Paul Wells

Hepatitis: The junkie disease

For five long years, the warnings have come thick and fast – but no-one seems to have listened: Hepatitis C is *the* major cause of viral infection among drug injectors. Give it another decade, and it could be the major cause of death too. Paul Wells simply asks – is there anyone out there who cares?

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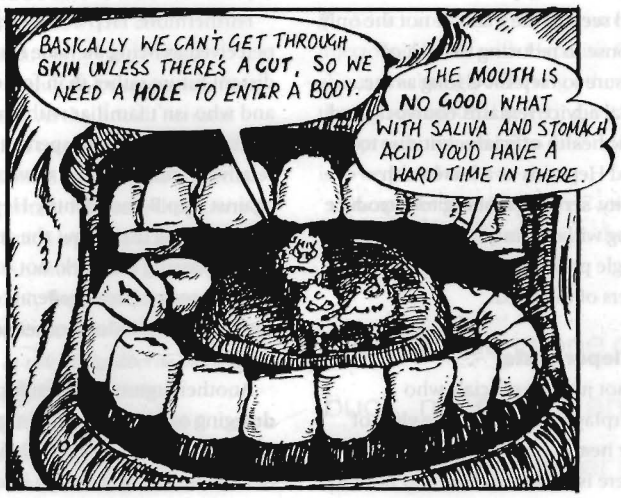
It is generally accepted that the Department of Health initiatives of 1987 and 1988 which enabled the establishment of needle exchanges – announced in DoH Circulars HC[87]8 and HC[88]26 – have been effective in minimising the overall incidence of HIV infection among drug injectors in Britain. It is also generally accepted however that this approach has not had the same success in respect to other blood-borne viruses. There is another viral epidemic among injecting drug users, but evidence of this epidemic has so far failed to set alarm bells ringing. It is, of course, Hepatitis C.

We should not underestimate the positive impact of the early HIV prevention strategy. Not only did it allow for the adoption of the principles of harm reduction by drug services but – by hastening the birth of needle exchanges – it also led to a reduction in the sharing of injecting equipment and to the low number of HIV+ injectors we see today. True prevalence is hard to identify but the *Unlinked HIV Prevalence Survey* has indicated that 'only' two per cent of injecting drug users are HIV+, while six per cent of diagnosed AIDS cases are injecting drug users.[1] Compare these figures to the American – where by the end of 1994, 32 per cent of AIDS cases were injecting drug users[2] – and you can see the drawbacks to the policy of 'zero tolerance'.

But this very success has bred complacency. The assumption is now

that because it has been effective against HIV, the same harm reduction advice can also be employed to stop Hepatitis, both B and C. The line taken by many drug professionals – promoted by 1993's *AIDS and Drug Misuse: Update* ACMD report[3] – is that if people follow the HIV advice, they're protected from Hep B and C.



The line taken by many *drug users* is that the visibly low levels of HIV infection among drug injectors are a sign that rigid adherence to using clean injecting equipment is not that important.

Who are we kidding?

Unfortunately, neither position is supported by the evidence – the Public Health Laboratory Service has found that 22 per cent of injecting drug users test positive for Hepatitis B (and others put it at more than double this figure), while 60-85 per cent are believed to be infected with Hepatitis C.[1] And the induction rate into Hepatitis is even more alarming: Australian research has found that nearly one in three injectors (32 per cent) become infected with Hep C within a year of commencing injecting,[4] while other studies have found 70-85 per cent infected within six years.

In Australia, where much of the Hep C research has been conducted, many regard the virus as the most common life-threatening infection – *to the general population*. It is also singled out as the most likely single cause for future liver transplants.[5]

The relevance of this to the British drug field is that since 1991, the spread of Hep C has largely been confined to injecting drug users with little risk of a generalised spread into the wider community. This may explain the low priority given to tackling the virus, but it also explains the growing awareness among drug professionals that it is going to become a major health issue for drug injectors, who have been – and who will continue to be unless something is done – exposed to Hep C risk.

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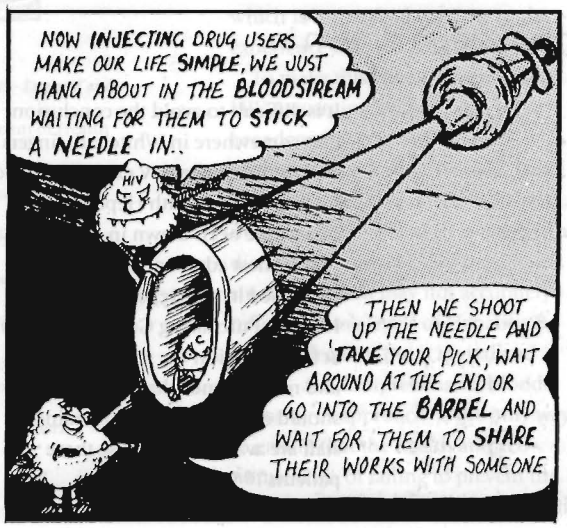
This risk and the associated levels of Hepatitis infection largely flows from the realisation that although needle exchanges have dramatically reduced reported levels of sharing injecting equipment from up to 90 per cent to less than 20 in just a decade, this change in injecting behaviour has not been sufficient to stem the tide of Hepatitis as it has HIV. The conclusion, of course, is well understood: Hepatitis is a hardier virus than HIV.

You say sharing, I say . . .

Many studies have shown that a less than perfect understanding of what is meant by 'sharing' may have led to continued multiple exposure to Hepatitis infection among injecting drug users. While the passing of 'works' directly from one injector to another in the course of a single drug-taking session may have tailed off, 'indirect' sharing of needles and syringes (back and frontloading, time lapses between uses and inadequate cleaning) and also of injecting paraphernalia such as spoons, water, swabs and tourniquets is probably higher than we would like to believe. If this is the case, then the transmission of Hep C is likely to be occurring with little effective action being taken to counter it, especially as the evidence suggests that transmission requires only a minor lapse in 'infection control'.

Evidence for these lapses is worrying, both in its widespread availability and in the failure to pay it any heed. Unpublished research into the drug injecting and sexual risk behaviour of over 300 injecting drug users in the West Midlands indicates that there is great cause for concern. In the last six months, a third of the sample had used injecting equipment previously used by others. There were even higher rates for sharing paraphernalia – 85 per cent in the last six months and 69 per cent in the last four weeks.[6]

Australian and American researchers, who have filmed drug users injecting in their usual social setting, have identified numerous opportunities for contamination and the spread of infection.[7,8] Other research has shown that injecting drug users have a



hierarchy of risks, in which overdosing risks are viewed as more important than viral infection, resulting in users injecting in the 'safe' company of others.[9] The West Midlands research found that 89 per cent of the sample injected in the presence of others both for 'safety' and friendship. As all the research has shown, repeated exposure to low level contamination is the norm, with environmental factors – *such as the communal use of paraphernalia* – being an identifiable source of potential infection.

Crisis? What crisis?

But given all this, official UK advice on services for drug users still either ignores Hepatitis C completely or attempts to minimise its significance.

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It is difficult to avoid the conclusion that somewhere in Whitehall, fingers were burnt by the HIV experience, and so – when faced with Hepatitis – the claws have been drawn in.

The latest advice on Hepatitis, contained in the Department of Health's Purchasing Guidelines, does at least mention the risk of infection and recommends that "purchasers should ensure that suitably trained staff are available to advise these patients".[10] Unfortunately, no indication is given as to what form this advice should take in relation to Hepatitis C – a real omission, as the sort of prevention advice which drug workers are used to giving (HIV prevention advice) is clearly not 'good enough' to prevent the spread of the virus. The DoH's recommendation for Hepatitis B advice is more obvious – vaccinate those at risk.

But current injecting drug users and ex-users are not being encouraged to seek Hepatitis B vaccinations, let alone get tested for Hepatitis C. Information is still seen as the main, if not the only, response to reducing the risk of exposure to Hep C. As long as the official advice remains equivocal and public health officials continue to regard Hepatitis as a low health priority, services wishing to introduce testing will continue to face an uphill struggle persuading health commissioners of the need.

The leper state

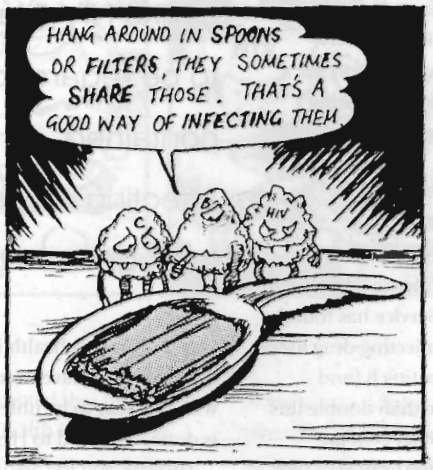
It is not just the officials who underplay Hepatitis C. The view of some health care professionals is that as there is no cure, we should not test for Hepatitis C, and it has even been suggested that without full or nearly full coverage of drug service users, there is little point in vaccinating for Hepatitis B.

A frequent justification for not testing for Hepatitis C – that without a cure it would be yet another problem for the user to contend with – is not a robust argument. Encouragement has been given to test drug users for HIV, despite the fact that HIV would be 'another problem to contend with'.

This is perhaps where the roots of the 'Hep C reticence' can be found. An important element in the earlier thinking was to "prevent the spread of HIV among and *from* drug misusers." [emphasis added][11] What has changed, is that unlike HIV, Hepatitis C has grown to be regarded by some as self-contained, as a 'junkie disease' affecting only drug users who have 'brought it on themselves'. The apparent minimal risk of sexual transmission of Hep C into the wider community has effectively shut down any consideration of wider risk.

Furthermore, Hep C is widely perceived as being an issue for the distant future rather than for today, and who isn't familiar with 'mañana, mañana'? Rather than spend a relatively small amount to vaccinate against Hep B and identify Hep C infected drug users now, the attitude is one of passing the buck, not only to another sector (from general to acute services) but also to another generation.

Another argument given for dragging our heels is that drug users are incapable of changing their behaviour – once a sloppy injector, always a sloppy injector – and so unlikely to be offered treatment in the prioritisation of resources. But, as HIV prevention has shown, drug users *can and do* change their drug use, and the earlier a health risk can be identified, the easier it is to reduce the damage. Using the junkie stereotype (where does the steroid injector fit in?) as a justification for not offering treatment does little to address drug users' health needs, just as it also does little for the medical ethic.



Ignorance is bliss

All these arguments ignore the very real opportunities that exist for

reducing the future incidence of Hepatitis C, which – given the existing high levels of infection and the anticipated growth in injecting – should be our priority. It is now time to refocus the strategy to include all blood-borne viruses with an emphasis on Hepatitis C, as this appears to be most prevalent. By attempting to reduce the transmission of this virus we should be able to maintain the low prevalence rates of the other viruses.

Matters are only made worse without testing and vaccination for Hepatitis B. As the British Medical Association recently reported:

"Hepatitis B vaccination is particularly important for those drug users with chronic Hepatitis C infection, as the combination of the two viruses considerably worsens the prognosis. *It is therefore important to encourage drug misusers at risk of bloodborne pathogens to be tested*".[12]

Testing for Hepatitis B and C must be made easily available from drug services, concentrating on service users who are either currently injecting or who have a history of injecting but who are now being prescribed methadone. This would have a number of benefits:

- The necessity for Hepatitis B vaccination could be determined.
- Advice could be given to those infected with Hep C on reducing liver damage through lifestyle change, in line with the Purchasing Guidelines.
- Advice could be given to current injectors infected with Hepatitis C about unwittingly infecting others through communal injecting, vital if the spread of the virus to new injectors is to be prevented.

Comprehensive Hepatitis C testing costs £36.70, hardly excessive, though it is £8.90 more expensive than HIV testing.[13] Targeting current injectors would be an effective use of resources – costing around a million pounds to test all known injectors[14] – especially as it is likely to identify (and begin dealing with) higher rates of Hepatitis C positivity compared to HIV.

The attitude is one of passing the buck, not only to another sector but also to another generation

There Is No Alternative

Ultimately, it is questionable whether changes in injecting behaviour alone will be sufficient to stem the Hepatitis epidemic. As long as injecting continues as a preferred route of administration, then so will opportunities exist for infection. Some have promoted 'Non-Injecting Routes Of Administration' (NIROA) as the only effective means of stemming future infection.[5] By itself, this is questionable, as it was the emergence of 'Chasing the Dragon' in the early to mid-1980s that introduced large numbers of British drug users to heroin and in turn led to increased injecting. To be successful, a NIROA strategy depends on a wide range of factors including price, purity and suitability of drugs available which, given the illicit nature of the market, will be hard to ensure over any given period.

But make no mistake – the continued focus on HIV above and beyond the other blood-borne viruses is the central issue which needs to be addressed. Targeting information and awareness of Hepatitis C as a disease which affects the majority of injecting drug users in Britain is more likely to bring about behaviour change than continuing to concentrate on HIV which is increasingly remote in the experience of most drug users.

To make this change, the existing HIV prevention budget must be broadened to enable Hepatitis prevention work to be funded. This may prove difficult in the short-term, now that the HIV budget is targeted at districts with greater HIV prevalence, a situation which may not accurately reflect existing levels of Hepatitis B and C infection. But it is vital and urgent, as a comprehensive 'blood-borne virus approach' is the only way to ensure that the health and economic costs of failing to prevent the spread of Hepatitis C are avoided. An early response – far from being merely alarmist – is the only alternative ■

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