Current status of HCV therapy in Taiwan

Chen-Hua Liu

National Taiwan University Hospital

Based on the excellent safety and efficacy, direct acting antiviral agents (DAAs) have become the standard of care for the treatment of hepatitis C virus (HCV) infection. Currently, 7 DAA regimens, including daclatasvir/asunaprevir (DCV/ASV), paritaprevir /ritonavir/ombitasvir plus dasabuvir (PrOD), elbasvir/grazoprevir (EBR/GZR), sofosbuvir plus ribavirin (SOF/RBV), sofosbuvir/ledipasvir (SOF/LDV) glecaprevir/pibrentasvir (GLE/PIB), and sofosbuvir/velpatasvir (SOF/VEL) have been licensed and been reimbursed by NHI for HCV treatment. Amon the 7 regimens, GLE/PIB and SOF/VEL have pan-genotypic activity and have been recommended as the first line of therapies for HCV. The criteria for reimbursement is the presence of HCV viremia, irrespective of the fibrosis status, genotype, or other patients' demographics. Generally, the efficacy of these regimens is excellent, with an SVR rate > 95%, and most patients tolerate these regimens well. Furthermore, for patients with DAA failures, GLE/PIB can serve as the rescue therapy for HCV-1 patients receiving NS5A or NS3A DAA regimens. Despite most patients can achieve sustained virologic response (SVR) after DAA therapies, periodic patient surveillance for these patients should also be done, particularly in patients with advance hepatic fibrosis, compensated or decompensated cirrhosis for hepatocellular carcinoma (HCC) or cirrhosis-related complications, in hepatitis B virus (HBV)-coinfected patients for potential HBV reactivation, in human immunodeficiency virus (HIV)-coinfected patients, patients with intravenous drug use (PWID), incarcerated patients, patients on hemodialysis, or patients with high risk behaviors for potential reinfection. The clinical outcome would be substantially improved by applying potent DAA treatment and prudential post-SVR surveillance.