REAL-WORLD OUTCOMES OF DIRECT-ACTING ANTIVIRAL THERAPY FOR CHRONIC HEPATITIS C FOLLOWING UNRESTRICTED ACCESS IN AUSTRALIA: THE SOUTH AUSTRALIAN EXPERIENCE

Authors:
Haridy J[1,2], Wigg A[3], Muller K[3], Ramachandran J[3], Tilley E[3], Waddell V[4], Gordon D[4,5], Shaw D[6,7], Huynh D[8], Stewart J[8,9], Nelson R[7,9], Warner MS[7,9], Boyd M[7,10], Chinnaratha MA[7,11], Harding D[11], Ralton L[10], Colman A[12], Liew D[13], Iyngkaran G[2], Tse E[12] on behalf of the Adelaide Liver Group

[1]University of Melbourne, Parkville, Australia; [2]Department of Gastroenterology, Royal Melbourne Hospital, Melbourne, Australia; [3]Hepatology and Liver Transplantation Unit, Flinders Medical Centre, Adelaide, Australia; [4]Department of Microbiology and Infectious Diseases, Flinders Medical Centre, Adelaide, Australia; [5]Flinders University, Bedford Park, South Australia; [6]Department of Infectious Diseases, Royal Adelaide Hospital, Adelaide, Australia; [7]Faculty of Health and Medical Sciences, University of Adelaide, Adelaide, South Australia; [8]Department of Gastroenterology, The Queen Elizabeth Hospital, Adelaide, Australia; [9]Department of Infectious Diseases, The Queen Elizabeth Hospital, Adelaide, Australia; [10]Department of Infectious Diseases, Lyell-McEwin Hospital, Adelaide, Australia; [11]Department of Gastroenterology Lyell-McEwin Hospital, Adelaide, Australia; [12]Department of Gastroenterology, Royal Adelaide Hospital, Adelaide, Australia; [13]Department of Epidemiology and Preventative Medicine, Monash University, Melbourne, Australia

Introduction:
In March 2016, the Australian Government offered unrestricted subsidized access to Hepatitis C (HCV) directly-acting antiviral (DAA) therapy. The primary aim of this study was to determine the outcomes of DAA therapy over the first 12 months for the entire state of South Australia (SA).

Methods:
Prospective outcome data (SVR12; sustained virological response twelve-weeks after treatment) was collected on all patients initiating DAA therapy for HCV at or in consultation with four tertiary hospitals in Adelaide between March 2016 and Feb 2017. Biochemistry, co-morbidity and fibroelastography data was collected retrospectively. Primary analysis included all patients intended for DAA treatment and secondary analysis included only those completing follow-up and SVR12 testing.

Results:
1909 patients were included representing estimated 90-95% of total patients treated in SA over the first twelve-months of unrestricted DAA access. Demographics were: mean age 52 years (range 18-92), 67% male, 77% history of injecting drug use, 6% currently injecting, 5% incarcerated, 1% HIV co-infection, <1% hepatitis B co-infection, 25% cirrhotic and 19% had prior HCV treatment experience.

SVR12 in primary and secondary analyses was 80% and 96% respectively. 14% were lost to follow-up (LTFU), 4% failed therapy; <1% discontinued treatment due to adverse effects, poor adherence or death. Community-based remote consultation (Odds Ratio [OR], 1.50; P=0.03) and prison-based treatment (OR, 2.02; P=0.03)

were independent predictors of LTFU on multivariate analysis. We observed a marked decline in treatment initiation over the study period combined with an increase in community-based treatment via remote consultation.

Conclusion:
Our findings support the high responses observed in clinical trials, however a significant gap exists in SVR12 in our real-world cohort due to loss to follow-up. A declining treatment initiation rate and shift to community-based treatment highlights the need to explore additional strategies to identify, treat and follow-up remaining patients to achieve elimination targets.

Disclosure of Interest Statement:
The conference collaborators recognise the considerable contribution that industry partners make to professional and research activities. We also recognise the need for transparency of disclosure of potential conflicts of interest by acknowledging these relationships in publications and presentations.