

Hepatitis C Virus: Close behind HBV and Closing

Pages with reference to book, From 194 To 194

Saeed Hamid (Department of Medicine, Aga Khan University Hospital, Karachi.)

The recent discovery of hepatitis C virus (HCV) and the development of antibody tests for its diagnosis have been major advances in the field of viral hepatitis¹. It has now become clear that hepatitis C infection is the major cause of what for many years used to be called Non-A, Non-B hepatitis (NANBH) because the identity of the causative virus was not known. Hence HCV is not a new disease. It is just that with the highly sensitive methods now available for the detection of HCV infection, we are rapidly gaining new insights into an old disease. These clearly has been an explosion of information on hepatitis C in recent times. Many aspects of the disease have been defined while other issues still remain to be solved. The purpose of this article is to bring some of these questions to the fore. HCV was initially thought to behave very much like hepatitis B virus², as the main mode of transmission of HCV is also parenteral. In countries where all transfused blood is screened for HBV, HCV has become the major cause of transfusion - associated hepatitis³. HCV is also prevalent in other groups at high risk for parenteral transmission like intravenous drug users and haemodialysis patients and others who require regular blood transfusions⁴. However, it quickly becomes clear that in upto 40% of patients infected with HCV, no clear risk factors for parenteral transmission were identifiable⁵. They had not received blood transfusions or parenteral injections and were not drug addicts. These patients are termed as having 'sporadic or community-acquired HCV infection'. How these patients acquire HCV is a question that is still not clearly answered. Sexual and perinatal transmission may occur (from mother to infant) but do not seem important modes of transmission as they can be for HBV^{6,7}. like HBV, HCV has been clearly shown to cause chronic liver disease and hepatocellular cancer⁸. In fact HCV leads to liver cirrhosis in a higher proportion of patients than does HBV. The simple reason for this may be that it seems to be very hard to get rid of HCV infection. Whereas, HBV becomes chronic in only 5- 10% of the infected individuals, HCV infection will persist on a long term basis in upto 75-80% of patients⁹. There is a whole spectrum of chronic HCV infection that is emerging. Patients may be completely asymptomatic and yet demonstrate raised transaminase (SGPT) levels and chronic active hepatitis on liver biopsy. On the other hand, patients may present with advanced liver cirrhosis and its complications, generally 15-20 years after the onset of HCV infection. What is our local experience of HCV infection so far? Unfortunately we do not yet have the prevalence rates for HCV infection in our general population. However, it seems clear that HCV infection is currently responsible for atleast 30-50% of our patients presenting to hospital with chronic liver disease¹⁰. There is a prevalence rate as high as 46% in our patients on haemodialysis. We are also seeing an increasing number of asymptomatic patients with chronic HCV infection. These numbers are likely to rise as we become more aware of HCV infection. For the present HCV remains our major problem. It is hoped that as health awareness increases and vaccination against HCV begins to show its impact, this disease will be checked. However, HCV seems all set to take the place of HBV as a major killer in our region. What can be done to stem this imminent epidemic of HCV which seems to be upon us? Certainly testing of donated blood for HCV in institutions which can afford to do so will help to some extent. In places where this has been instituted, post- transfusion hepatitis has dropped from 10% to 1%. Until this becomes routinely available, encouraging our practitioners to keep the giving of blood transfusions down to the bare minimum that is necessary, will help. Determining the mode of transmission in the 'sporadic' cases would be a significant step forward. It is our suspicion that a lot of our so called 'sporadic' cases have received parenteral injections with unsterile needles. Clearly, exhorting our general practitioners to employ sterile techniques is needed. Until effective treatment modalities and

vaccination are developed against HCV, these common sense measures may be our only hope to reduce this menace.

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