The Changing Landscape of Liver Care

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The Evolution of the OSU Liver Program...
From Then…

To Now… Hepatology MDs

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Hepatology Referrals

![Graph showing the number of referrals from 2007 to 2017. The graph indicates an increase in referrals from 0 in 2007 to 382 in 2014, followed by a decrease to 287 in 2016 and then an increase to 295 in 2017.](Image)
Collaborative Clinical Efforts

- Multi-disciplinary and sub-specialized clinics
  - Liver tumor clinic
  - HCV treatment
  - NASH and metabolic liver disease
  - Post-transplant care
New Tools and Treatment Options

- Hepatocellular Carcinoma (HCC):
  - TACE
  - RFA
  - Y-90
  - SBRT
- Portal hypertensive bleeding:
  - Cyanoacrylate injection of gastric varices
  - Balloon-Occluded Retrograde Transvenous Obliteration (BRTO)
- EUS-guided liver biopsies

Transient Liver Elastography (Fibroscan)

- The most efficient approach to fibrosis assessment is to combine direct biomarkers and vibration-controlled transient liver elastography
- A biopsy should be considered for any patient who has discordant results between the 2 modalities that would affect clinical decision making.
Rotational Thromboelastometry (ROTEM)

NIH Research Trials

Acute Liver Failure Study Group

Targeting Acute Liver Failure in the 21st Century
Towards the Elimination of Hepatitis C in the United States

Sammy Saab, Long Le, Satvir Saggi, Vinay Sundaram, Myron Tong

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DOI: 10.1002/hep.29685
Cited by (CrossRef): 0 articles

Current Population: Hepatitis C

- Baby Boomers (Born in 1945–1965) account for 76.5% of HCV in the US
- Almost 35% of undiagnosed baby boomers with HCV are estimated to currently have advanced fibrosis (F3-F4; bridging fibrosis to cirrhosis)


Future Population: Non-alcoholic Fatty Liver Disease (NAFLD)

Dallas Heart Study (2,200 adults)
Assessed NAFLD with liver imaging
General prevalence of fatty liver 31% (range 24% - 45%)
Most individuals (79%) with fatty liver do not exhibit aminotransferase elevations

NHANES III (15,700 adults)
Assessed NAFLD with aminotransferases
General prevalence of NAFLD 5.5%

NAFLD prevalence 5.5-31%
3-10 x more prevalent than Hepatitis C
NAFLD: Risk Factors

NAFLD Natural History

Liver-related morbidity and mortality

NAFL  NASH  Cirrhosis
**NAFLD in High-Risk Populations: Morbidly Obese Gastric Bypass Patients**

Liver disease often unsuspected pre-operatively
Intraoperative liver biopsy typically shows NAFLD

- Steatosis: 30-90%
- Steatohepatitis: 33-42%
- Fibrosis:
  - idiopathic portal fibrosis: 33%
  - advanced fibrosis: 12%
  - cirrhosis: 1-2%

**Advanced fibrosis 13-14%**

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**NAFLD in High-Risk Populations: Type 2 Diabetes Mellitus**

Prevalence of NAFLD is high
- ultrasound detects fatty liver in 50%
NASH unusually common
- NAFL: 12%
- NASH: 87%

Fibrosis or cirrhosis documented in 20%

Standardized mortality rate for death from liver disease > than that for coronary disease
Prognostic Implications of NASH + Fibrosis

More consistent and rapid progression to cirrhosis than NAFL

\[ \text{NAFL} \quad \rightarrow \quad \text{Cirrhosis} \quad > 10 \text{ years} \quad 3\% \]
\[ \text{NASH + fibrosis} \quad \rightarrow \quad \text{Cirrhosis} \quad 5-10 \text{ years} \quad 30\% \]

Matteoni et al. Gastroenterology 1999; 116:1413

Prognostic Implications of NASH + Fibrosis

- More consistent and rapid progression to cirrhosis than NAFL
- Rate of liver related mortality about 10% within 10 years
- Liver disease is a major cause of mortality

Cardiovascular disease > cancer = cirrhosis

# 1
# 2

Matteoni et al. Gastroenterology 1999; 116:1413
Major Changes in Liver Transplant

NASH Epidemic
Multiple medical comorbidities: obesity, HTN, T2DM, hyperlipidemia.

Aging Population
Median age at transplant is rising by ~1 year, every 2 years

Share 35
ACLF is increasingly common

New HCC Policies
"Healthy" HCC patients now wait longer

HCV Cure
Patients with HCV don’t need transplant

Patients with advanced liver disease are getting sicker and sicker
Acute on Chronic Liver Failure (ACLF)

- Acute decompensation (defined as worsening coagulopathy and jaundice) in a patient with chronic liver disease
- Often precipitated by infection
- Multi-organ system dysfunction
- Associated with poor prognosis

Severity and Prognosis of ACLF

- Circulatory failure
- Cerebral failure
- Renal failure
- Pulmonary failure
- Death

Severity of liver disease / Portal hypertension (MELD, Child Pugh)

HTN, CHF, CAD
Small vessel dz, beta-amyloid plaques, ETOH dementia
HTN/DM/IgA nephropathy
COPD, OSA, obesity hypovent
Co-morbidities Matter in Cirrhosis

- Diabetes increases risk of death in patients with ESLD
- Older age is associated with increased waitlist mortality
- Older age is associated with increased risk of post-transplant mortality
- CHF, COPD, and DM are predictive of mortality after liver transplant

For the Increasingly Complex Patient, We Need...

Frameworks

For dynamic, personalized decision-making for patients with multi-organ dysfunction

Tools

To provide us with information that incorporates all systems to help us prognosticate and engage in shared decision-making
“Frailty”

- From the geriatrician’s toolbox
- “A distinct biologic syndrome of decreasing physiologic reserve and increasing vulnerability to health stressors”
- “Aggregate expression of risk resulting from age- and disease-related subthreshold decrements of multiple physiologic systems”


Karnofsky Performance Status

- High
  - Predicts 3-month mortality after hospitalization (better than MELD + age alone)
  - Predicts 30-day mortality after liver transplantation

- Intermediate
  - Predicts 3-month mortality after hospitalization (better than MELD + age alone)

- Low
  - Predicts 30-day mortality after liver transplantation

Frailty Assessment

The Liver Frailty Index
liverfrailtyindex.ucsf.edu

Grip + Chair stands + Balance

LFI Predicts Mortality Better Than MELD-Na Alone

Sarcopenia

* Robust / Frailty defined as the 20% / 80%ile Liver Frailty Index values.

A Multicenter Study to Define Sarcopenia in Patients With End-Stage Liver Disease

ORIGINAL ARTICLE

CAREY ET AL.
Final Thoughts

- A framework for medical decision-making that accounts for frailty can facilitate more individualized decisions
- Tools for medical decision-making need to move beyond organ-specific assessments and incorporate the aggregate effects of multi-morbidity and aging
- “Frailty” tools such as the KPS, ADL, Liver Frailty Index, and skeletal muscle index should be incorporated into routine assessments
Acknowledgements

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- Nicole O’Bleness Gray, CNP, Division of Gastroenterology, Hepatology and Nutrition, The Ohio State University

Update on Hepatitis C

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Objectives

1. Review methods of diagnosis.
2. Describe modalities of staging fibrosis.
3. Review current therapeutic options.
4. Discuss how to choose appropriate candidates for therapy.

Disclosures Last 12 Months

- Speaker Contract: Gilead, Abbvie, DOVA
- Advisory Board: Gilead, Abbvie
Background

- RNA virus with different subtypes
  - (i.e., genotypes 1-6 (G1 most common in the US))
- Blood exposure (IVD in the US)
- Can cause an acute and/or chronic infection
- Can cause extrahepatic manifestations
  - **Hematologic:** Mixed cryoglobulinemia
  - **Renal:** Glomerulonephritis
  - **Dermatologic:**
    - Porphyria cutanea tarda
    - Leukocytoclastic vasculitis
    - Lichen planus

Natural History

- Jaundice
- Hepatic Enceph
- Variceal Bleed
- Ascites
- HCC

Worldwide Seroprevalence of Hepatitis C: ~200 million

Updated Prevalence of Hepatitis C in the U.S. Results from a Simulation Model Including the Non-NHANES Population

- In 2010, 4.0 million people were infected with HCV when accounting for non-NHANES groups.
- In 2017, 2.8 million people have chronic HCV (1.4 million in NHANES and 1.4 million in non-NHANES population).
- By 2030, 1.7 million people could remain viremic under current screening and treatment practices.
- From 2017 to 2030, the burden of HCV will shift from the NHANES to non-NHANES populations, implying a needed shift in resources in addressing these HCV populations, especially those who are incarcerated.

- In 2017, 1.8 million viremic people were unaware of their HCV status.
- By 2030, 1.1 million people would still remain unaware of their HCV.

Chhatwal et al. The Liver Meeting, 2017, #989
USA not projected to eliminate HCV by 2030 due to projected increase in new HCV infections and projected decrease in treatment rates.

In 2016, WHO called for a 90% reduction in new HCV infection by 2030. Far higher rates of treatment are required worldwide for elimination of HCV.

Need to Improve Our Screening and Linkage to Care

- Only approximately 50% of chronic HCV pts in the US have been diagnosed.
  - Approximately 9% of these patients have been successfully treated.
Need to Improve Our Screening and Linkage to Care

- Baby Boomers (Born in 1945–1965) Account for 76.5% of HCV in the US
- Almost 35% of undiagnosed baby boomers with HCV are estimated to currently have advanced fibrosis (F3-F4; bridging fibrosis to cirrhosis).


How to Screen and Diagnose?

- Hepatitis C Antibody
  - If positive, then can check for Hepatitis C RNA levels to actually DIAGNOSE.
- Hep C RNA
  - If POSITIVE, this indicates a current infection. Won’t know chronicity until have a repeat RNA level in 6 months.
    - Can obtain a genotype to help further differentiate
  - If NEGATIVE, then the patient doesn’t have an active infection (previous exposure with subsequent clearance vs a false positive)
Pretreatment Assessment

• The most efficient approach to fibrosis assessment is to combine direct biomarkers and vibration-controlled transient liver elastography.
  
• A biopsy should be considered for any patient who has discordant results between the 2 modalities that would affect clinical decision making.


HBV Reactivation Associated with HCV DAA Therapy

Query of the FDA Adverse Event Reporting System (FAERS) for cases of HBV-R associated with HCV DAAs from 11/22/2013–10/15/2016

<table>
<thead>
<tr>
<th>Descriptive Characteristics</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td># of cases/geography</td>
<td>29 cases (5 in US, 19 Japan, 5 in other)</td>
</tr>
<tr>
<td>Timing</td>
<td>Temporally related to HCV therapy and occurred within 4-8 weeks (mean time to HBV-R was 53 days)</td>
</tr>
<tr>
<td>Baseline HBV viral parameters</td>
<td>HBsAg+ (n=13) (n=12 not reported); HBcAb+ (n=6) (n=23 not reported); HBV DNA undetectable/detectable (n=16/9)</td>
</tr>
<tr>
<td>Outcome</td>
<td>Death (n=2) (due to decompensated liver failure); transplant (n=1); hospitalization (n=6); other (n=20)</td>
</tr>
<tr>
<td>Specific DAAs used</td>
<td>SOF-based (n=16); DCV+ASV (n=11); PI-based (n=2)</td>
</tr>
<tr>
<td>HBV treatment</td>
<td>In 16 patients who received HBV treatment, treatment was delayed in at least 7 of the cases (44%); one of these 7 patients died; possible delay in at least 7 other cases (one had a liver transplant)</td>
</tr>
</tbody>
</table>

• “Our data show that HBV-R is a safety concern in pts previously infected with HBV who take DAAs”
• “The benefit of high HCV cure rate with DAAs continues to outweigh the risks, even in those patients who may be at risk of HBV-R”
• “Patients with a history of HBV require careful clinical monitoring while on DAA therapy”

*Bersoff-Matcha , AASLD 2016, Poster LB-17*
Targeting the Viral Life Cycle: Direct Acting Antivirals (DAAs)


Current Treatment Options Simplified

- Treatment Naïve and IFN Experienced Patients
  - Glecaprevir+Pibrentasvir 8-16 wks
  - Sofosbuvir+Velpatasvir 12 wks
    - Sofosbuvir+Ledispavir for 8-24 wks +/- RBV (insurance driven)
    - Elbasvir+Grazoprevir 12-16 wks +/- RBV (insurance driven)
- DAA Experienced Patients
  - Sofosbuvir+Velpatasvir+Voxilaprevir 12 wks
    - (96% overall SVR12 in Polaris-1 (99% in noncirrhatics and 93% in cirrhatics))
  - Glecaprevir+Pibrentasvir
    - (i.e, Sofosbuvir+Ledispavir relapsers would get 16 wks)
  - All HCV patients prior to starting therapy need HBV screening
Sustained Virologic Response

>90%

Decompensated Cirrhotics
Co-Infected
G3
Post Transplant
Fibrosing Cholestatic C
Active Drug Users
ESRD
HCC
Elderly
Morbidly Obese

Hepatitis C Treatment

• More Common Side Effects of the Current DAAs
  • Headache
  • Fatigue
  • Nausea
  • Insomnia
• Overall very well tolerated
  • Discontinuation rates <1%
SVR Associated With a Reduction in HCC, Liver-Related Mortality, Transplantation, and All-Cause Mortality


Impact of SVR with DAAs on Mortality and HCC

ACLD, FIB-4>3.25 at DAA start

Veterans Affairs HCV Clinical Case Registry

Impact of SVR with DAAs on Mortality and HCC

All-cause mortality rates and incident HCC rates in Veterans ± advanced chronic liver disease (ACLD) in the HCV registry treated with DAAs through Sept 2016

* SVR was associated with 80% reduction in mortality and 84% reduced incidence in HCC

SVR was associated with 59% reduction in mortality

ACLD, FIB-4>3.25 at DAA start
Backus, AASLD 2017, Oral 78
Reduction in Liver Transplant Waitlist in the Era of HCV DAAs

Cohort study of 47,591 adults wait-listed for liver transplant (LT WL) using the Scientific Registry of Transplant Recipients database from 2003–2015

The rate of liver transplant wait-listing for HCV secondary to decompensated cirrhosis has decreased by 32% in the era of DAA therapy as compared to the IFN era and is now equal to that of NASH

Impact of the DAA era on short-term post-LT outcomes among HCV patients compared to non-HCV etiologies [pre-DAA era (n=3,672); DAA era (n=3,855)]

Patient and graft survival rates have improved during the DAA era and they are no longer different from non-HCV transplant patients
Current Treatment Options

• Issues still with treatment
  • Not everyone can be treated
    • Insurance/Cost
    • Fibrosis stage
  • Should we be treating active drug users or alcoholics?
  • Pediatrics/Adolescents
  • Should we be treating everyone?
    • Significant comorbidities
    • Older patients with early stage disease
  • What to do with DAA relapsers? Any options left?
  • Need more treaters