2, 2017

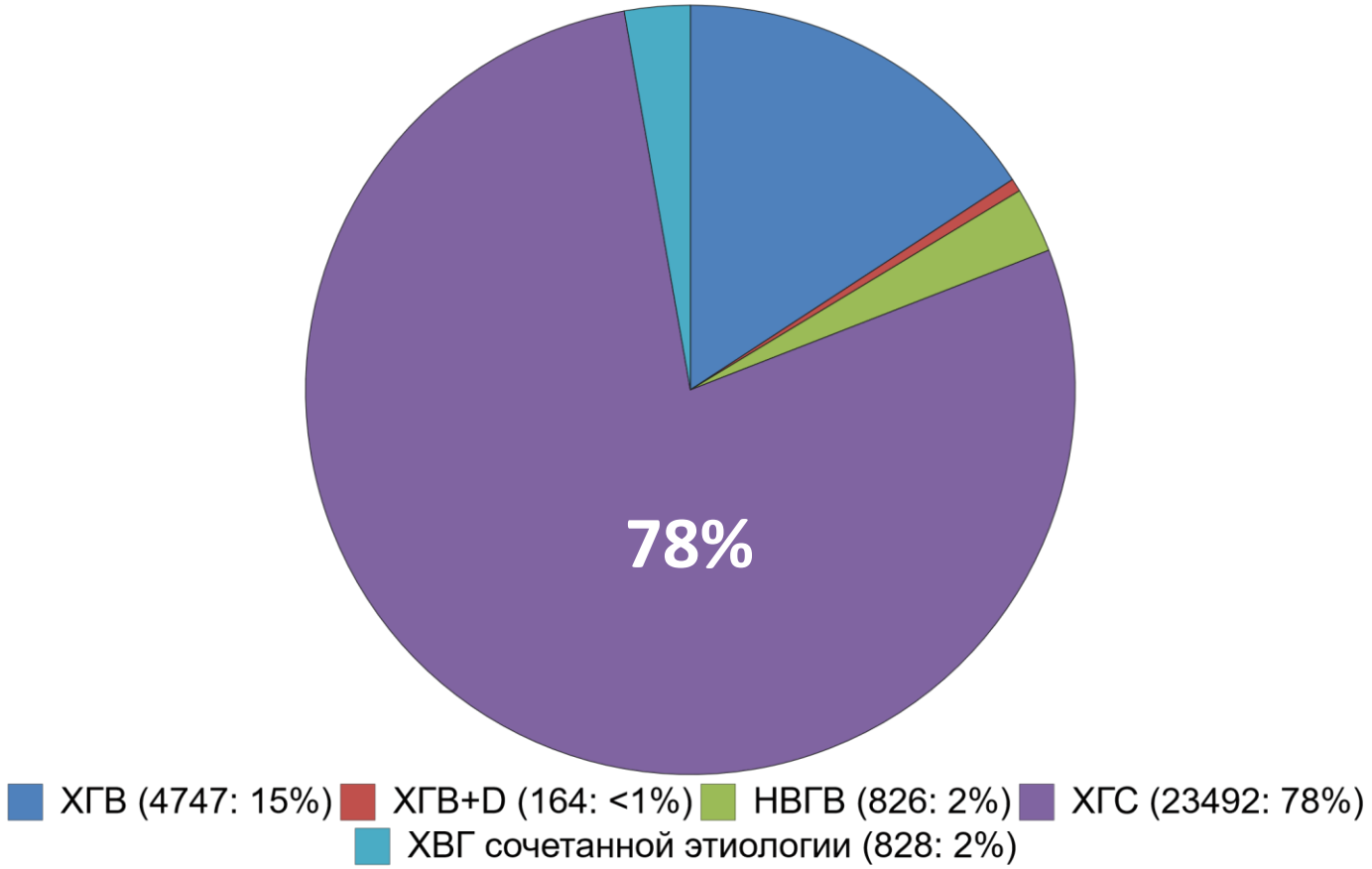
HCV elimination in ChR by 2030: myth or reality?

Key health sector cascade efforts: current state in ChR?

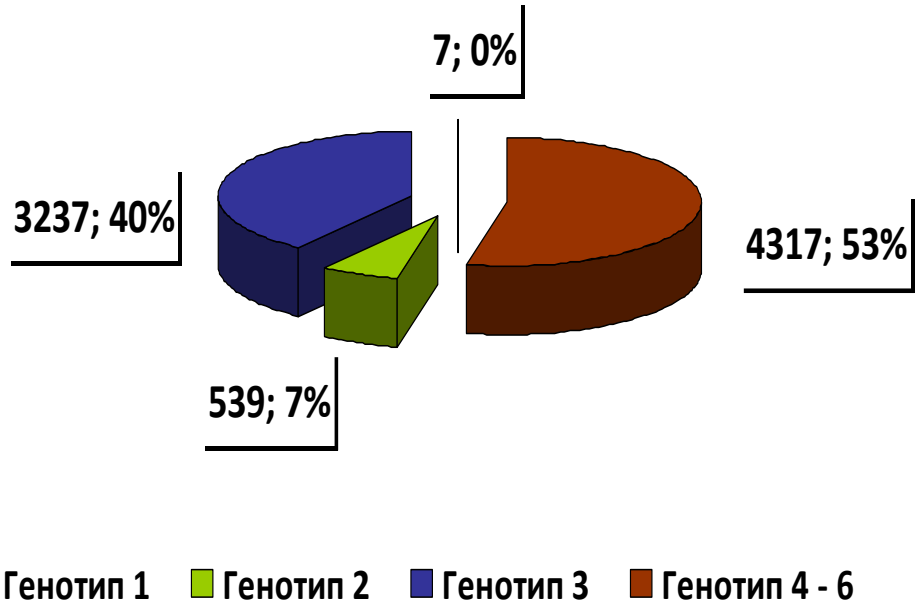


Road to Elimination: Barriers and Best practicies in Hepatitis C Management. BCG, Boston, 2017

ChR: ChHV etiology, n = 30057



HVC genotypes

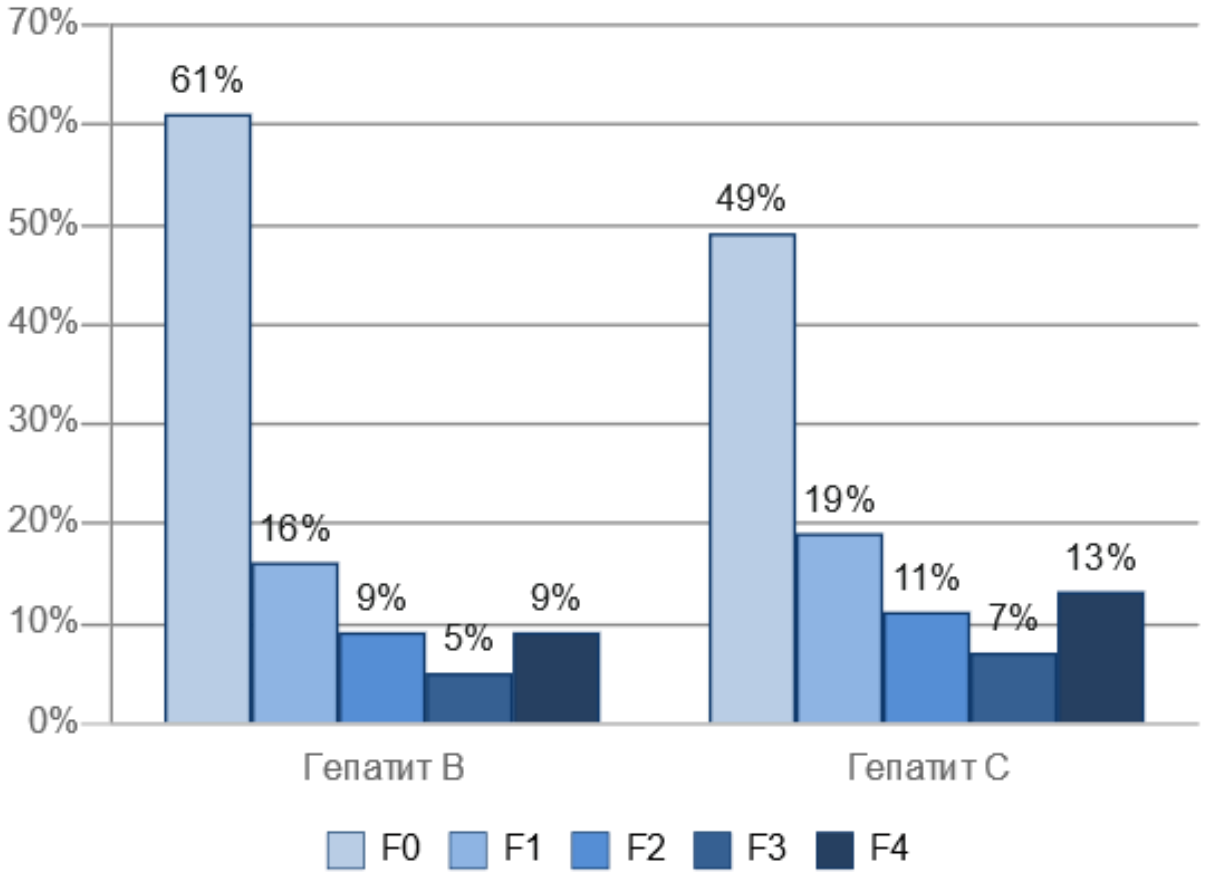


HCV mono-infections/ patients' register without SVR – 21790

Данные сегмента Челябинской области Регистра больных вирусными гепатитами, 13 октября 2018 года. https://hepreg.ru/main.html

ChVHC fibrosis stages as comparable with the Russian HV register

F2-F4 – 31%



RF

F2-F4 – 41,96%

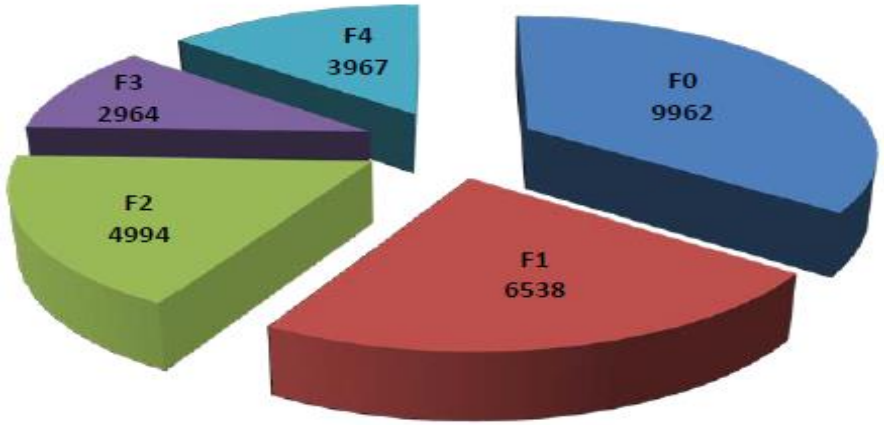
F0 - 9 961 (35,05%)

F1 - 6 538 (23,00%)

F2 - 4 994 (17,57%)

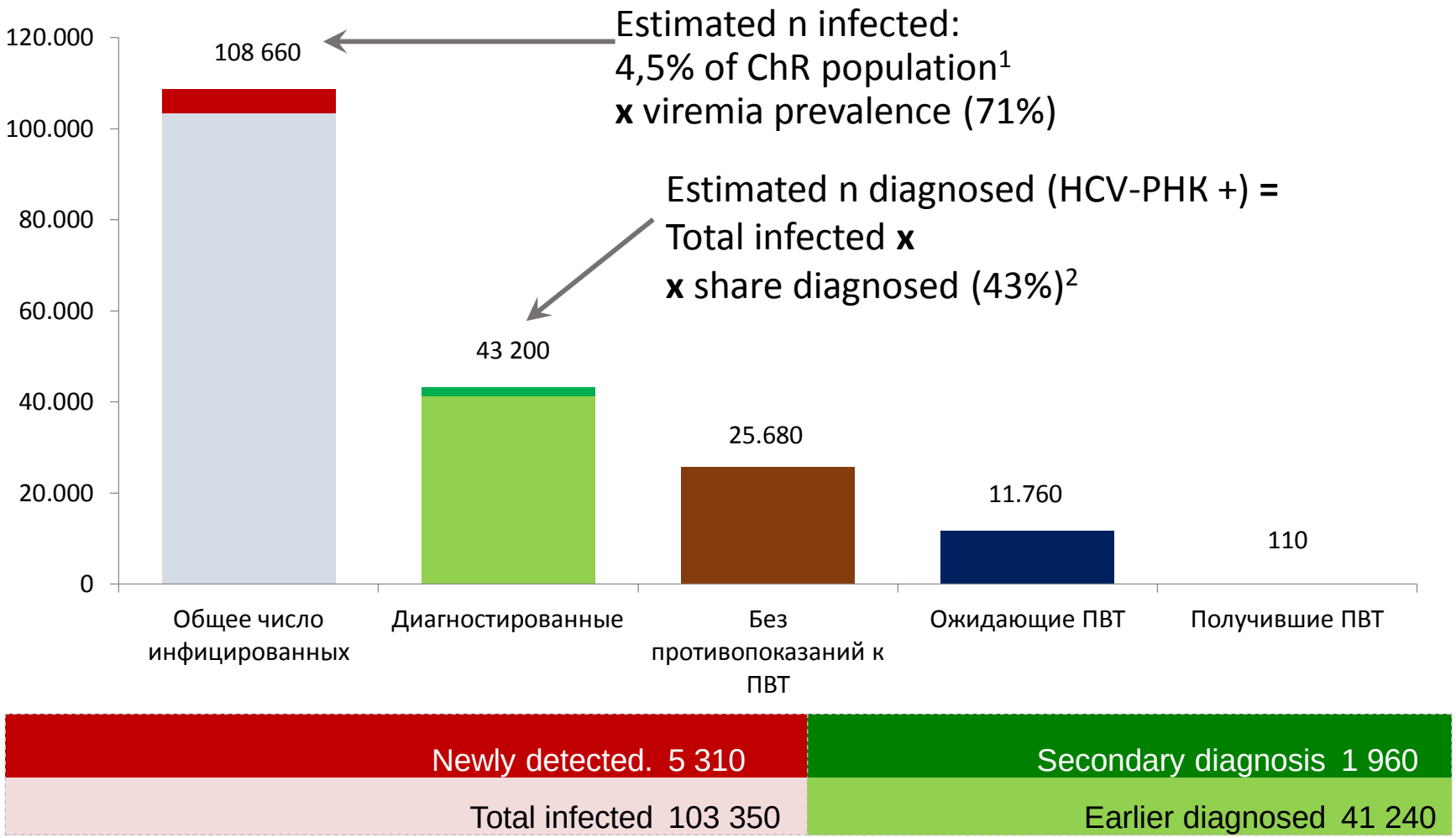
F3 - 2 964 (10,43%)

F4 - 3 967 (13,96%)



Данные Федерального Регистра больных вирусными гепатитами (2016) и регионального сегмента Челябинской области (13 октября 2018)

ChHCV health care cascade in ChR in 2015



1 Чуланов В.П., Пименов Н.Н., и др. Терапевтический архив 2015; 11: 5-10
2 Яшина Т.Л., Фаворов М.О., и др. Журнал микробиологии эпидемиологии и иммунобиологии 1993, (5): 46-9.

Projected ChHCV epidemiology pattern change in ChR: WHO scenario

- Gradual increase in treated patients up to 3 320/ year;
- Gradual increase in primary cases detected up to 7 270/ year;
- Gradual incidence decline down to 530 cases/year;
- ≥F2 express fibrosis treatment.

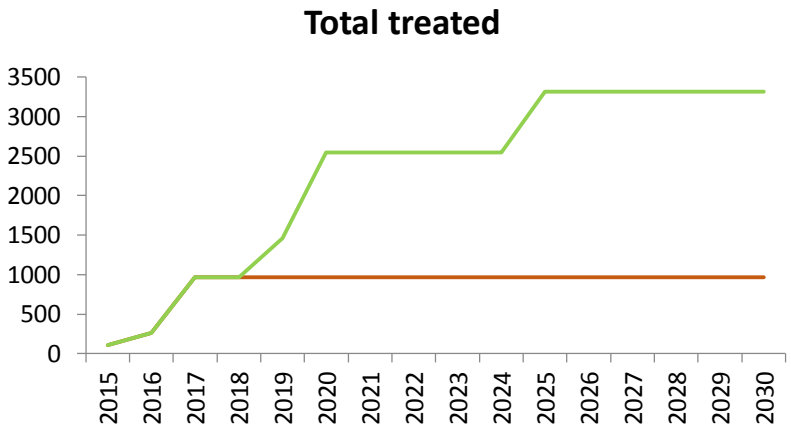
	2015	2018	2019	2020	2025	2030
Primary cases	1 960	1 960	2 940	4 400	6 600	7 270
N treated	110	970	1 460	2 550	3 320	3 320
Infected cases	5 310	5 340	4 810	2 410	1 060	530
Fibrosis stages	≥F1	≥F1	≥F2	≥F2	≥F2	≥F2
Age groups on treatment	15-64	15-64	15-64	15-64	15-69	15-69
SVR	59%	94%	95%	95%	95%	95%

- Disease burden:

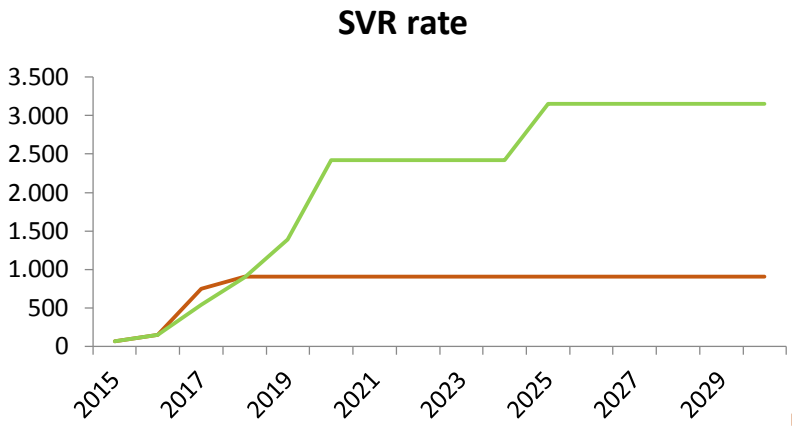
	2015
n ChHVC patients (with viremia)	108 660
Mortality from liver disease outcome	156
HCC rate	145
Decompensated cirrhosis	418

Unpublished data compiled by Center for Disease Analysis and register holder

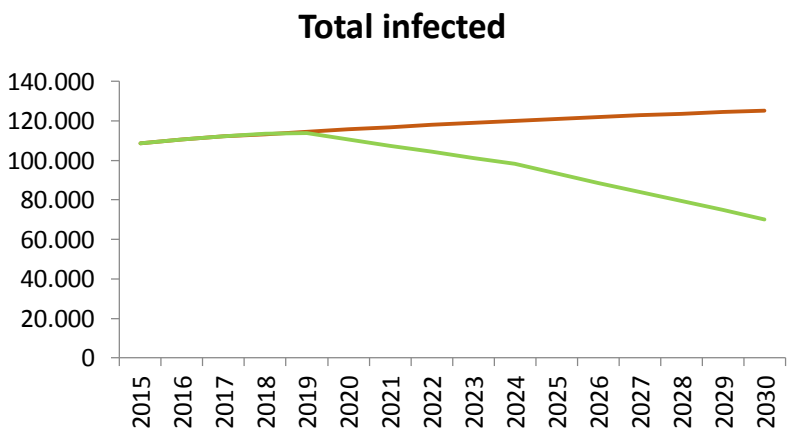
Projected ChHCV epidemiology pattern: WHO strategy vs basic scenarios



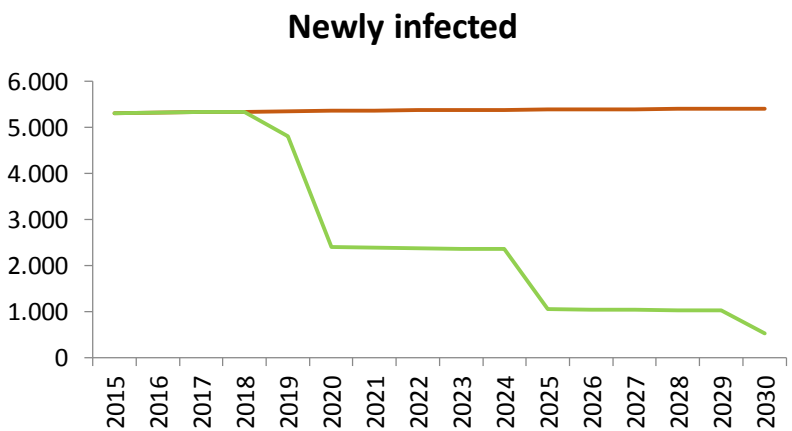
Increased n treated(2015-2030) 22 453



Increased n with SVR CBO (2015-2030) 21 351



Decrease in n infected (2015-2030) 55 078



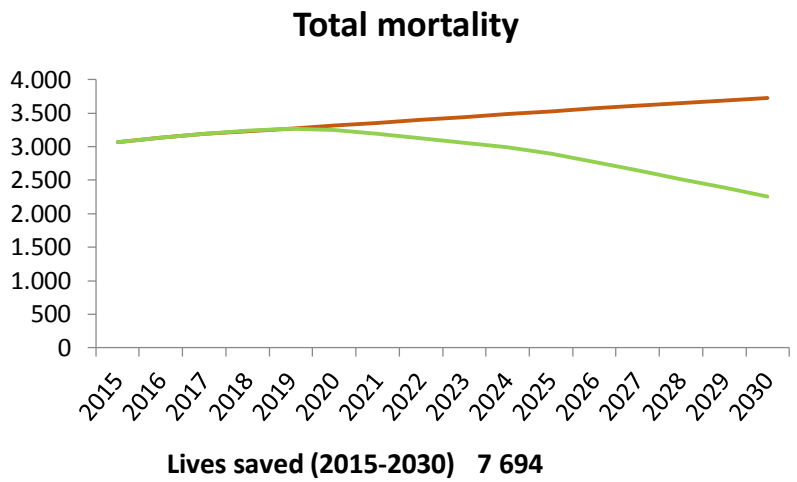
Less new cases (2015-2030) 42 122

Basic scenario

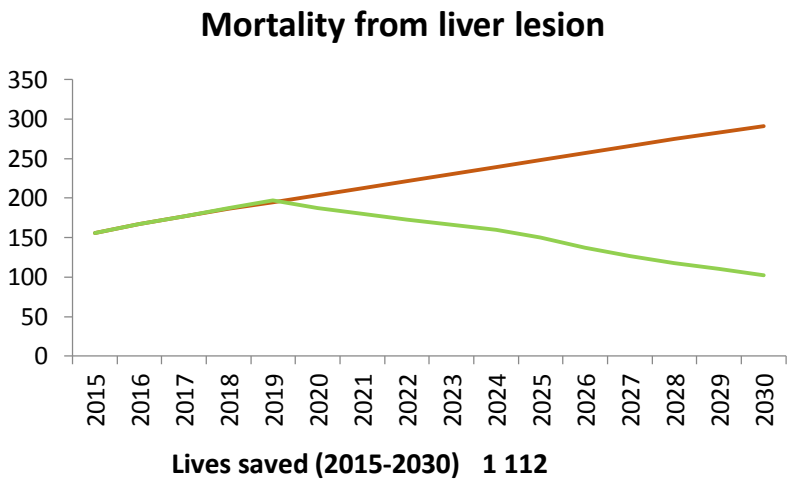
WHO scenario

Unpublished data compiled by Center for Disease Analysis and register holder

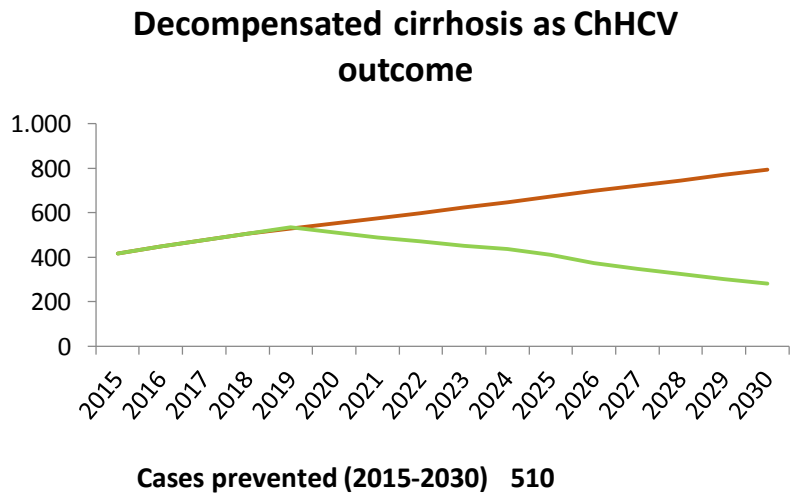
WHO strategy scenario: lives saved



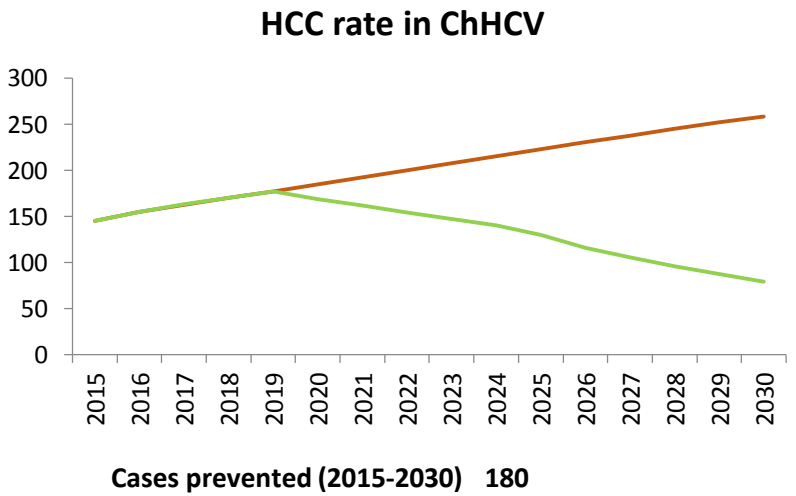
Lives saved (2015-2030) 7 694



Lives saved (2015-2030) 1 112



Cases prevented (2015-2030) 510



Cases prevented (2015-2030) 180

Basic scenario

WHO scenario

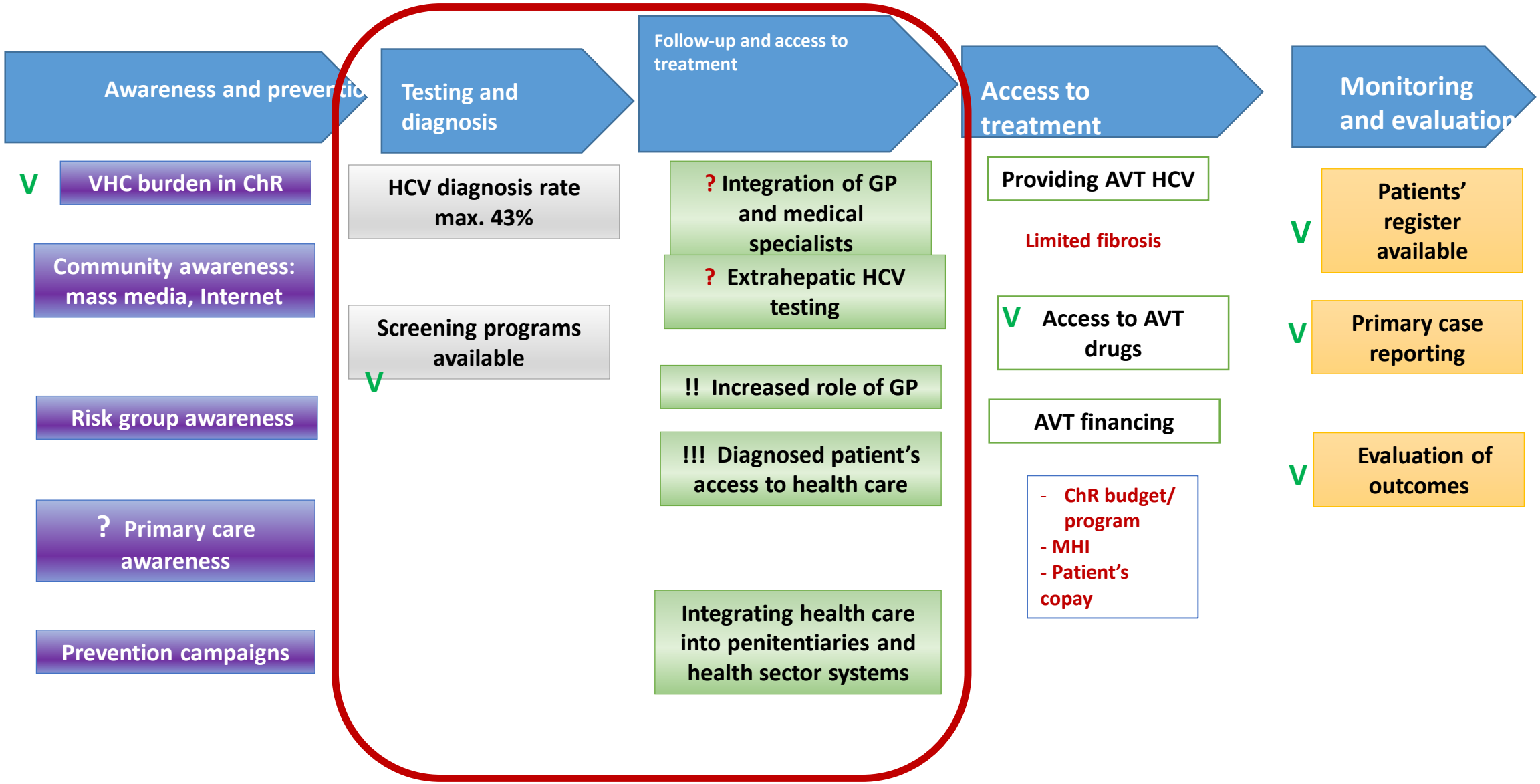
WHO strategy can meaningfully revers ChHCV incidence in ChR to result in:

- 51% reduction of those infected

- 70% reduction of decompensated cirrhosis incidence

- 66% reduction in HCC incidence

Key health sector cascade efforts for HCV control: current state in ChR



Road to Elimination: Barriers and Best practicies in Hepatitis C Management. BCG, Boston, 2017

VHC elimination: testing and diagnosis

Main barriers in implementation

X Screening plans or regulations unavailable (not our case: СП 3.1.3112-13 “VHC prevention"

(Decree 58 of October 22, 2013)

X Vaguely identified groups with HCV above average incidence, including age cohorts (blood recipients, patients after physician/coach follow-up exercises)

X The patient has to go far to be screened.

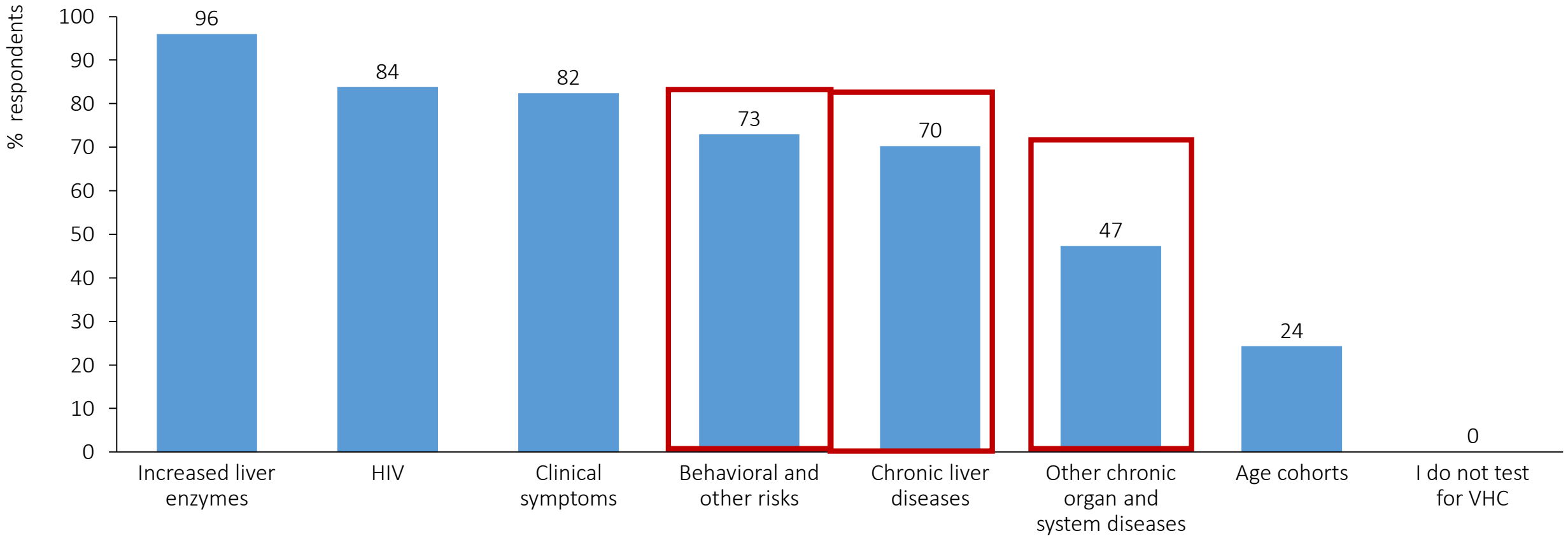
X PAVT of patients lost to follow-up after screening without PCR confirmation.

X GP do not comply with screening regulations due to lack of knowledge and time, nor consider ChHCV a priority.

X Limited access to treatment results in lost motivation to screening

Road to Elimination: Barrierrs and Best practicies in Hepatitis C Management. BCG, Boston, 2017

GP criteria for testing antibodies to HCV



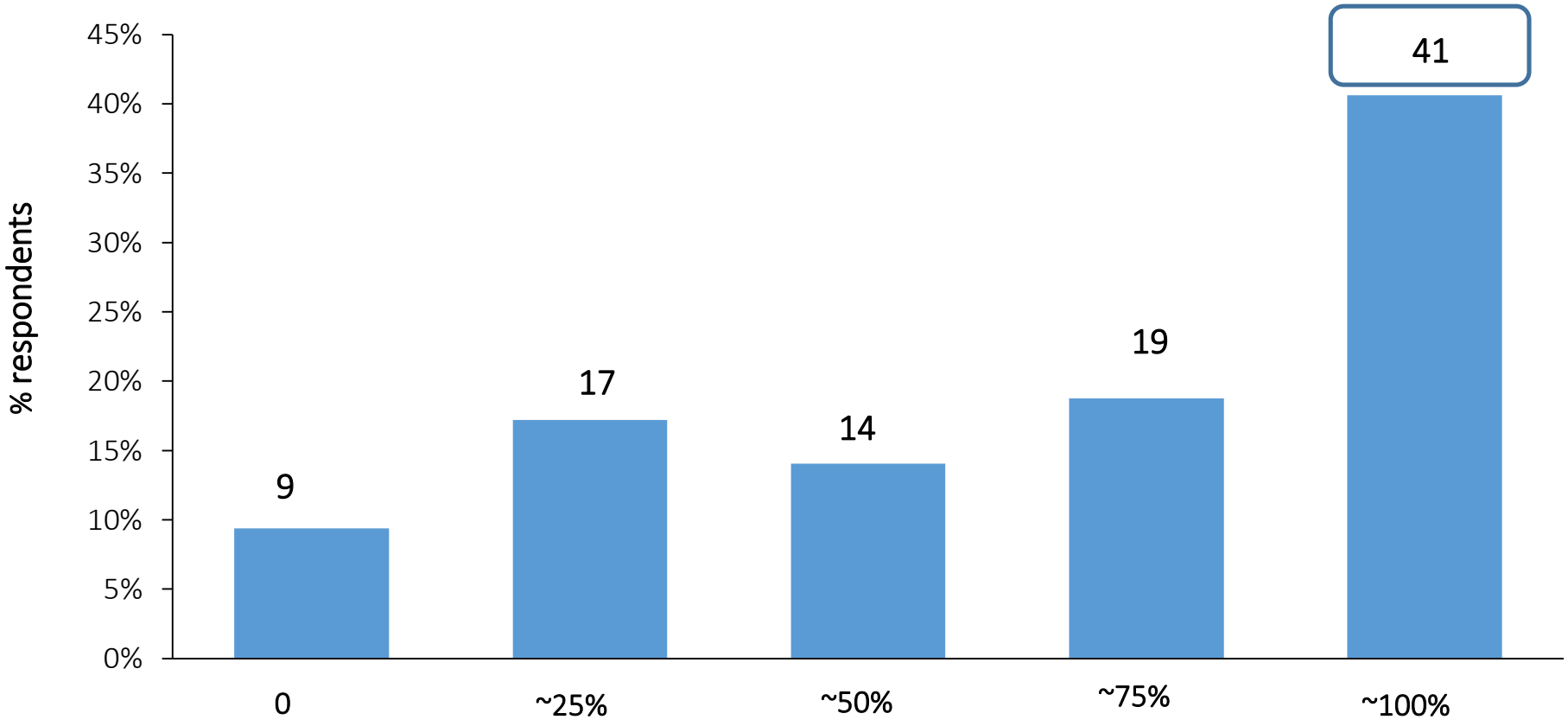
GP survey in ChR, 19.05.2018

ChHCV treatments provided in 2017 - 2018

- ✓ **Three-tier testing/treatment (also AVT) and D follow-up provided to ChVHC and viral cirrhosis patients (Decree 2111 of 13.12.2016 by ChR Ministry of Health: On VH Adult Patient Routing in ChR.**
  1. **Communicable disease surgeries at polyclinics (or internists and GP, if no infectious disease physician is available);**
  2. **Inter-district liver disease center in ChR south (Magnitogorsk);**
  3. **Liver Disease Center of ChR Clinic, Ministry of Health RF (Chelyabinsk).**
- ✓ **Modern VH serologic and molecular diagnosis available;**
- ✓ **Intensive use of non-invasive fibrosis testing (Fibroscan US transient elastometry) at LDC CHR;**
- ✓ **HCC screening for ChHBV (any fibrosis grade) and ChVHC (F3-F4) and subclinical Cushing syndrome (SCS) ;**
- ✓ **HVB and HAV vaccine prophylaxis;**
- ✓ **Systematic health worker training (all levels and specialties) by leading Russian professionals : 2017 - 2018 ChR conference: Hepatitis Virus Agenda; 2 inter-disciplinary roundtables on HCV off-liver patterns; and presentations at regional conferences of other medical specialties (nephrologists, GP);**
- ✓ **Interface with patient associations (hemophilia, nephrology).**
- ✓ **Extended collaboration of LDC ChR with other medical professionals (nephrologists, endocrinologists, rheumatologists, hematologists, etc…). Involving nephrology, endocrinology and other patient in multi-disciplinary follow-up and AVT.**

GP-detected ChHCV patients under follow-up by infectious disease physician

or, if unavailable, referral for consultation to Liver Disease Center ChR Clinic



GP survey, 19.05.2018

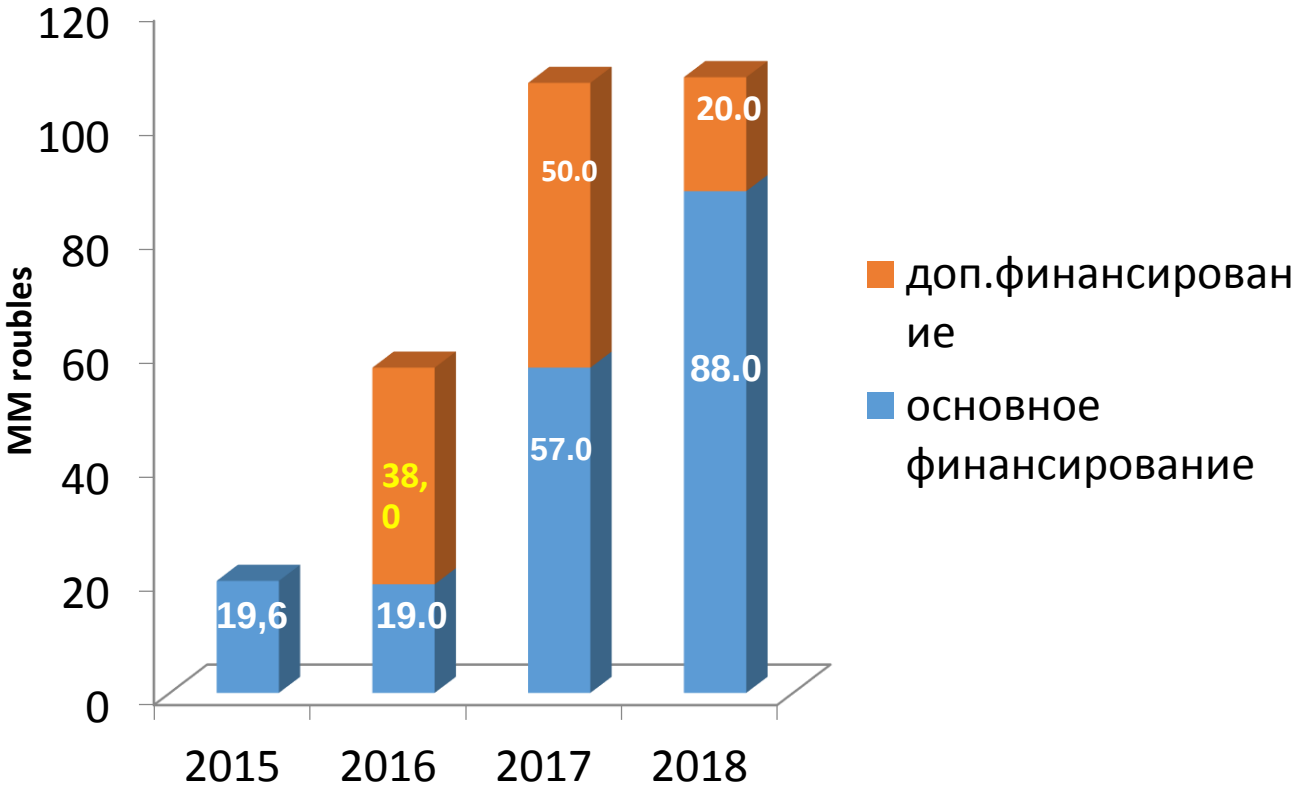
HCV elimination: providing follow-up and access to treatment

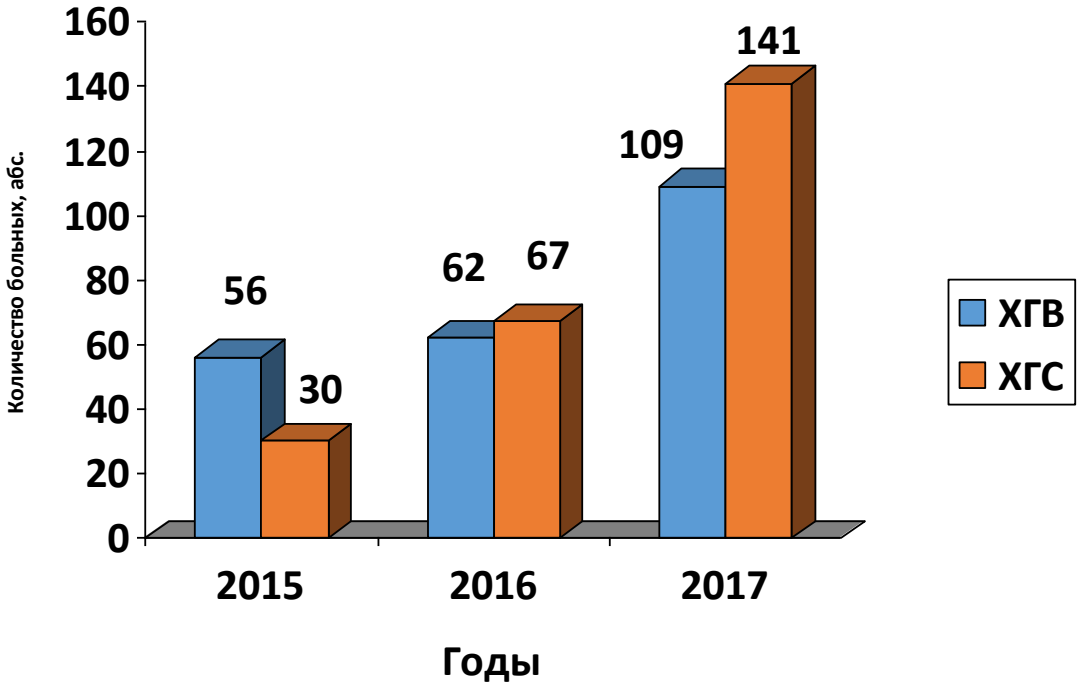
Main barriers in implementation

- X Earlier diagnosed, not having treated due to lack of AVT drugs, not reported.
- X Patients, detected outside public health sector, do not reach medical specialists.
- X Ex-convicts.
- X Convicts and patients on physician/coach follow-up exercises
- X Diagnosed patients do not get follow-up at their residence due to various reasons (infectious disease physician or GP unavailable).
- X Patients are not routed as required by ChR Decree 2111 of December 13, 2016.

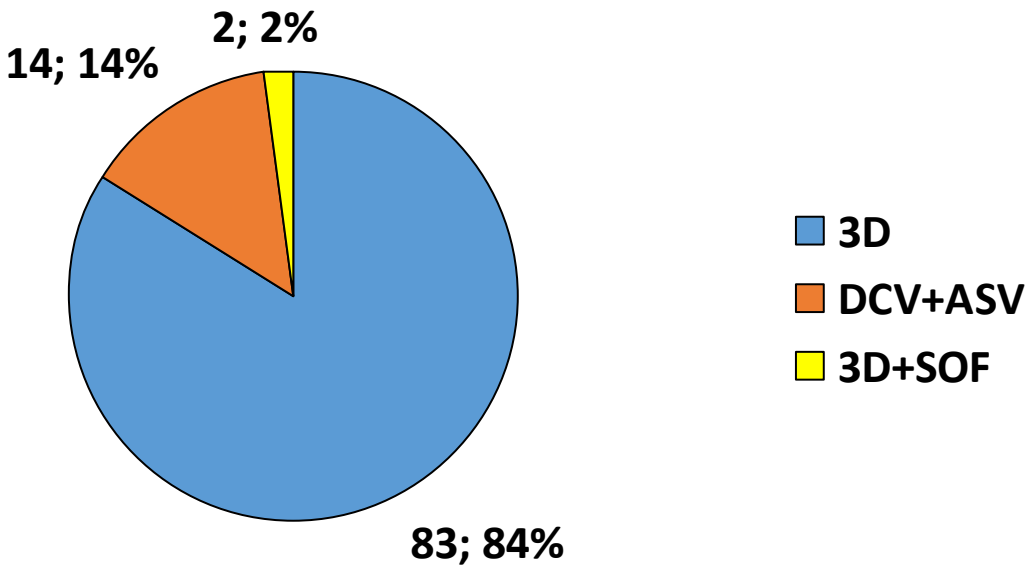
Road to Elimination: Barrierrs and Best practicies in Hepatitis C Management. BCG, Boston, 2017

Financing and total treated under the Public Commitments Program: Developing ChR Health Sector in 2015-2018 (ChHBV – blue, ChHCV – orange)





Basic data, treatment regiments and SVR in H1 patients treated under the ChR Program in 2016-2017 rr., n=99



Age	54 (29-71)
Liver cirrhosis, n (%)	67 (79%)
Treated earlier, n (%), including	19 (19%)
- Triple with ID	4 (5%)
- AVT drugs without IFN	1 (1%)
EVVD, n (%)	28 (28%)
DM2, n (%)	14 (14%)
CVD, n (%)	31 (31%)
Renal problems, n (%)	18 (18%)
GIT , n (%)	43 (43%)
Cryoglobulinemia , n (%)	32 (32%)
Early treatment termination due to SAE, n (%)	4 (4%) – 2 SVR, 2 – no response
Response to AVT, n (%):	
- SVR12	90/91 (99%)
- relapse	1 (1%)
- no data	4

Summary: **AVT effectiveness in ChVHC H1 patients, provided under Public Commitments Program: Developing ChR Health Sector in 2016-2017, matched the respective clinical trial and global clinical practice data.**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Thank you!


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