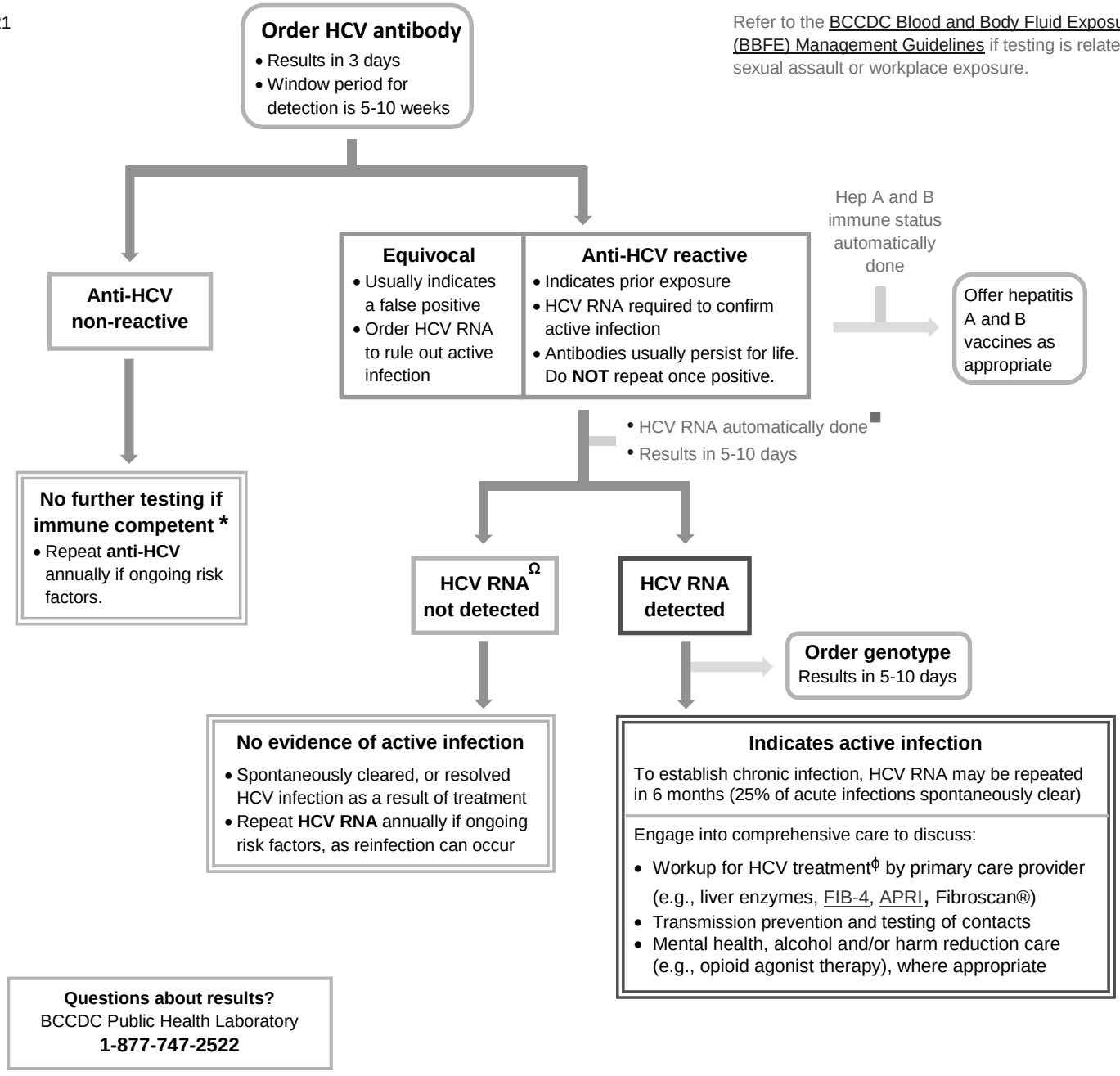
BC Centre for Disease Control
Provincial Health Services Authority

Hepatitis C Testing Guide

Quick Reference Guide for Health Care Providers

April 2021

Refer to the BCCDC Blood and Body Fluid Exposure (BBFE) Management Guidelines if testing is related to a sexual assault or workplace exposure.



Questions about results?
BCCDC Public Health Laboratory
1-877-747-2522

■ Automatic HCV RNA testing done as of Jan.13/20 on all ***first time*** anti-HCV reactive results, and previously anti-HCV reactive results where HCV RNA testing has ***never*** been done. Instructions will be provided on the BCCDC PHL lab result in situations where an additional EDTA tube is required for HCV RNA testing to be completed.

***** False negatives may occur in the presence of major immunosuppression (e.g., HIV+ where CD4+ < 50 cells/mm^3 and agammaglobulinemia). Order HCV RNA where appropriate.

Ω Instructions will be provided on the lab result an EDTA tube is required to confirm an initial HCV RNA 'not detected' result.

ϕ For treatment information and treatment approval forms, see the 2018 CASL Hepatitis C Guideline and BC Special Authority Request Forms.

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Background

Indigenous peoples continue to be impacted at a significantly higher rate due to historic and present colonial policies and systems that disrupt connection to land, language, and culture, and diminish Indigenous sovereignty. Historical and present intergenerational trauma contributes to the social determinants of health in Indigenous peoples and impacts acquisition risks.

In addition to a lack of support to address social determinants of health, persons who use drugs may lack access to necessary harm reduction supplies and testing that can greatly increase risk for HCV infection.

In BC, injection drug use is the major source of new infections. While prevalent infections are more commonly seen in people born in 1945-65, immigrants from endemic areas (includes regions of Central and East Asia, and North Africa/Middle East, see the 2018 CASL HCV Guidelines) and people who have used illicit drugs in the past.

Direct acting antiviral (DAA) curative treatment is well tolerated and over 95% effective across all genotypes after 8-12 weeks of treatment. Treatment is free for anyone who has current HCV infection and BC medical coverage, regardless of liver fibrosis stage.

Clinical Description
Acute HCV infection (< 6 months)
• Symptoms are usually absent, but can include a wide spectrum of illness, including jaundice • Around 25% will spontaneously clear within 6 months
Chronic HCV infection (≥ 6 months)
• Symptoms are usually absent • Over decades, 20% will develop cirrhosis and 1-5% will develop hepatocellular carcinoma (HCC) • Major cause of liver transplantation
Laboratory
HCV Antibody: produced when infected with HCV and usually remains present for life
• A reactive anti-HCV test does not distinguish between resolved or current HCV infection • Does **NOT** need to be repeated once result is reported as reactive
HCV RNA: confirms active infection
• Does not correlate with disease progression • Performed 12 weeks after treatment completion to assess for a virologic cure, known as a sustained virologic response (SVR-12) • Used to screen people who have prior anti-HCV reactive results and have cleared the infection spontaneously or after HCV treatment
HCV Genotype: becoming less important with increasing availability of pangenotypic DAA regimens

Priority populations experiencing a disproportionate burden of HCV infection *

- Born between 1945 to 1965
- Persons who have ever been incarcerated
- Born, lived in or received healthcare in endemic regions
- Indigenous peoples

* See Blueprint to Inform Hepatitis C Elimination Efforts in Canada

Likelihood of Transmission

High

Transmission occurs through blood-to-blood contact.

- Injection drug use (IDU) past or present
- Receipt of healthcare in HCV endemic area where infection control practices were not followed and/or blood supply not tested
- In Canada, receipt of blood transfusion, blood products or organ transplant before 1992
- Tattooing, body piercing or acupuncture where there were poor infection control practices
- Non-IDU (e.g. snorting, smoking), past or present
- Condomless sex, multiple partners (more frequently reported in gbMSM engaging in group sex and/or party 'n play)
- Mother to infant, where mother is HCV RNA positive
- Condomless sex with one long-term partner
- Sharing personal care items (e.g. razors, nail clippers)
- Workplace exposure (e.g. accidental needle sticks)

Low

Education
After testing - engage into care
• Assess alcohol and substance use, providing harm reduction and mental health care as appropriate. • Review immunizations (e.g., hep A and B vaccines) • Offer STI screening, counsel about safer sex • Healthy liver (e.g., diet, acetaminophen use)
Active infection - transmission prevention
• Do not share personal care items • Do not donate blood, semen, breast milk or body organs/tissues • Dispose items and sharps with blood in separate bags or containers • Keep open cuts and sores covered with bandages • Blood spills can be cleaned with a solution of 1 part bleach to 9 parts water. Apply and let sit for 10 minutes before rinsing. • There is no immunization and no post-exposure prophylaxis for HCV

Resources

BCCDC PHL – requisition forms
eLab Handbook – BCCDC PHL information on lab tests
BCCDC Hepatitis C course for public health providers
University of Washington - HCV Online Course
Hepatitis Education Canada
Help4Hep – peer-to-peer helpline