

HEPATITIS C INFECTION : ELIGIBILITY FOR ANTIVIRAL THERAPIES. R. El Saouda (1), J. Delwaide (1), C. Gérard (2), J. Belaiche (1), A. de Roover (3), O. Detry (3), P. Honoré (3), M. Meurisse (3), B. Rentier (4), D. Vaira (4) + GLEVHE (Groupe Liégeois Etude Virus Hépatotropes). (1) Gastroentérologie ; (2) Immunohémato ; (3) Chirurgie ; (4) Virologie, CHU Sart Tilman, Liège.

Current treatments of chronic hepatitis C are effective but expensive. To estimate the global cost of treatment for a country, it is important to evaluate the proportion of patients that are treatment candidates.

Aim of the study : To determine the applicability of antiviral therapy in chronic hepatitis C patients (pts).

Methods : the files of 237 consecutive pts referred for positive PCR-C between 1996 and 2003, when effective therapies were available, were reviewed.

Results : Mean age was 49.2 ± 15.1 , 50.4 % were male. Risk factors were transfusion (43%), IV drug use (23%), needle stick injury (1%), sexual (0.5%), others (32.5%). Genotypes were 1 (66%), 2 (10%), 3 (11.5%), 4 (10.5%), 5 (2%). Were not treated 151 pts (64%). The reasons for not being a treatment candidate were : normal ALT levels (21%), non adherence to evaluation procedures (24.5%) (for example pts who did not attend the appointment for liver biopsy, or who missed more than two office appointments), medical contraindications (34 %). 18% declined therapy despite being considered a treatment candidate. A refusal of reimbursement was the cause of no treatment in 2.5%. The medical contraindications were : psychiatric (29.5%) including poorly controlled severe depression, previous suicide attempt or suicide ideation, ongoing drug or alcohol use, age (25.5%), cirrhotic decompensation (15.5%), willingness of pregnancy (14%), neoplasm (8%), cardiac contraindication (8%), hematological disturbances (4%), and retinopathy (4%). Only 86 pts (36%) were treated. A sustained viral response was obtained in 42 %. The treatment was interrupted in 16% for adverse events.

Conclusions : Only one patient out of three is eventually treated. Only 15% of the whole population of pts referred for chronic hepatitis C becomes sustained responders.

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HIGHER MELD SCORES PRE LIVER TRANSPLANTATION HAVE NO INFLUENCE ON THE LONG TERM SURVIVAL OF THE LIVER TRANSPLANT PATIENT. E. Nagler (1), H. Van Vlierberghe (1), R. Troisi (2), I. Colle (1), M. De Vos (1), B. de Hemptinne (2). (1) Dpt of Gastroenterology, Ghent University Hospital ; (2) Dpt of Hepatobiliary Surgery and Liver Transplantation, Ghent University Hospital.

Introduction : Since the implementation of the MELD score in the USA as a score to allocate livers to patients on the liver transplant waiting list, fewer patients died or were removed from this waiting list. Early survival (90 days) showed no difference under the MELD system compared with early survival in the pre-MELD era. However, if the principle 'sickest patient first' could result in a worse long term survival is unknown. We examined the influence of the MELD score on the long term survival of liver transplant patients.

Materials and methods : By a search through the files of Belgian adult patients transplanted for a non fulminant liver failure in the period between January 1991 and December 2001, we included 121 patients. MELD score was calculated as stipulated by Wiesner et al by using variables taken as close as possible prior to liver transplantation. Log rank testing and Kaplan Meier survival curves were performed using different cut off levels for the MELD score (15, 18, 20 and 25).

Results : Indications for transplantation were mainly alcoholic (38 %) or HCV (26.4%). Gender distribution was male : 62 % versus female 38%. Mean age was 54 years \pm 10 years. Mean MELD score was 16 ± 6 . The follow up time was 5.38 years (range : 1.6-12.3 years). By using different MELD cut off levels, no difference in survival at different time points was noted.

Discussion : Using the MELD score as an allocation tool, has no influence on the long term survival of the liver transplant patient. Together with the better selection of the patients on the waiting list, the MELD score seems to be a superior allocation system.