A Comparison of SVR4 and SVR12 Attendance and Loss to Follow Up Among Clients of The Kirketon Road Centre (KRC), A Primary Healthcare Service for Marginalised People in Kings Cross, Sydney, Australia

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BACKGROUND

KRC is a targeted primary health care facility focused on the prevention, treatment and care of viral hepatitis, HIV and sexually transmissible infections. Clients on hepatitis C (HCV) treatment, are regularly contacted during treatment to support adherence. Upon treatment completion, staff make three contact attempts over six weeks to facilitate clients to return for sustained viral response (SVR). This is time intensive due to transiency, homelessness, mental health issues, incarceration and client priorities. We have noticed an increase in the proportion of clients who are LFTU during their treatment journey over the last few years, and wished to address this drop off in the care cascade.

APPROACH

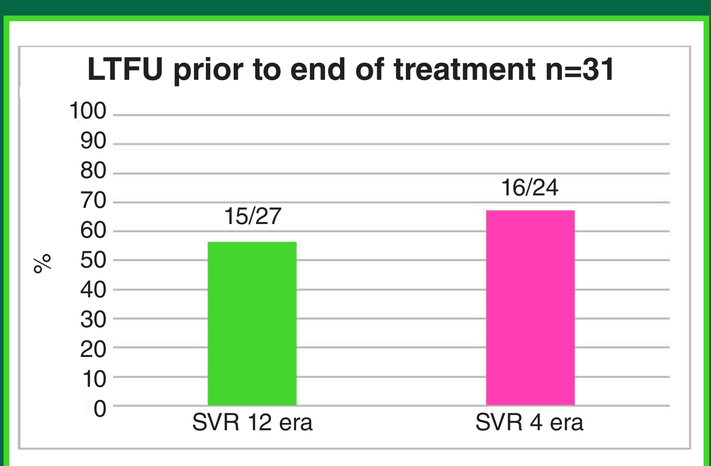
As loss to follow-up (LFTU) impedes determination of SVR after HCV treatment, we hypothesised that reducing the time to SVR testing by 2 months would reduce LFTU for SVR. This is consistent with the Australian Hepatitis C guidelines from January 2023, where reduction in the SVR test time from 12 (SVR12) to 4-12 weeks (SVR4) was included as an option. We changed our protocol to offer SVR from week 4, and the aim of this study was to compare the proportion of clients prescribed HCV treatment who had an SVR test from week 4-12 or 12+, and the point at which they were LTFU before and after this change.

ANALYSIS AND OUTCOME

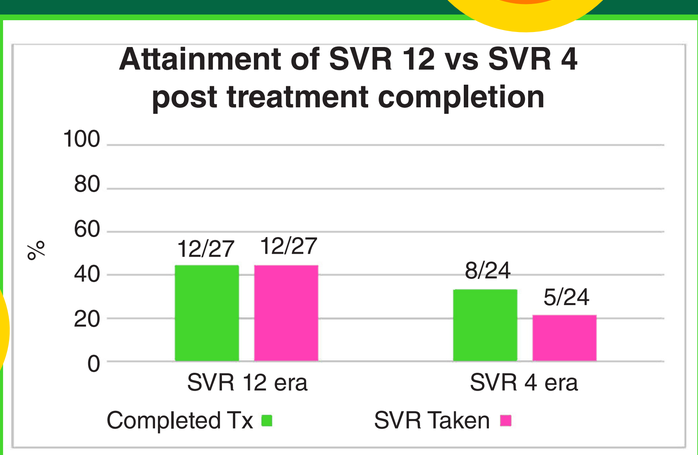
Between 2021-2023, 51 clients were prescribed HCV treatment. Of 27 clients in the SVR12 era, 15 (56%) discontinued (≤4 weeks) or were LTFU prior to end-of-treatment, and of the remaining 12 (44%), all (100%) were tested for SVR12.

In the SVR4 era, 24 clients-initiated treatment, of whom 16 (67%) were LTFU prior to end-of-treatment, and of the remaining 8 (33%), 5/8 (62.5%) were tested for SVR4. All SVR tests were RNA negative. ***See graph 1 and 2***

In those who had not completed >4 weeks treatment or were previously LTFU (n=31), seven subsequently returned for HCV testing opportunistically >3/12 post intended SVR date, of whom 6/7 were negative. ***See flow diagram 1***

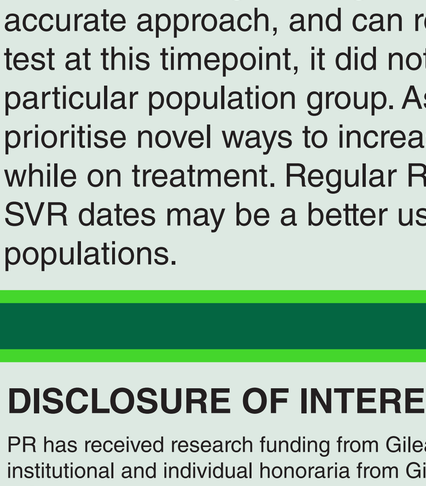


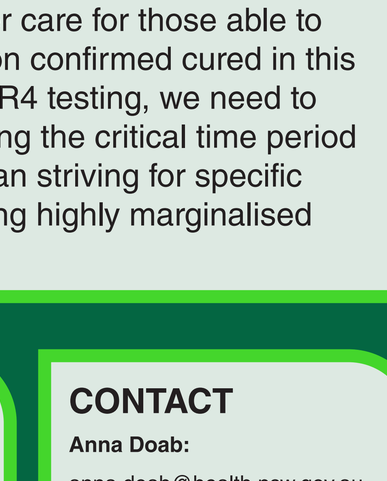
Graph 1: Lost to follow up prior to end of treatment



Graph 2: SVR 12 vs SVR 4

Flow diagram 1: Lost to follow up overview





CONCLUSION AND APPLICATION

The majority of clients who were able to complete treatment were tested for SVR. SVR4 testing did not improve proportional SVR testing compared to SVR12 (21% vs 44%). We found most clients were LTFU post-prescription early in the care-cascade not between end of treatment and SVR stage, therefore although testing from the SVR4 timepoint is a reasonable and accurate approach, and can reduce the time under care for those able to test at this timepoint, it did not impact on proportion confirmed cured in this particular population group. As well as offering SVR4 testing, we need to prioritise novel ways to increase engagement during the critical time period while on treatment. Regular RNA testing rather than striving for specific SVR dates may be a better use of resources among highly marginalised populations.

DISCLOSURE OF INTEREST STATEMENT

PR has received research funding from Gilead Sciences, as well as institutional and individual honoraria from Gilead Sciences, Abbvie and MSD.

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