Preface

Hepatitis C Therapy: Simple for the Patient, not so Simple for the Clinician

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Editor

Not since the late 1990s with the arrival of highly active anti-retroviral therapy for HIV has there been such an explosion of new compounds and regimens in the field of virology. The slow beginnings of this new era, the direct-acting antiviral (DAA) therapy for hepatitis C, started a few years ago with the first protease inhibitors, boceprevir and telaprevir, each being paired with interferon and ribavirin, leading to a significant improvement in response rates, but only in the easiest-to-cure population of treatment-naive patients with genotype 1 virus. For other populations, the poor benefit/risk profile did not justify the widespread use of such toxic regimens.

It was not until all-oral regimens became available that previous predictors of treatment failure were eliminated, including gender, ethnicity, weight, past treatment experience, HIV/HCV coinfection, posttransplantation, and even cirrhosis. So, that made it easier, right? Well, perhaps for the patient and for the clinician managing side effects. However, the field has become more complex for the clinician in terms of understanding mechanisms of how these medications work, the development of resistance, and drug-drug interactions. Unfortunately, one size does not fit all. Different regimens are still required based on genotype and presence, or absence, of cirrhosis, both of which may alter duration.

In this issue of Clinics in Liver Disease, Drs Teriaky and Reau discuss how to evaluate the patient with HCV in this modern era, while Drs Chacko and Gaglio review the different classes of DAA.s Drs Ayoub and Tran, and Drs Kushmer and Khungar, give overviews of how to treat treatment-naive and treatment-experienced patients. Drs Costilla, Mathur, and Gutierrez discuss how patients fail these regimens, while Dr Kwo, Drs Saxena and Terrault, and Dr Wyles all summarize the data for special populations such as patients with cirrhosis, peritransplant patients, and HIV/HCV-coinfected patients. Finally, while the hope is that we can eventually cure all
HCV-infected patients, some patients still fail these highly effective regimens. Drs Vizuete, Hubbard, and Lawitz discuss how best to manage these complicated patients.

Hepatitis C is a curable viral infection and many wonder if it can be eradicated completely someday. While that ambition is a wonderful goal, there is still much work to be done before that. Identifying all patients who are infected, preventing the spread of HCV, and providing access to care/treatment are still major roadblocks for many marginalized individuals.

Importantly, new regimens continue to be developed, and some novel mechanisms of action are being investigated. It will require a few more years, and perhaps other medications, to reach a goal of having an “easy button”: one regimen for all patients. That would truly make it simple for clinicians, patients, and the health care system. However, I would not hold my breath. The HCV virus is dynamic, and with the variations we see in the genome, it is very likely that one of several regimens will be chosen based on specific features of the virus and patient. This will then require some evaluation and thought on the part of the clinician to maximize the chances of success for the patient. Simple? No, but it will be effective, and that is all that matters.

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