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With all the new treatment regimens, complete elimination of hepatitis C virus in Canada is a possibility! But when will Canadians have access to these drugs?

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Finally, we will be able to achieve sustained viral response (SVR) in patients chronically infected with hepatitis C virus (HCV) using several interferon-free, all-oral, short-course antiviral regimens. This is a welcome proposition, not only for patients, but also for all of our ‘traditional’ HCV treating practitioners, namely, gastroenterologists, hepatologists, infectious disease specialists and nurses. At first glance, the direct-acting antiviral agents (DAAs), including inhibitors of NS3/4A protease, NS5A, and both nucleoside and non-nucleoside NS5B polymerase inhibitors, the long list looks daunting. The concise review by Yau and Yoshida (1) (pages 445-451) in the current issue of the Journal summarizes the interferon-free regimens available now or in the near future. There are multiple DAA combinations with potent efficacy (>95% SVR rates), pan-genotypic coverage, high resistance, minimal side effects, and concurrently demonstrating favourable features of low pill burden, short treatment duration and few drug interactions. The pharmaceutical industry will attempt to package and market these DAA combinations for HCV in the simplest possible way, similar to what they did when the different combination regimens for the treatment of Helicobacter pylori were offered (2). The optimal antiviral regimen will likely include a combination of an NS5B nucleotide polymerase inhibitor with either a second-generation NS3/4A protease inhibitor or NS5A replication complex inhibitor (1).

HCV is a major cause of liver cirrhosis and hepatocellular carcinoma worldwide. Although HCV is significantly more common than HIV/AIDS among global populations, it tends to be less well recognized. Approximately 170 million people (~3% of the world’s population) are chronically infected with HCV. By comparison, it is estimated that there are 40 million HIV carriers. In Canada, nearly 250,000 individuals are viremic with HCV (3). Over the next two decades, this cohort will require a 60% increase in total health care spending associated with these high-priced HCV medications available for treating all HCV-infected subjects. Testing high-risk populations without treating them will not help. The Canadian experience with the introduction of the first-generation DAAs boceprevir and telaprevir exposes the slow bureaucracy at both the federal and provincial levels to bring HCV treatments to patients (Figure 1). The time from submission of application for Drugs and Technologies in Health; NOC Notice of compliance; TDR Therapeutic Products Directorate
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to Health Canada’s Therapeutic Products Directorate to listing of boceprevir in provincial drug formularies took a median of 21 months (range 11 to 40 months); boceprevir is still not on the Newfoundland and Labrador drug formulary. For telaprevir, the time was a median of 21 months (range 15 to 40 months) and telaprevir is still not on the Manitoba drug formulary. In Canada, effective approaches to control costs for high-priced medications need to be developed and evaluated to ensure broad, equitable and appropriate use of these new interventions in an already stressed health care system. We hope these new HCV treatments reach those who need them most without resorting to political pressure and community mobilization.

REFERENCES

4. Favaro A, St Philip E. Hepatitis C drugs show promise, but price is too high for most patients. <www.ctvnews.ca/health/hepatitis-c-drugs-show-promise-but-price-is-too-high-for-most-patients-1.1837917> (Accessed August 14, 2014).