



KY Hepatitis Connections

Summer is quickly approaching; it's hard to believe its June and summer time weather is finally here! We hope you are able to get out and enjoy some of the beautiful weather and would like to encourage you to plan events using information provided in our June newsletter to create hepatitis awareness and prevention in your communities.

Our newsletter provides current information about viral hepatitis, opportunities for viral hepatitis continuing professional education and information about educational materials available. See all the exciting things happening here in the Kentucky Adult Viral Hepatitis Prevention Program in this issue of *KY Hepatitis Connections*.

Please feel free to forward and/or copy and distribute to other professionals in your network. Your knowledge and input are greatly valued, as we are committed to keeping you up to date on shared progress in the medical community on viral hepatitis and its impact on our families throughout the Commonwealth. Follow us on Facebook at: KY Viral Hepatitis.

Kathy Sanders, RN MSN



Kentucky Rural Health Association, in partnership with Kentucky Department for Public Health's Adult Viral Hepatitis Prevention Program and Kentucky Immunization Program, is proud to present

Hepatitis: The Silent Epidemic in Kentucky

Hyatt Regency

401 West High Street, Lexington, KY 40507

July 24, 2014

FREE: All day training: Registration begins at 7:30

CMEs and CEUs will be offered

Target Audience: Family Medicine physicians, Internal Medicine physicians, Pediatricians, Infectious Disease physicians, Nurses, Nurse Practitioners, Physicians Assistants, Infection Preventionists, Employee Health staff, Local Health Department medical providers, Local Health Department Nurses, Regional Epidemiologists, and other health professionals involved in the screening, diagnosis, treatment, management, prevention, and control of hepatitis.

For additional information: Contact Julie Miracle at Julie.miracle@ky.gov or Kathy Sanders at kathyj.sanders@ky.gov

Limited Space: REGISTRATION IS NOW OPEN!

<https://ky.train.org>

Course #1050937

No on-site registration

Hepatitis: The Silent Epidemic in Kentucky
AGENDA
July 24th, 2014

TIME	PRESENTATION	FACULTY
7:00 a.m.- 7:30 a.m.	Conference and Exhibit Setup	
7:30 a.m. – 8:30 a.m.	Registration Exhibit viewing Continental Breakfast provided	
8:30 a.m. – 8:45 a.m.	Welcome and Opening of Conference	Dr. Kraig Humbaugh, M.D., M.P.H. KY Department for Public Health Deputy Commissioner
8:45 a.m. – 9:15 a.m.	Epidemiology of Hepatitis in Kentucky	Dr. Kraig Humbaugh, M.D., M.P.H. KY Department for Public Health Deputy Commissioner
9:15 a.m. – 9:30 a.m.	Hepatitis A	Dr. Robert Brawley, MD, MPH, FSHEA KY Department for Public Health Chief, Infectious Disease Branch
9:30 a.m. – 10:30 a.m.	Perinatal Hepatitis... What about the children?	Dr. John Stutts, MD Pediatric GI Division University of Louisville
10:30 a.m. – 10:45 a.m.	Break Exhibit viewing Light snack provided	
10:45 a.m. – 11:45 a.m.	Hepatitis B & C Diagnosis & Treatment Case Studies	Dr. Rosenau, MD Assistant Professor, Medical Director of Liver Transplantation University of Kentucky
11:45 a.m. – 12:30 p.m.	Hepatitis B & C: Persons Who Inject Drugs	Jon Zibbell, PhD Health Sciences/ Medical Anthropologist Division of Viral Hepatitis/ CDC
12:30 p.m. – 1:45 p.m.	Working Lunch: “What do you see? What do we need?”	
1:45 p.m. – 2:45 p.m.	Challenges and Benefits of Incorporating Hepatitis into Primary Care Settings & Tele-health Review	Dr. Schaninger, MD University of Kentucky Infectious Disease
2:45 p.m. – 3:45 p.m.	Novel Approaches to Care and Treatment	Dr. Matthew Cave, MD University of Louisville Hepatology
3:45 p.m. – 4:00 p.m.	Break Exhibit viewing--Light snack provided	
4:00 p.m. – 4:15 p.m.	Prevention of Hepatitis: Where do we start?	Jon Zibell, PhD Health Sciences/ Medical Anthropologist Division of Viral Hepatitis/ CDC
4:15 p.m. – 4:45 p.m.	Panel Discussion & Issues Discussed at Lunch	
4:45 p.m. – 5:00 p.m.	Evaluation & Closing	
5:00 p.m. – 6:00 p.m.	Exhibit viewing	

Reminder:

Hepatitis C: Perinatal and Children Aged Five Years or Less

Dear Healthcare Provider,

The Kentucky Department for Public Health (KDPH) is requesting your ongoing assistance to report pregnant women and children aged five years and less who are infected with hepatitis C virus (HCV), and seen in birthing hospitals, medical practices, and clinics throughout the Commonwealth.

Since January 1, 2014, KDPH has asked healthcare providers to voluntarily report: 1) all HCV-positive pregnant women; 2) all infants born to HCV-positive women; and 3) all HCV-positive infants and children aged five years or less seen in birthing hospitals, medical practices, and clinics, in addition to the current hepatitis B virus (HBV) infection reporting requirements in these populations (i.e., perinatal HBV-positive reports).

We most appreciate your excellent cooperation with the voluntary reporting about HCV-positive individuals in the above categories (i.e., perinatal HCV-positive reports). In the first 10 weeks of 2014, the number of perinatal HCV-positive reports has exceeded the total number of perinatal HBV-positive reports received for all of 2013.

Please complete the reporting form at the end of this newsletter and fax to the Kentucky Department for Public Health at: 502-564-4760 to continue to report any HCV-positive individuals in the above categories.

We deeply appreciate your time and effort in assisting us with this active surveillance project for perinatal HCV infections. If you have additional questions or concerns, please call Kathy Sanders, RN, MSN at 502-564-3261, ext. 4236 or Julie Miracle, RN, BSN at 502-564-4478, ext. 4260.

Robert L. Brawley, MD, MPH, FSHEA

Chief, Infectious Disease Branch
Division of Epidemiology and Health Planning
Kentucky Department for Public Health
275 East Main Street, MS: HS2GW-C
Frankfort, KY 40621-0001

Hospital Infection Preventionists: Please distribute to medical providers, nursing staff, and other health-care personnel in Emergency Medicine, Critical Care, Laboratory Medicine, Infectious Diseases, Obstetrics, Newborn Nursery, NICU, Pediatrics, Internal Medicine, Family Medicine, and Primary Care or Ambulatory Care.

LHD staff: Please distribute to community healthcare providers in Infectious Diseases, Obstetrics, Pediatrics, Internal Medicine, Family Medicine, and Primary Care or Ambulatory Care and to FQHCs and RHCs.

HEPATITIS C TREATMENTS: LATEST UPDATE

Expensive New Hepatitis C Drug Raises Alarms

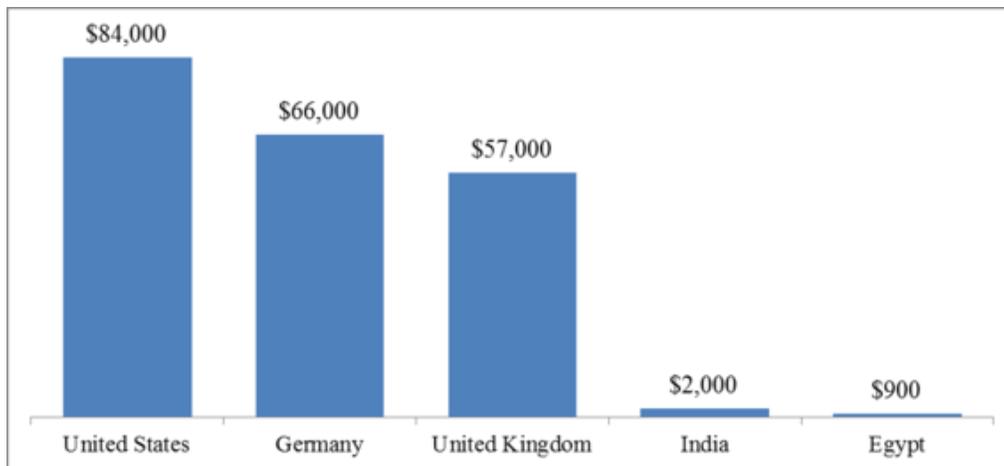
Hepatitis C is a serious liver disease that results from infection with the hepatitis C virus. It currently affects more than three million Americans, many of whom do not know that they are infected. Left untreated, it can lead to liver damage, cirrhosis, liver failure, or liver cancer.

Until recently, hepatitis C treatments only cured about half of patients and often had undesirable side effects. Fortunately, a new drug called Sovaldi entered the market in late 2013 that had a higher cure rate, a shorter duration of treatment, and fewer side effects than previous treatments. However, this remarkable advance came with an equally remarkable price: \$1,000 per pill, or \$84,000 for a typical course of treatment.

Why so expensive? Gilead, the drug company that makes Sovaldi, argues that drug's high price pays for itself by avoiding future complications like liver transplants. However, experts have thus far concluded that projected savings would not offset the cost.

In addition, sales of Sovaldi are increasing at a record-breaking pace, with analysts expecting U.S. sales of \$10 billion in 2014. Gilead bought the company that originally developed Sovaldi for \$11 billion, and its entire research and development budget was just over \$2 billion in 2013. Thus, Gilead will likely recoup its investment in less than two years based on its U.S. sales alone, raising questions of whether Sovaldi's high price is really just profiteering.

It is also noteworthy that Sovaldi's price is considerably lower outside of the U.S. While the U.S. government continues to decline to regulate drug prices, many other countries have been able to obtain Sovaldi for far less than \$84,000.



Source: B. Berkrot and D. Beasley, "U.S. lawmakers want Gilead to explain Sovaldi's hefty price," Reuters, March 21, 2014.

Read More: http://www.huffingtonpost.com/debra-b-whitman-phd/expensive-new-hepatitis-c_b_5398818.html

U.S. health insurers say Gilead hepatitis C drug too costly

May 20 (Reuters) - The leading U.S. health insurance trade group on Tuesday hit out at the extremely high cost of new specialty medicines, accusing drug makers of taking advantage of the insurance system by pricing products at unsustainable levels.

The latest salvo in the war on escalating U.S. healthcare costs came from AHIP - America's Health Insurance Plans - and targeted Sovaldi, the new \$84,000 hepatitis C treatment from Gilead Sciences Inc.

"Sovaldi has shown tremendous results, and it's the kind of medical innovation we need to sustain. Unfortunately, the drug's maker has priced it at an astronomical level that is not sustainable for consumers, innovation, or society," AHIP said on its Coverage blog.

Sovaldi is the first in a new wave of all-oral treatments for the liver disease that has been a tremendous advance over prior treatments. The new drug has demonstrated an ability to cure well over 90 percent of patients in just 12 weeks or less with few side effects.

Prior to the Sovaldi approval, hepatitis C treatments took 24 or 48 weeks, cured about 75 percent of patients and involved many more pills as well as injectable interferon that causes flu-like symptoms and other side effects that led many people to avoid or discontinue treatment.

John Castellani, chief executive of PhRMA, the leading pharmaceutical industry trade group, said the problem is an insurance system that pushes too much of the cost of treatment onto the patient with high co-pays and deductibles for drugs.

"The insurance model makes medicine seem like the most expensive part of the healthcare system," Castellani said. (Reporting by Bill Berkrot and Caroline Humor; Editing by Ken Wills)

Read More: <http://www.reuters.com/article/2014/05/20/insurance-gilead-sciences-drugcosts-idUSL1N00628320140520>



Medicaid Calls Evidence for Sovaldi Lacking and Biased

The National Association of Medicaid Directors has denounced as poor and potentially biased the available evidence and guidelines supporting the use of Gilead Sciences' hepatitis C virus (HCV) therapy Sovaldi (sofosbuvir), MedPage Today reports. In a report, Medicaid called into question whether Sovaldi, which costs \$1,000 a day and is placing a substantial financial burden on both private and governmental insurers, is a substantial improvement over the standard of care of interferon, ribavirin and either Victrelis (boceprevir) or Incivek (telaprevir).

The report points out that the published research on Sovaldi is limited to just 10 studies, nine of which were sponsored by Gilead and that none of them compared the drug's use among those with genotype 1 of hepatitis C with an alternate drug regimen. Nor did any of the studies include comparisons to a Victrelis- or Incivek-based regimen. While the cure rates were relatively high in these trials, the report questions if such figures will remain as elevated in real-world use of Sovaldi.

Read More: <http://www.medpagetoday.com/InfectiousDisease/Hepatitis/45944>



Sustained response to treatment reduces fatigue in hepatitis C patients

Curative treatment that eliminates hepatitis C virus (HCV) from the body can reduce central fatigue, one of the most concerning symptoms associated with chronic hepatitis C, according to research presented at the 49th annual meeting of the European Association for the Study of the Liver (EASL), held recently in London.

Fatigue is a common and debilitating symptom for many people with hepatitis C. Central fatigue refers to weakness originating in the central nervous system (the brain and spinal cord), as opposed to peripheral or physical fatigue that originates in the muscles.

Fatigue is also a common side-effect of treatment with interferon and ribavirin. Ribavirin often causes anemia, which can lead to fatigue by reducing the blood's capacity to carry oxygen. New direct-acting antiviral agents allow people with hepatitis C to either take interferon or ribavirin for a shorter duration or to avoid them altogether.

Zobair Younossi and colleagues with Inova Health System in Virginia evaluated changes in fatigue among people with hepatitis C treated and cured with sofosbuvir, either with pegylated interferon and ribavirin in the NEUTRINO trial (genotypes 1, 4, 5 and 6) or with ribavirin alone in the FUSION trial (genotypes 2 and 3). Read More: <http://www.aidsmap.com/Sustained-response-to-treatment-reduces-fatigue-in-hepatitis-C-patients/page/2850798/>

Sofosbuvir + ribavirin is safe and effective for HCV recurrence after liver transplantation

An interferon-free combination of sofosbuvir (*Sovaldi*) plus ribavirin taken for up to 24 weeks led to sustained virological response in 70% of liver transplant recipients with hepatitis C virus (HCV) recurrence, according to a poster presented at the 49th annual meeting of the European Association for the Study of the Liver (EASL), held recently in London.

Direct-acting antiviral agents (DAAs) have begun to revolutionise treatment for chronic hepatitis C. The first of the next-generation DAAs – Gilead Sciences' HCV polymerase inhibitor sofosbuvir and Janssen's HCV protease inhibitor simeprevir (*Olysio*) – were approved late last year, and several more are in the pipeline. But therapeutic options remain scarce for people with severe liver disease who have the most urgent need for treatment.

Didier Samuel of Université Paris-Sud and colleagues conducted a single-arm, open-label study of sofosbuvir plus ribavirin for liver transplant recipients who experienced HCV recurrence.

Hepatitis C virus almost always re-infects the new liver after a transplant. This can lead to rapid fibrosis progression with an increased risk of graft loss and life-threatening complications. Interferon – the former standard of care for hepatitis C – is often poorly tolerated and not very effective for people with advanced liver disease. Sofosbuvir is a promising option because it is well tolerated and does not interact with immunosuppressant drugs used to prevent organ rejection.

Read More: <http://www.aidsmap.com/Sofosbuvir-ribavirin-is-safe-and-effective-for-HCV-recurrence-after-liver-transplantation/page/2851593/>

Janssen Submits Supplemental New Drug Application to U.S. FDA for OLYSIO™ (Simeprevir) for Once-Daily Use in Combination with Sofosbuvir for 12 Weeks for the Treatment of Adult Patients with Genotype 1 Chronic Hepatitis C

RARITAN, N.J., May 7, 2014 -- Janssen Research & Development, LLC (Janssen) today announced it has submitted a Supplemental New Drug Application (sNDA) to the U.S. Food and Drug Administration (FDA) for simeprevir, an NS3/4A protease inhibitor marketed as OLYSIO™ in the United States, in combination with the nucleotide analog NS5B polymerase inhibitor sofosbuvir developed by Gilead Sciences, Inc. This regulatory submission is for the treatment of genotype 1 chronic hepatitis C (HCV) in adult treatment-naïve patients with advanced fibrosis and null responders with all stages of liver fibrosis.

OLYSIO™ is currently approved for the treatment of chronic hepatitis C infection as a component of a combination antiviral treatment regimen. OLYSIO™ efficacy has been established in combination with peginterferon alfa and ribavirin in HCV genotype 1-infected patients with compensated liver disease, including cirrhosis.

"Hepatitis C places a significant burden on the lives of those infected and if left untreated may cause significant damage to the liver, including cirrhosis and complications such as liver failure," said Gaston Picchio, Hepatitis Disease Area Leader, Janssen Research & Development. "This filing brings us closer to

potentially offering these patients a once-daily all-oral treatment combination that includes the direct-acting antiviral agents simeprevir and sofosbuvir."

Read More: <http://www.prnewswire.com/news-releases/janssen-submits-supplemental-new-drug-application-to-us-fda-for-olysio-simeprevir-for-once-daily-use-in-combination-with-sofosbuvir-for-12-weeks-for-the-treatment-of-adult-patients-with-genotype-1-chronic-hepatitis-c-258268141.html>

New hepatitis resolution is passed at world health assembly; challenges World Health Organization and member states to act

Geneva, Switzerland, May 22, 2014 —Today, four years after introducing its first viral hepatitis resolution, the World Health Assembly (WHA)—the decision-making body of the World Health Organization (WHO)—passed the **Hepatitis Resolution**, which commits the WHO and United Nations (UN) member states to urgent action to address the global hepatitis pandemic, including that of hepatitis C virus (HCV). Read **Hepatitis Resolution**:

http://www.treatmentactiongroup.org/sites/g/files/g450272/f/201405/WHA%20Hepatitis%20R%20FINAL_May2.pdf

Globally, an estimated 185 million people have been infected with HCV. Since 2010, more than a million of them have died from HCV-related liver disease, although hepatitis C is treatable and curable. Since 2010, 9–12 million people have become infected with hepatitis C, although it is preventable. In addition, in an increasing number of countries, liver disease caused by HCV has become the leading cause of non-AIDS-related death in people co-infected with HIV/HCV.

The resolution comes at a critical moment, as new drugs to treat HCV are entering the market. These new drugs, called direct-acting antivirals (DAAs), demonstrate cure rates of more than 90 percent in clinical trials and provide radically simpler treatment. DAAs offer the unprecedented promise of global HCV eradication, especially in low- and middle-income countries (LMICs), where 85 percent of people with HCV live.

Yet, in high-income countries, a 12-week combination regimen of DAA treatment can cost US\$140,000, although it costs less than US\$250 to produce. During the resolution proceedings, dozens of countries, including Malaysia, Ukraine, South Africa, Venezuela, and France remarked on the prohibitive cost of new HCV treatments.

The World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) provides LMICs with certain legal flexibilities. The Hepatitis Resolution supports LMICs' use of these flexibilities to produce or import generic versions of DAAs and other medications if companies refuse to offer them at affordable prices. Brazil, the sponsor of the resolution, which was unanimously voted in, stated during the vote that governments, "should use TRIPs flexibilities whenever needed" in order to gain access to safe, effective, quality generics.

The WHO must vocally and unequivocally support countries' use of compulsory licenses, parallel importation, and other TRIPs flexibilities to facilitate universal access to lifesaving treatment and to stop the 500,000 annual deaths related to HCV.

The inclusion of harm reduction—an evidence-based approach to reducing transmission of blood borne viruses and mortality among people who inject drugs (PWID)— is retained in this resolution as a key recommendation, despite early opposition by some countries. During the vote, a number of governments, including Indonesia, Iran, Russia, and Canada spoke out on the need to address PWID as a key population. Now the WHO must prioritize providing technical assistance to UN member states to dramatically scale up needle and syringe programs, opioid substitution therapy, access to HCV treatment, and decriminalization of PWID and harm reduction for this critically important population, 67 percent of whom are HCV-infected. Most new infections occur among PWID, yet access to sterile injection equipment and other HCV prevention tools is staggeringly inadequate, reaching only a tiny percentage of those who need it. This egregious public health failure allows the epidemic to continue spreading.

The Hepatitis Resolution challenges WHO Director-General Margaret Chan and her agency to mobilize global political will and resources to effectively address viral hepatitis, and to help UN member states develop the technical capacity to implement prevention, treatment, and care plans. Without a massive resource investment from donors and UN member states to support a global plan, millions will continue to become infected and die. Read More: <http://www.treatmentactiongroup.org/hcv/2014/WHA-resolution>

HEPATITIS IN CORRECTIONS

To curb hepatitis C, test and treat inmates

PROVIDENCE, R.I. [Brown University] — Problematic as it is for society, the high incarceration rate in the United States presents an important public health opportunity, according to a new "Perspective" article in the *New England Journal of Medicine*. It could make staving off the worst of the oncoming hepatitis C epidemic considerably easier.

Nearly 4 million Americans may be infected with the hepatitis C virus (HCV). Many of them don't know they carry HCV, which can take decades to make them ill with cirrhosis, cancer, or liver failure. About a million people could die because of HCV by 2060, the authors wrote, and many who are saved will have required critical and costly treatments, including liver transplants.

"We know this is going to come crashing down on us," said lead author Dr. Josiah D. Rich, professor of medicine and epidemiology at Brown University and director of the Center for Prisoner Health and Human Rights at The Miriam Hospital. "It's already starting to come crashing down. The next 10 to 20 years are going to be ugly."

The single best setting for fighting the epidemic is U.S. prisons and jails, where more than 10 million people cycle through each year. In part because a major means of HCV transmission is through injection drug use, a large portion of the nation's infected population passes through the criminal justice system. In the journal, for example, Rich and his coauthors estimate that one in six inmates is infected and one in three infected Americans ends up locked up for at least a little time in their lives.

"We can head off a lot of disease and expense if we invest now," Rich said. "How do we do that most efficiently and effectively? What we're arguing in the paper is that we do it using the criminal justice system infrastructure."

Worth the considerable cost: The key barrier, Rich readily acknowledges, is the very high cost of hepatitis C drugs. A 12-week course of Sovaldi, made by Gilead Sciences, costs \$84,000 a person. Treating all current inmates with HCV would therefore cost \$33 billion, the authors estimate. Treating just half the people who cycle through prisons and jails in a given year would cost \$77 billion.

But drug costs don't have to be nearly so high if state prison systems can negotiate reasonable discounts with drug makers, as the federal government does for its prisoners. And while prisons have a clear disincentive to spend money to treat people who may well be released before they become sick, the money cannot and need not come solely from their budgets.

"The criminal justice system cannot be expected to shoulder the prohibitive costs of hepatitis C treatments alone," said co-author Dr. Brie A. Williams, associate professor of Medicine at the University of California–San Francisco. "Recognizing that infectious disease epidemics cannot be contained behind prison walls, we must develop a national strategy for responding to them that includes financial support and an infrastructure to test and treat prisoners, both within prisons and jails and after they return to our communities."

U.S. society as a whole will pay the costs of an inadequately addressed HCV epidemic, the authors said. Helping prisons to provide this treatment will also curb the need for litigation by prisoner advocates to a community standard of HCV care for prisoners, said co-author Dr. Scott A. Allen, professor of medicine at the University of California–Riverside. "Even with the high cost, the drugs appear to be cost-effective," Allen said. "Private insurers in the community appear to be covering it. That establishes a clear community standard, and prisons will be held to that standard by the courts. The public policy question isn't whether or not we pay for hepatitis C care but how we pay for it."

A potential model already exists in the Ryan White Care Act, the three authors note. Congress could consider replicating that achievement of funding widespread HIV services and treatment for people who couldn't obtain them otherwise. An HCV version could include programs and grants for prisons and jails, as well as programs to prevent reinfection of inmates after they are released.

"Seizing this opportunity for timely care will require leaders to consider the criminal justice system as part of the fabric of U.S. health care," the authors concluded. "This step will help to change the perception of the HCV epidemic in the criminal justice system, transforming it from a legal liability to a critical opportunity to change the course of HCV in the United States."

http://www.eurekalert.org/pub_releases/2014-05/bu-tch050914.php

HEPATITIS: IN THE NEWS

UMN halts blood-sugar screenings at St. Paul high-rise

The University of Minnesota is alerting 300 people about an infectious disease risk after students providing blood sugar screenings at a St. Paul high-rise used monitoring equipment on multiple patients. No infections have been reported as a result of the possible exposure, the U said in a statement released Thursday. Free screening tests for illness are being offered next month to residents.

"The risk of HIV/AIDS, hepatitis B or hepatitis C infection from a shared device is low, but there is still a risk," officials said in a statement.

The blood sugar screenings were being offered as part of a diabetes awareness program at Skyline Tower, a high-rise residence located in the Midway area of St. Paul.

"We regret that this situation has occurred and we apologize to the Skyline community for the mistake," said Dr. Chris Bowron, director of a program called Skyline Healthcare Awareness Resident Education (SHARE), in a statement.

Michael Osterholm, an infectious-disease expert at the U, said in a statement: "While the risk for infection is low, we know that every possible exposure to infectious disease transmitted via blood must be taken seriously. Our goal is to make sure that if anyone has been infected, they are identified and provided appropriate medical care."

The U launched the SHARE program in 2009 as an outreach effort to residents of Skyline. Faculty physicians supervise students in the medical, nursing and pharmacy school programs as they work on various health promotion efforts.

In 2010, program volunteers started offering free blood sugar screenings, in which student volunteers were trained to use finger stick devices and blood sugar monitors. "They took numerous precautions to avoid infection," the U said in its statement. "Before each blood test, the volunteers replaced the lancet used in the device, cleaned the device with alcohol and put on clean gloves. They also used alcohol swabs to clean patients' fingers."

But in April, program officials learned that the practice of using the devices on more than one person does not meet federal guidelines.

Read More: http://www.twincities.com/localnews/ci_25859496/umn-halts-blood-sugar-screenings-at-st-paul

USPSTF Recommends Hepatitis B Screening for High-Risk Groups

The U.S. Preventive Services Task Force now recommends screening for hepatitis B virus (HBV) infection in high-risk groups, given the accuracy of serologic testing and the effectiveness of antiviral therapy. High-risk groups include: people born in areas with an HBV prevalence of 2% or more, including Africa, Asia, the Middle East, Eastern Europe, and parts of South America; HIV-positive patients; injection-drug users; men who have sex with men; household contacts of HBV-infected patients. The grade B recommendation, published in the *Annals of Internal Medicine*, updates the task force's 2004 statement, which recommended against HBV screening in the general population. (Of note, the new statement applies only to non pregnant individuals; the USPSTF already recommends HBV screening in pregnancy.) - See more at: <http://www.jwatch.org/fw108870/2014/05/27/uspstf-recommends-hepatitis-b-screening-high-risk-groups?query=pfwRS#sthash.U4QyPrbQ.dpuf>

Read More: <http://www.jwatch.org/fw108870/2014/05/27/uspstf-recommends-hepatitis-b-screening-high-risk-groups?query=pfwRS>

New liver scanner could help avert 'crisis in the making'

A Calgary outreach organization is trying to help Calgarians suffering from liver diseases using a painless diagnostic technology.

FibroScan works much like an ultrasound and can provide an immediate diagnosis for many high-risk patients who wouldn't otherwise seek care.

"Often patients have heard about older tests we used to do like liver biopsies to stage liver disease severity and so by introducing them to this non-invasive test, we're hoping that we can help these patients access care and engage them in care for their underlying liver disease," said Dr. Rob Myers, a hepatologist at the University of Calgary.

Myers says many patients have heard nightmare stories about liver biopsies and so are less likely to get tested for liver damage, even though hepatitis, alcohol-related liver problems and fatty liver disease are a "crisis in the making." However, catching problems early can help stop major problems before they develop.

Read More: <http://www.cbc.ca/news/canada/calgary/new-liver-scanner-could-help-avert-crisis-in-the-making-1.2660106>

HEPATITIS PREVENTION: SPREAD THE WORD

IV DRUG ABUSE and HEPATITIS C go HAND in HAND



TEEN MEDICINE ABUSE IS AN EPIDEMIC - ONE THAT IS NOT POISED TO GET BETTER.

MORE TEENS ARE ABUSING PRESCRIPTION MEDICINE THAN EVER. RECENT FINDINGS FROM THE PARTNERSHIP ATTITUDE TRACKING STUDY, SHOW THAT

ONE IN FOUR TEENS

HAS MISUSED OR ABUSED A PRESCRIPTION DRUG AT LEAST ONCE IN THEIR LIFETIME. THAT IS A 33 PERCENT INCREASE SINCE 2008.

ONE STEP WE CAN ALL TAKE IS TO HAVE FREQUENT CONVERSATIONS WITH THE TEENS IN OUR LIVES ABOUT THE DANGERS OF MEDICINE ABUSE.

IT IS IMPORTANT THAT PARENTS MONITOR, SAFEGUARD AND PROPERLY DISPOSE OF THE MEDICINES THEY KEEP AT HOME, AS MORE THAN FOUR IN TEN TEENS WHO HAVE MISUSED OR ABUSED A PRESCRIPTION DRUG HAS TAKEN IT RIGHT OUT OF THEIR PARENT'S MEDICINE CABINET. KIDS WHO ABUSE MEDICINE ARE STARTING EARLY. IN FACT, ONE IN FIVE KIDS HAS DONE SO BEFORE THE AGE OF 14. PARENTS ARE THE FIRST LINE OF DEFENSE IN PROTECTING TEENS FROM THIS DANGEROUS BEHAVIOR.



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Kentucky Reportable Disease Form

**Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001**

**Hepatitis Infection in Pregnant Women or Child (under the age of five)
Fax Form to 502-564-4760**

DEMOGRAPHIC DATA					
Patient's Last Name	First	M.I.	Date of Birth	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk
Address		City	State	Zip	County of Residence
Phone Number	Patient ID Number	Ethnic Origin <input type="checkbox"/> His. <input type="checkbox"/> Non-His.		Race <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am.Ind. <input type="checkbox"/> Other	

DISEASE INFORMATION			
Describe Clinical Symptoms:	Date of Onset: / /	Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Diagnosis: / /
Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # wks _____	Expected Date of Delivery: / /	Name of Hospital for Delivery:	
Physician Provider Name: Address: Phone:			

LABORATORY INFORMATION				
Hepatitis Markers	Results	Date of test	Viral Load *if applicable	Name of Laboratory
HBsAg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
IgM anti-HBc	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
HBeAg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
IgM anti-HAV	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
HCV Antibody	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
HCV RNA Confirmation	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		

SERUM AMINOTRANSFERASE LEVELS			
Patient	Reference	Date of test	Name of Laboratory
AST (SGOT) U/L	U/L	/ /	
ALT (SGPT) U/L	U/L	/ /	

<p>Mother: Hepatitis Risk Factors <input type="checkbox"/> IDU <input type="checkbox"/> Multiple Sexual Partners <input type="checkbox"/> Tattoos <input type="checkbox"/> STD <input type="checkbox"/> HIV <input type="checkbox"/> Foreign Born/ Country _____ <input type="checkbox"/> Exposure to known HBV/HCV Pos contact</p>	<p>Child: Hepatitis Risk Factors <input type="checkbox"/> Mother HBV Pos <input type="checkbox"/> Household member exposure HBV Pos <input type="checkbox"/> Mother HCV Pos <input type="checkbox"/> Household member exposure HCV Pos <input type="checkbox"/> Foreign Born / Country _____</p>
<p>Mother: Hepatitis A vaccination history: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Dates Given: / / Hepatitis B Vaccination history: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If yes, how many doses <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 Year completed: / /</p>	
<p>Child: Hepatitis A vaccination history: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Dates Given: / / Hepatitis B Vaccination history: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Dates Given: / / Was PEP Infant of Positive HBV mother given at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

