hepatitiswa
Newsletter
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LETTER FROM THE EDITOR

Welcome to the December edition of the HepatitisWA Newsletter! This issue covers a variety of articles on both hepatitis B and hepatitis C, such as 'The link between hep B and liver cancer', and 'Increasing the GP's role with hep B diagnosis and treatment', as well as an article on Bristol-Myers' plan to widen access to its hep C drug. We cover a round-up of viral hepatitis articles in our 'Going Viral' section, and feature a personal perspective from Perth-based Natásha. She shares her story about her journey through the treatment of hep C and offers some positive words for our readers. With the holiday season drawing in, we feature an article in our health and lifestyle section on fatty liver disease, with some tips on how to stay healthy, plus a delicious 11 veg shepherd's pie recipe. HepatitisWA shares our community activities in 'Hepatidings' and WASUA shares an article on equality for hep C treatment. This also ties into a media release from Hepatitis NSW. They have launched a new national campaign calling on Health Minister Peter Dutton to ensure new drugs are made available without delay to all Australians living with hepatitis C. Please take the time to visit the link at http://bit.ly/ETA2014 and sign the petition. Lastly, HepatitisWA would like to take this opportunity to wish all our clients, fellow organisations and general readers a happy and safe holiday season, wishing you all the best for 2015!

Felicia Bradley

Editor

ON THE COVER

Fatty Liver Disease Feature

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HepatitisWA (Inc).
HepatitisWA is a community based organisation which provides a range of services to the community in response to viral hepatitis, particularly hepatitis A, B and C.

Please contact us for more information, or make an appointment to call by and talk with an appropriate member of our staff.

Natásha's Story

Natásha shares her personal perspective with HepatitisWA, and speaks about her journey through the treatment of hepatitis C, and encourages others to remain positive in their outlook.

This story is shared in aid of all who wish to commence treatment, for those who support those going through treatment and for anyone who would like to know more about it. The treatment is by no means an easy journey, but definitely a journey well worth it.

Ever since I can remember I've always taken on types of employment that some would describe as "extreme", "dangerous", "high risk" – that's the way I like it... push yourself to the limits, loved the excitement and the physical workout that went with it all, not to mention the adrenalin, really making you feel "alive" – a bit of a plain Jane, no frills type of gal with a healthy party appetite.

It's July 2007 and I thought, it's time to go for the "woman's check-up" at the doc's. It had been a while and in the back of my mind I knew I had to, cause I'd had a huge party weekend in January and had had unprotected sex... totally going against my grain... I rocked up at the doc's and said I'd like to be tested for the works – test me for everything!!! Sitting in the doc's office two weeks later, thinking nothing of it, she calmly says "everything is good... oh wait... you have hepatitis C!" I said "Nooo way, let me see that screen" Yep there in red print it was..." Nup, don't believe it, it's a mistake, I'd like another test please." Sure enough the test came back positive a second time – HCV Genotype 1A, the most aggressive hepatitis virus. I was nearly 40 years old, and having unprotected sex is not how you contract HCV. I cried for days, uncontrollably, absolutely devastated, sending myself crazy trying to figure out how this came to be, how and where did I contract this virus, this disease. I'll never know, not much I could do about it, can't change it, it is what it is... at least that's what I tried to tell myself...

From then on, I let no one touch me or anywhere near me, no way did I want to infect anyone, I felt like a leppa, even with the knowledge that unless blood to blood is exchanged in some sort of fashion it still did not stop me from feeling this way... I basically became a recluse, the shame and stigma attached to this disease reigned supreme in my head...

From 2008 I turned down multiple opportunities from Dr Wendy Cheng at the Royal Perth Hospital to participate in "clinical research studies" straight out of Europe and the United States... I chickened out, even after prepping for it, liver biopsy, blood samples etc... the side effects scared the hell out me.

Three years later in 2011 I was asked if I would like to participate in the new trials just released – phase three study, 2 dose regiments of Telaprevir in combination with Peginterferon (known as Interferon) and Ribavirin. This gave me the opportunity to prepare myself and save money (to have time off work) so I could commence treatment in 2012.

Late January 2012 I commenced the combination treatment, a single self-administered injection of Interferon once a week for six months, two Ribavirin tablets twice a day for six months and three Telaprevir tablets every 8 hours (three times a day) for three months.

Written by Natásha. Image available under license at www.photodune.net. © All Rights Reserved Chokniti 2014.

> "The secret ingredient throughout the treatment is to stay and think positive!!!"

Follow up visits to the hospital and regular blood samples were taken.

Waking up the next morning after the first dose of the treatment I felt like I'd been hit with a tranquillizer, only conscious momentarily throughout the day and the next. Every Tuesday after that was then known as "D Day" – the psychological affect it had, you just knew what was ahead of you and what it was going to do to you – you just had to shape up to it. First time going to the toilet to pass was a new experience and a scary one, I definitely recommend to eat good size proportions of those good fats, all good after that. Three weeks into the treatment I was watching a movie and all of a sudden started to cry then laugh, cry again, laugh and so on and so on... I thought to myself this is not normal... so anti-depressants where prescribed to my distaste, however this helped me to complete the treatment. Two months into the treatment I made the decision to share my diagnosis and treatment with one of my very best friends – that was the best thing I could have ever done – to be understood and supported throughout was a deal clencher. I'll never forget seeing clumps of my hair on the bathroom floor around the 9 week mark. I didn't lose it all, however I did cut my hair very, very short.

Throughout the treatment other side effects I experienced was large proportions of my body had a skin rash, as well as a secondary rash that itched like crazy around the two month mark, so much so the kitchen egg flip utensil doubled as a back scratcher, showering and lathering myself in moisturiser, and anything else anti-itch and wet face clothes helped to relieve this for short durations. This faded away when the Telaprevir finished. Heavy bruising at the injection site, fevers so hot, generating sweats that poured from you and so cold could not get warm, diarrhoea, purging, extreme fatigue, weakness, short of breath, fluid retention around the knees and ankles, extreme weight gain (anti–depressants) and other effects of a lesser degree. I did recommence work after two months into the treatment and think back and say to myself "How did I ever get through that?"

Twelve months post treatment I was still feeling the effects of the treatments and it's surprising how much the body has MEMORY and seemed to go through cycles trying to remove the left over toxins from my system, going through withdrawals, and really needing rest and support through these stages as well.

On the up side, I am now cured of hepatitis C and can live a normal, happy and healthy life again. I feel fantastic and it was all worth it!!!

The secret ingredient throughout the treatment is to STAY AND THINK POSITIVE!!!

I welcome and invite anyone who would like to ask questions. I am contactable via email at cr8pathways@gmail.com.

Good luck and just GO FOR IT! You can do this!

Cheers,

Natásha

GOING VIRAL

A ROUND-UP OF ARTICLES ON VIRAL HEPATITIS

SOFOSBUVIR/ LEDIPASVIR EFFECTIVE FOR RELAPSED HEP C PATIENTS

Patients in the US with chronic hepatitis C genotype 1 infection who relapse after sofosbuvir plus ribavirin may be successfully retreated with sofosbuvir plus ledipasvir, a new study demonstrated.

During the study, investigators approached patients treated with sofosbuvir plus ribavirin for 24 weeks in the National Instiatute of Allergy and Infectious Diseases (NIAID) SPARE study who relapsed after treatment. The participants, mostly black men with an interleukin-28B non-CC genotype, were offered retreatment with sofosbuvir plus ledipasvir for 12 weeks in the ongoing, phase IIa, open-label NIAID SYNERGY study. Fourteen enrolled. The medication was a single daily tablet of 400 mg of sofosbuvir and 90 mg of ledipasvir.

All patients achieved sustained viral response to treatment (SVR12), including seven who had advanced liver disease and one with a detectable NS5B S282T mutation, according to work directed by Dr. Anu Osinusi of Gilead Sciences, manufacturer of the combination drug. Most adverse events, including loose stool, constipation, headache, myalgia, nasal congestion, and pruritic rash, were mild.

The research suggests that patients who have viral relapse after sofosbuvir/ribavirin "can be successfully retreated with sofosbuvir/ledipasvir for 12 weeks," the authors wrote. "The low incidence of adverse events, low pill burden, short treatment duration, and high efficacy demonstrated in this group and other populations make this drug combination attractive in a real-world setting."

The study was supported by NIAID, the National Institutes of Health, the National Cancer Institute, and Gilead Sciences (manufacturer of sofosbuvir/ledipasvir). Two authors are employed by Gilead; two others disclosed other company-sponsored findings during the study period.

BY KAREN BLUM

Nov 03, 2014 Family Practice News.
tinyurl.com/Sofosbuvir-ledipasvir

HBV PREVALENT IN UGANDAN PREGNANT MOTHERS AND INCREASED EARLY CHILDHOOD TRANSMISSION

PHILADELPHIA—Hepatitis B virus is highly prevalent among the population in northern Uganda, including pregnant mothers aged 20 years or younger, according to data presented at IDWeek 2014.

"Hepatitis B is highly prevalent in Uganda, with a national average of 10%, but the Northern part of Uganda has a lot higher prevalence of 20% or more," researcher Emmanuel Ochola, MBChB, MSc, of St. Mary's Hospital Lacor in Gulu, Uganda, told Healio.com/Hepatology. "In this study, we wanted to see the prevalence amongst pregnant mothers and to get a glimpse of transmission to the babies."

Forty-seven pregnant women tested positive for hepatitis B surface antigen of 397 pregnant women receiving services at antenatal clinics in the Gulu district of northern Uganda. Of those, four were positive for the hepatitis B e antigen. The HBsAg positivity rate was more prevalent in mothers aged 20 years or younger (20%) compared with mothers older than 20 years (8.7%; OR=2.54; 95% CI, 1.31-4.90).

"We found a hepatitis B prevalence of 12% among all the mothers," Ochola said. "The risk is 2.54 times higher in mothers 20 years of age or below. Of the 47 mothers, 15% were positive for Hepatitis B e antingen. We think this gives us an indication that there is quite some transmission taking place to the babies, and currently the program for vaccination starts at 6 weeks for babies, and if they are exposed [to hepatitis B before vaccination] and then we have a problem, it is too late."

HBsAg positivity was not associated with HIV status (overall 11.8% HIV infected), according to the abstract, and no differences were observed between HBsAg-positive and HBsAg-negative for liver enzymes, hemoglobin level, neutrophil or mean white blood cell count.

“We want to recommend vaccination at birth for hepatitis B for exposed babies,” Ochola said.

BY MELINDA STEVENS

Oct 29, 2014 for Healio.
tinyurl.com/Uganda-hep-b

JAMES PETERS FACES CIVIL CASE FROM PATIENTS HE INFECTED WITH HEP C

More than 50 women are taking civil action against an anaesthetist who infected them with Hepatitis C at a Melbourne clinic.

Peters was jailed in 2013 for 14 years, with a minimum term of 10 years, after admitting 55 counts of negligently causing serious injury to patients who had abortions at Croydon Day Surgery between 2008 and 2009.

The Victorian Supreme Court previously heard Peters, who has hepatitis C, was addicted to the painkiller Fentanyl and would inject the drug before using the same syringe on his patients.

More than 60 women who contracted hepatitis C were awarded a share of $13.75 million in compensation earlier this year, after winning a class action against the surgery, practice boss Dr Mark Schulberg and the Australian Health Practitioner Regulation Agency.

million in compensation earlier this year, after winning a class action against the surgery, practice boss Dr Mark Schulberg and the Australian Health Practitioner Regulation Agency.

The court heard 54 women are now seeking personal compensation from Peters personally for an undisclosed amount and a hearing has been listed for next month.

Appearing via video link from prison, Peters said he was unable to get a lawyer to contest the case and expected to represent himself.

He said he had been defending the women’s application to “retain some funds for the use of my children”.

Peters was reportedly dropped as a defendant in the original class action because he could not afford to pay.

“It looks highly unlikely you’ll be represented,” Justice Terry Forrest said to Peters.

“Absolutely true, Your Honour,” Peters replied.

Justice Forrest said it would be up to each victim involved in the case to make a statement satisfying him of her injuries. “It shouldn’t be too hard to prove, I would have thought,” he said. The court heard there were complainants of varying levels of injury but Justice Forrest said in order for the matter to proceed in a short hearing, it would be necessary for the women to consent to having their cases heard as one.

“If there is just one applicant outside the test, that will be fatal to the short form process,” Justice Forrest said.

“Dr Peters, basically what the complainants are saying is that rather than consider every individual claim, I ought to consider each of the 54 complaints as a group... and make a single award.”

“There’s an obvious practical attraction to that... but I would need to be satisfied it’s legally appropriate to take that course.”

Law firm Slater and Gordon is representing the 54 victims involved in the case.

The case has been brought under the Sentencing Act and involves funds confiscated by the Director of Public Prosecutions.

BY PETER CARLYON

Oct 30, 2014 for ABC News
tinyurl.com/james-peter

BRISTAL-MYERS PLAN TO WIDEN ACCESS TO ITS HEP C DRUG IS CRITICISED

In a bid to widen access to its hepatitis C drug, Bristol-Myers Squibb has begun talks with health authorities in numerous countries and generic drug makers, according to a brief statement posted on the drug maker's website late last week.

Bristol did not offer many specifics, other than to say it is pursuing licensing and tiered pricing, which refers to offering a drug at a different price in different countries.

The move comes as pricing over hepatitis C treatments – notably, a pair of medications sold by Gilead Sciences has helped to fuel a growing controversy over the cost of medicines. In the U.S., for instance, the Sovaldi treatment costs $1,000 a pill, or $84,000 for a 12-week regimen, while a newer treatment called Harvoni is priced at roughly $95,000. The prices have alarmed Medicaid and private insurers.

Similar concerns have been expressed elsewhere. Gilead, in fact, two months ago struck a deal with seven large generic drug makers based in India to sell lower-cost versions of its Sovaldi treatment in 91 developing countries. And Bristol-Myers, which has recently received regulatory approval in Europe to sell its Daklinza medication in combination with Sovaldi, appears to have taken a similar approach.

"We believe a coalition approach, which brings multiple stakeholders to the table to discuss the best path forward is needed to enable broad access to treatment over time," said Amadou Diarra, who is vice president for global policy and government affairs at the drug maker, in the statement. The lowest pricing tier for a licensed version of Daklinza will apply to all low-income and least-developed countries. As many as 90 countries would be included in any licensing.

The plan was quickly met with criticism. In a statement of its own, Doctors Without Borders called the licensing terms "restrictive" and lambasted the decision to pursue tiered pricing. The advocacy group argues such a policy could mean many middle-income countries with numerous hepatitis C patients are excluded from access to more affordable generic versions.

Source: Silverman, E, 2014. WSJ Pharmalot. Available at http://tinyurl.com/hep-c-drug-BMS (06 Nov 2014).

The drug maker was also chastised for deciding plans “in secret.” In its statement, the advocacy group maintains Bristol-Myers shared few details on pricing or access in advance, which is “reminiscent of industry approaches in the early years of the AIDS epidemic and unacceptable by any standard today.” Specifics on licensing and pricing structures, the group says, have been “purposefully vague.”

“Unfortunately, history seems to be repeating itself with BMS, who hasn’t learned from the company’s poor track record responding to the HIV epidemic,” says Rohit Malpani, director of policy and analysis for the group’s access to medicines campaign. He maintains that more than 70% of people who are infected with hepatitis C live in countries where a lower price version of Daklinza will not be available.

The advocacy group also pointed to a study published earlier this year in Clinical Infectious Disease that suggested the predicted manufacturing costs for the newest hepatitis C treatments are just a few hundred dollars per patient for a 12-week regimen.

A Bristol-Myers spokeswoman would not comment on the criticism or the study, but did send a note saying “our prices in developing countries will take into consideration several factors that include economic development and the burden of disease within a country, as well as the commitment of the government to holistically address hepatitis C, including treatment and care. We are currently engaged in discussions with several high disease burden developing-countries on their plans to address hepatitis C, and the role that Bristol-Myers Squibb can potentially play.”

BY ED SILVERMAN

Nov 03, 2014 for WSJ Pharmalot.
http://tinyurl.com/hep-c-drug-BMS

THE LINK BETWEEN HEPATITIS B & LIVER CANCER

About 1 in 30 people worldwide has chronic hepatitis B, the main underlying cause of liver cancer. New York liver cancer specialist Dr Steven Brower explains.

The specialist: Dr Steven Brower

The director of cancer surgery at Mount Sinai Beth Israel (New York), Dr. Steven Brower specialises in liver cancer and gastrointestinal cancers. November is Liver Cancer Awareness Month.

Who's at risk

The second most common cancer worldwide is liver cancer, with 700,000 new cases diagnosed each year — about 33,000 of which will occur in the U.S.

"Liver cancer is an abnormal growth that arises in a liver, usually one that has been damaged by other causes," says Brower. "Hepatitis is the single most common underlying cause of liver cancer — up to 80% of all liver cancer worldwide is due to hepatitis B alone."

Millions in the metro New York area are at risk, especially Asian-Americans and Pacific Islanders, who come from two regions where the disease is endemic.

It's impossible to live without a functioning liver. "Its main function is to produce important proteins and compounds that help us with digestion, blood clotting and blood detoxification," says Brower. "Liver cancer usually grows over the course of time when the liver is subject to persistent inflammation. It's as a result of that inflammation."

Because hepatitis is the underlying cause for the majority of liver cancers, being at risk of hepatitis B puts you at risk of liver cancer — and 1 in 30 people around the world currently has chronic hepatitis B.

"The disease is endemic in certain areas, especially Asia and Africa, but also parts of South America, the Middle East and Eastern Europe," says Brower. "Anyone who has resided in these regions or who has lived with family from there should be screened for hepatitis B." Hepatitis C and all forms of cirrhosis are also risk factors for liver cancer.

Article first published on the Daily News as 'Daily Checkup: The link between hepatitis B and liver cancer' on 02/11/2014.
Available at http://tinyurl.com/hep-b-and-liver-cancer (06 Nov 2014).

Hepatitis B is a blood-borne disease, so you need to have been exposed to the virus to contract it. “Exposure to the virus can also happen through needle injections, tattoos and unprotected sex,” says Brower. “Hepatitis B is a vaccine-preventable disease, so adults should talk to their doctor about getting vaccinated.”

> *“Lifelong hepatitis B is indolent, usually causing no symptoms until it leads to liver cancer or liver cirrhosis.”*

Signs and symptoms

One of the reasons that screening for hepatitis B is so crucial is that it tends to move by stealth. “Lifelong hepatitis B is indolent, usually causing no symptoms until it leads to liver cancer or liver cirrhosis,” says Brower. “It’s a silent killer.”

Liver cancer also tends to fly below the radar. “The early stages have no signs and symptoms, and we want to catch it in the early stages, when we have the best chance of curing it,” says Brower. “In the advanced stages, liver cancer causes problems related to the malfunctioning liver itself: fatigue, weight loss, jaundice and sometimes a palpable mass in the abdomen.”

Traditional treatment

Identifying and screening high-risk populations is key to catching liver cancer early — and in some cases, it’s possible to prevent the cancer entirely.

“Everyone with hepatitis B should be screened, treated and under surveillance for liver cancer,” says Brower. “If someone is treated for hepatitis B, that decreases the risk that it will develop into cancer. However, we can’t remove the virus completely, which is why you need lifelong surveillance.” Hepatitis C only leads to liver cancer if it has caused cirrhosis first.

Early detection of liver cancer gives patients the best treatment options. “The most important treatment option is surgery, which can either remove the tumor or perform a liver transplant,” says Brower. “If the tumor is more advanced, we can give treatment directly into the liver in the form of chemotherapy or radiation. And we have every hope that this disease will become even more treatable in coming years.”

Research breakthroughs

Identifying and screening high-risk populations is key to catching liver cancer early — and in some cases, it’s possible to prevent the cancer entirely.

Questions for your doctor

If you think you might be at risk of hepatitis, don’t be shy about asking, “Should I be tested for hepatitis B and C?” If you were in school before the hepatitis B vaccine become available and mandatory, then ask, “Should I be vaccinated for hepatitis B?” And if you are diagnosed with hepatitis B, then ask, “What kind of doctor should be overseeing my care?”

“The thing to bear in mind is that although liver tumors may not be as common as breast cancer, for some populations the risk factors are very prevalent,” says Brower. “Being screened for hepatitis is one of the best things you can do to protect your health — and possibly prevent yourself from developing liver cancer down the line.”

What you can do

Get informed. Ask your GP or contact HepatitisWA on (08) 9328 8538 (Metro) or 1800 800 070 (Country).

Get screened. If you’re at risk of liver cancer and under surveillance, the diagnostic tests are extremely good at detecting small tumors, which are the most treatable.

Get vaccinated. The single most important preventive step you can take is to get vaccinated for hepatitis B.

BY KATIE CHARLES

Nov 02, 2014 for the Daily News.
tinyurl.com/hep-b-and-liver-cancer

INCREASING THE GP'S ROLE

Hepatitis B is a viral infection that affects some 225,000 Australians, with up to half of the cases remaining undiagnosed.[1]

'About 1% of the Australian population are living with chronic hepatitis B and there has been quite a demographic shift, particularly in the last 30 years,'

Associate Professor Benjamin Cowie, epidemiologist at the World Health Organization Regional Reference Laboratory for Hepatitis B, Victorian Infectious Diseases Reference Laboratory and a physician with the Victorian Infectious Diseases Service at the Royal Melbourne Hospital, told *Good Practice*.

'There are priority populations within that, particularly Australian born overseas in endemic areas, like the Asia-Pacific region and Sub-Saharan Africa, where hepatitis B is prevalent. They make up more than half the people with hepatitis B in Australia.'

PRIMARY TREATMENT

Last year's National Notifiable Diseases Surveillance System shows that around 7000 Australians are being diagnosed with hepatitis B every year[2] and relatively few are receiving adequate treatment.

The Department of Health's Second National Hepatitis B Strategy 2014-2017, released in July this year, included targets to increase childhood and priority population vaccination, diagnosis of those who are living with chronic hepatitis B to 80% and the uptake of antiviral treatments to 15%.[3]

'We are only treating 5% of people [with hepatitis B] and the result is that, without clinical management of chronic hepatitis B, one in four people will die as a result of the infection,' Hepatitis Australia CEO Helen Tyrrell told *Good Practice*.

As GPs continue to treat and manage a wide range of healthcare issues, many are calling for the diagnosis and treatment of hepatitis B to be included in general practice.

'My belief is that one of the major tasks that GPs can do is not just carry out screening of hep B patients, but also start treating those we find to have hep B,' Sydney GP Dr Christopher An told *Good Practice*.

'The liver clinic, hospitals and specialists are [potentially] a bit of a distance away so the patient won't seek their help as the first point of contact.

'As GPs, we are the main point of contact and will continue to be in the future, especially if patients come back for scripts.'

> "If hepatitis B treatment does not triple, we will continue to see liver cancer being the fastest increasing cause of cancer deaths in Australia."

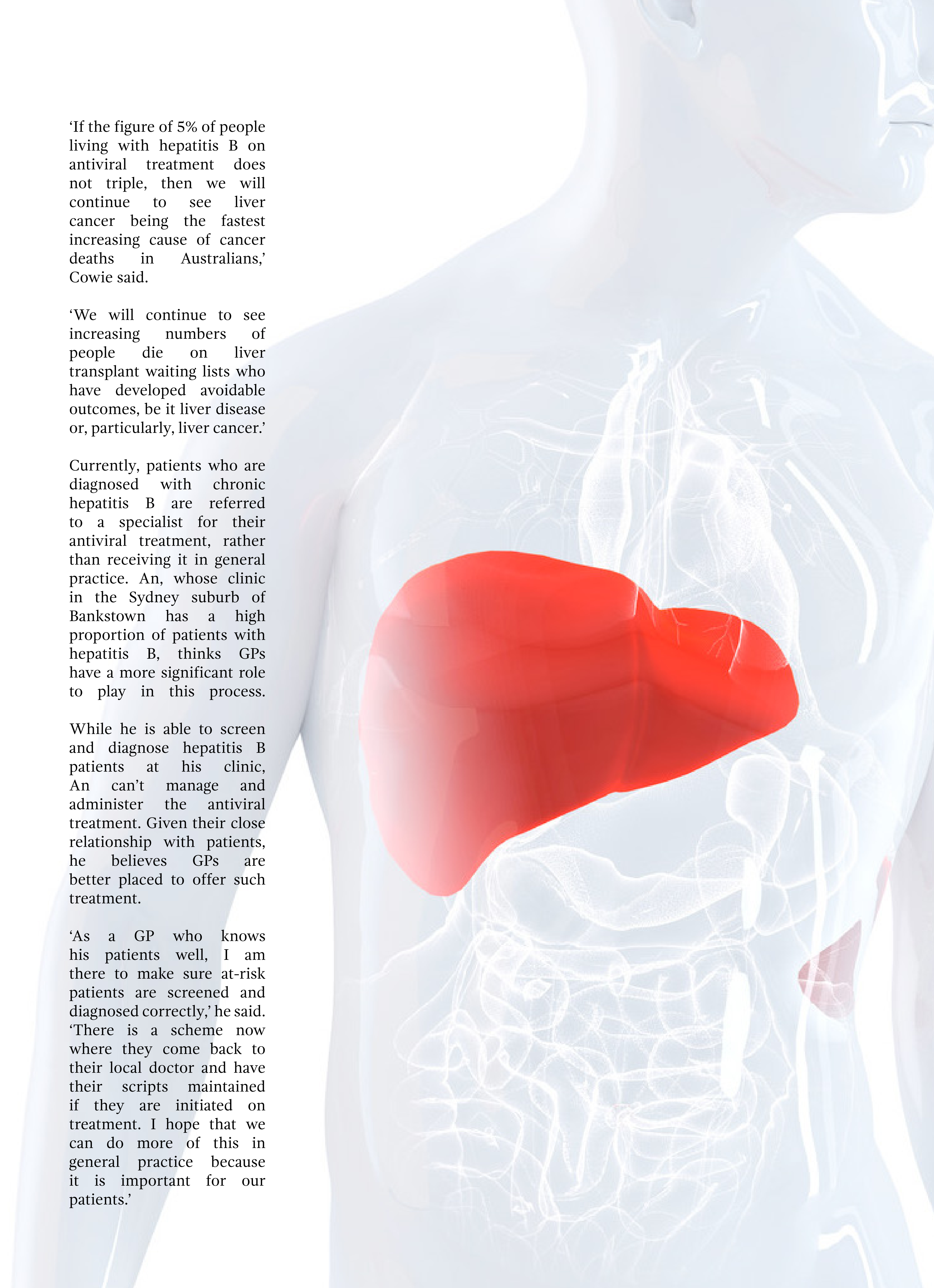
Tyrell believes that if hepatitis B patients are to be treated in primary care, GPs must not only target those who are at risk, but also make sure patients understand their treatment needs to continue over a longer term.

'There is the concept that you go to the doctor's only when you are sick, the doctor then gives you something and then you go away and get better,' she said. 'That is not how it works with chronic hepatitis B because you may feel no symptoms, but you need really regular monitoring to make sure that you can have treatment when you have a very high viral load.'

> "There are continued calls for hepatitis B to be diagnosed and managed by GPs at the primary healthcare level."

The large number of untreated hepatitis B cases in Australia is a major factor in rising rates of serious liver disease, including liver cirrhosis, liver failure and liver cancer, the latter of which is the most rapidly increasing cause of cancer death in the country.[4]

Hepatitis Australia CEO Helen Tyrell advises treating hepatitis B requires long-term care.



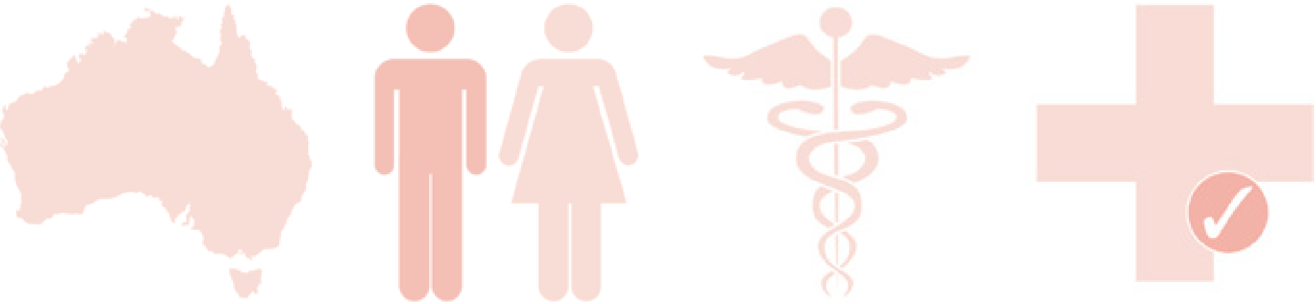
‘If the figure of 5% of people living with hepatitis B on antiviral treatment does not triple, then we will continue to see liver cancer being the fastest increasing cause of cancer deaths in Australians,’ Cowie said.

‘We will continue to see increasing numbers of people die on liver transplant waiting lists who have developed avoidable outcomes, be it liver disease or, particularly, liver cancer.’

Currently, patients who are diagnosed with chronic hepatitis B are referred to a specialist for their antiviral treatment, rather than receiving it in general practice. An, whose clinic in the Sydney suburb of Bankstown has a high proportion of patients with hepatitis B, thinks GPs have a more significant role to play in this process.

While he is able to screen and diagnose hepatitis B patients at his clinic, An can’t manage and administer the antiviral treatment. Given their close relationship with patients, he believes GPs are better placed to offer such treatment.

‘As a GP who knows his patients well, I am there to make sure at-risk patients are screened and diagnosed correctly,’ he said. ‘There is a scheme now where they come back to their local doctor and have their scripts maintained if they are initiated on treatment. I hope that we can do more of this in general practice because it is important for our patients.’



225,000
Australians are living with hepatitis B[1]

1 in 2
people with hepatitis B is undiagnosed[1]

25%
would benefit from treatment[5]

5%
are receiving treatment[6]

PATIENT DEMOGRAPHICS

Hepatitis B vaccination rates are mostly high among people born in Australia, but they remain low for many born overseas, particularly in Africa and the Asia-Pacific region.

Cowie believes the Australian healthcare community needs to look at these types of overseas locations in order to help stem the tide of hepatitis B and its associated illnesses.

'If we vaccinated every single person in [Australia] in the next six months we would prevent less than 5% of liver cancer over at least 50 years,' he said. 'What we are seeing is the consequences of infections which have occurred overseas.'

For Melbourne GP Dr Nicole Allard, who is completing her PhD research in hepatitis B, using foreign aid to target countries where hepatitis B is endemic may be a key to reducing its prevalence in Australia.

Benjamin Cowie wants to see Australia's current hepatitis B treatment rates triple.

'In 20–30 years' time, what is going to fix the number of new cases of hepatitis B won't be our own domestic vaccination program. It will be vaccination in other countries,' she told *Good Practice*.

'Our government continuing to support vaccination in other countries is also an important public health intervention for our own country because, if you look at it, people coming in from South-East Asian countries will already have a good vaccination program in their own country.'

For GPs like An, knowing your patient demographic and being able to determine those who are at risk of hepatitis B infection is crucial in a practice like his.

'If you look at the statistics, a lot of the hep B patients are from African and Asian backgrounds,' An said. 'We have a very big Chinese and Vietnamese population here in Bankstown and I have a duty to my patients to be knowledgeable and upskilled in this area.'

Part of Cowie's research into the demographics and prevalence of hepatitis B in Victoria has identified many of those affected live within particular geographic areas.

'We have found that three or four of the Medicare Locals here in Victoria, and particularly here in Melbourne, represent more than half the people living with hepatitis B in this state,' he explained. 'If you can actually engage with GPs serving large numbers of people living with hepatitis B in that local area you can have very efficient delivery of this sort of health program and education and support.'

Article reprinted and published with permission by Good Practice – The Royal Australian College of General Practitioners.
Available at www.racgp.org.au/publications/goodpractice (08 Sept 2014)

Allard believes as the waiting lists for liver specialists increase, some patients could be better managed in general practice.

'As GPs, we really need to be looking at the arrangement of appropriate referral and my strong belief is that not everyone should be managed in a specialist setting,' she said. 'General practice has to share that burden and eventually that would involve prescribing antivirals.

'[The majority] of HIV drugs are prescribed by GPs in the community and we know that it is a model that can be transferred and that you can have successful GP initiation and GP maintenance prescription of complex drugs.'

ACCESSIBLE RESOURCES

Despite the large number of deaths attributed to hepatitis B, many believe there continues to be a lack of knowledge and understanding of the disease, as well as limited resources, among those affected.

'A lot of my patients are from Vietnamese and Chinese backgrounds and the resources for hepatitis B are a little bit scarce in this language group,' An said. 'They have trouble accessing resources and, therefore, their understanding of the overall cause, diagnosis, screening and treatment is sub-optimal.'

One of the latest hepatitis B resources to hit the Australian market is PATH B, a product from pharmaceutical company Bristol-Myers Squibb that is endorsed by Hepatitis Australia.

PATH B consists of a 'roadmap' that is designed to offer information and help guide people experiencing hepatitis B through each step of managing their illness.

'It was first developed in Europe with a whole range of experts and advocacy groups,' Tyrrell said. 'I was very interested when [Bristol-Myers Squibb] indicated that they wanted to adapt the resource for the Australian environment and also translate it into Chinese and Vietnamese, which was terrific because we have very few resources that are suitable for that population.'

An commends the efforts to bring the resource to Australia and also highlights the multilingual aspect for those most at risk.

'There are a couple of advantages for this resource, but the biggest one is that it is presented in three languages: Vietnamese, Chinese and English,' An said. 'Pretty much everyone who is at high-risk and those who are from countries where it is really an epidemic can access it, regardless of language barriers.'

Providing GPs with adequate and up-to-date hepatitis B resources is another action that is urgently required, according to Cowie, especially for those practising in areas with at-risk populations.

'We need resources to not just equip patients who are at risk. We need to look at resources to support GPs so that when we move the management of hepatitis B to the general practice level, they would know what to do,' Cowie explained. 'If we can equip and have a few more of those GPs in the higher-prevalence areas, then people will have better access to care, less expensive care, and have a chance of actually getting onto treatment.'

Christopher An wants to see GPs do more to treat people with chronic hepatitis B.

References

1. WHO Regional Reference Laboratory for Hepatitis B, Victorian Infectious Diseases Reference Laboratory, Melbourne, Victoria, June 2014.
2. National Notifiable Diseases Surveillance System. Canberra: Department of Health, Australian Government; 2013.
3. Department of Health. Second National Hepatitis B Strategy 2014 – 2017. Canberra: Department of Health; 2014. Available at www.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-hepb [Accessed July 2014].
4. Australian Institute of Health and Welfare. Cancer survival and prevalence in Australia: period estimates from 1982 to 2010. Canberra: AIHW, 2012. (AIHW Cat. No. CAN 65.) 5. Cohen C, et al. Is chronic hepatitis B being undertreated in the United States? Journal of Viral Hepatitis 2011; 18:377–83.
6. Allard N, MacLachlan JH, Cowie BC. A National Health System Response to Chronic Hepatitis B: Using population data to define gaps in clinical care provision. Journal of Hepatology 2014; 60 (1) : S295 – S296.

For the original article, visit www.racgp.org.au/publications/goodpractice

An Introduction to Fatty liver disease

So what is fatty liver disease?

Fatty liver disease (FLD), as the name suggests, is a condition in which fat cells develop inside the liver. Inside a fatty liver, normal healthy liver tissue is partially replaced with unhealthy fats. This fat can fill the liver cells and the spaces between the liver cells, resulting in the liver becoming larger and heavier. Often the liver has a yellow and greasy appearance.

This is a rather common condition in Australia, especially for people living with hepatitis C (HCV). Currently 1 in 10 Australians are estimated to be living with FLD. This number has been found to be significantly higher for people living with HCV (from 40% to 80%).

How serious is fatty liver disease?

Although it is not desirable to have fat build up around the liver, it is not necessarily a serious condition. In many cases FLD will not cause a person any problems. However in some rare cases it can be very damaging to a person's health. If the fatty build up reaches excessive levels, and remains in the liver for a long period of time, it can cause the liver to become inflamed. This inflammation can impair the liver cells ability to perform their many important jobs, and can lead to scarring (cirrhosis). Cirrhosis results in the liver cells being unable to function as normal and can lead to irreversible damage and even liver failure.

Are there any symptoms of fatty liver disease?

FLD usually causes no signs and symptoms. Most cases of FLD are usually diagnosed incidentally through abnormally high results from a simple liver function test (and usually only after other causes of liver damage are ruled out). Although there maybe some symptoms, they will only present after a person has had fatty liver disease for some time, and after it has already caused some damage to the liver. The most common symptoms are pain or tightness under the right side of the rib cage (due to the liver becoming enlarged), fatigue, and malaise (a general feeling of being unwell).

What are the main causes of fatty liver disease?

Fat can enter the liver due to a number of factors. Often it results from a number of factors occurring simultaneously. It can be the result of metabolic conditions, such as insulin resistance, type II diabetes, or hyperlipidemia (raised blood fat levels). However the more common factors include;

Being overweight or obese – Being overweight or obese had been found to be significantly correlated with higher levels of triglycerides (the chemical form in which fats exist in our bodies) in the liver. One of the important roles of the liver is to process and release triglycerides as the body requires them. However, when there is an excessive amount of triglycerides in the liver, the chemical reactions required to process them slow down, and this results in a buildup of fat in and around the livers cells.

Excessive alcohol consumption – If alcohol is consumed at levels beyond the recommended guidelines (no more than 2 standard drinks a day) for long periods of time, it is likely that more fat will deposit on the liver. Unfortunately, the alcohol molecule itself (which is converted by the liver into acetaldehyde and then into fat) and the high levels of sugar in most alcoholic drinks (which is converted by the liver into glycogen and then into fat) both influence the levels of triglycerides in the liver. Just like with being overweight, if these levels get too high it can lead to fat building up in and around liver cells. It is also worth remembering that the process of breaking down and converting alcohol actually damages the liver, and can also lead to scarring over time.

Hepatitis C – Having HCV has been shown to independently increase the risk of someone having a fatty liver. This is particularly the case for people living with Genotype 3. Although the exact way in which the virus causes fatty liver is largely unknown, there are some interesting comparisons between fatty liver levels of people with and without HCV. For instance, fatty liver levels are estimated to be 10% to 15% for the general population, and as high as 40% to 50% for people living with HCV. Approximately 60% to 80% of people living with genotype 3 have

Article written by Matt Armstrong. References: www.ncbi.nlm.nih.gov/pmc/articles/PMC1856395, www.ncbi.nlm.nih.gov/pmc/articles/PMC1415843, www.ncbi.nlm.nih.gov/pubmed/15605308, www.liverfoundation.org.au/display/index/liver-diseases-NAFLD, www.loveyourliver.com.au/loving-your-liver/alcohol, www.hepctrust.org.uk/Hepatitis_C_Info/The+Liver/Steatosis+(fatty+liver) (14 Nov 2014)

moderate to severe fatty liver. Interestingly, biopsy samples of people with HCV have shown that the fat tends to be located in a different part of the liver than usual (the portal lobule), indicating that it is the virus itself that is causing the fat deposits as opposed to other factors.

How can we minimise the impact of fatty liver disease?

At this time there is no medication that can be used to treat FLD. Fortunately, in most cases a fatty liver can be reversed through weight loss and a healthy diet and lifestyle. Some simple steps to reduce fatty liver include;

- Eat a diet containing lots of healthy fresh produce such as seasonal vegetables, fruits, nuts, seeds, and meat.

- Limit the amount of unhealthy fats in your diet, such as trans fats and saturated fats. A common source of these include fried or heavily processed foods. However, it is important to include some fats in a balanced diet. Try to ensure they are the healthy fats, such as the fats that come from sources like nuts, avocados, or quality oils (such as olive oil).

- Drink plenty of water

- Try to minimize the amount of sugar consumed each day. It is widely known that sugar is found in things like soft drinks, confectionary, and deserts. However, sugar can also come from a variety of unexpected sources. Things such as condiments (like sauces and marinades), fruits juices, cereals, bread and grain products, flavoured yoghurts, or even 'healthy' snacks such as store bought muesli bars which can be loaded with hidden sugar.

- Exercise is a great way to lose weight and stay healthy. It is recommended that people start out slow and gradually increase the amount of exercise up to moderate levels. Walking, swimming, and cycling are some fun and easy exercises to start with. Always consult with your doctor or nurse before undertaking any new exercise regimes.

- Stop drinking alcohol or drink in moderation. Some great tips to help reduce alcohol intake include:

  - Switch to low-alcohol or alternate an alcohol drink with an alcoholic-free one.

  - Mix your favourite wine with plain mineral water.

  - Mix beer or stout with lemonade.

  - Avoid situations where there is peer pressure to drink in rounds.

If you're having difficult cutting back, talk to your doctor about getting professional help or speak to HepatitisWA's Support Officer on (08) 9328 8538 about the latest treatment for hepatitis C. With early successful treatment, fatty liver and other forms of liver damage can be completely reversed.

BY MATT ARMSTRONG

11 VEG SHEPHERD'S PIE

INGREDIENTS

1 Sweet potato (350g) (peeled, chopped)
1 cup Pumpkin (peeled, chopped)
2 tablespoons olive oil
1 Medium Onion (finely chopped)
1 tablespoon mild curry powder (can use gluten-free if required)
1 teaspoon tumeric
1 bay leaf
500 gram lamb or pork mince
1 cup green beans (chopped)
1 cup frozen peas and corn
1 carrot (diced)
1 cup broccoli (cut into florets)
1/2 zucchini (diced)
1 cup cauliflower (diced)
810 gram tin of chopped tomatoes
400 gram tin of lentils (rinsed, drained)

INSTRUCTIONS

1. Preheat oven to 180°C. Steam sweet potato and pumpkin until soft (about 10–15 minutes). Transfer to a bowl, add 1 tablespoon oil, then mash. Set aside and keep warm.

2. Add remaining oil to a large saucepan placed over medium-high heat. Add onion, curry powder and turmeric. Cook for 3–4 minutes, until soft. Add bay leaf and mince; cook until just browned.

3. Add beans, peas, corn, carrot, broccoli, zucchini and cauliflower. Lightly sauté for 5 minutes. Add tinned tomatoes and bring to a simmer. Stir through lentils and simmer until warmed through.

4. Transfer mixture to a large casserole dish and top with mash. Bake for 30–40 minutes.

NOTES

- Place pie under the grill for the last 5 minutes of cooking to make the mash crispy on top.
- Be sure to check your dried herbs and curry powder to make sure they are gluten-free. You can find gluten-free varieties in your supermarket.

ALLERGY ADVICE

- This recipe is dairy free and gluten free.

NUTRITIONAL INFO*

** Per serve*

Energy: 1408kJ
Calories: 337cal
Protein: 24.7g
Fat: 13.0g
- **saturated:** 3.1g
Carbohydrates: 26.4g
- **sugars:** 11.2g
Dietary fibre: 8.0g
Sodium: 275mg
Calcium: 100mg
Iron: 5.1mg

Recipe reproduced from Healthy Food Guide. For more recipes visit www.healthyfoodguide.com.au

CALL FOR EQUAL TREATMENT ACCESS TO NEW HEPATITIS C DRUGS

MEDIA RELEASE – MONDAY 17 NOVEMBER 2014

A new national campaign was launched today, calling on Health Minister Peter Dutton to ensure new drugs are made available without delay to all Australians living with hepatitis C.

A wave of new treatments, which can cure up to 90-95% of people in just 12 weeks, and in many cases without the need for interferon injections, has already been approved in the US, Canada, UK, Europe and elsewhere.

But, with the Pharmaceutical Benefits Advisory Committee (PBAC) rejecting the first key drug, sofosbuvir, at its July 2014 meeting, it is unclear when this wave will reach Australian shores.

"The health of Australians living with chronic hepatitis C is being put at risk because they cannot access drugs which are already being widely prescribed overseas," said Hepatitis NSW CEO, Mr Stuart Loveday.

Five of these Australians whose health is being put at risk – Phillipa, Len, Opi, Glenn and Jane – appear in a new video released as part of this campaign.

In the video, they discuss what life is like with hepatitis C, their experiences with existing treatments, and their hopes at a chance of cure – hopes that are dependent on the Australian Government listing the new drugs on the Pharmaceutical Benefits Scheme (PBS).

Len Minty, 71, has been living with hepatitis C for 31 years, and, like many people with long-term viral hepatitis, has developed cirrhosis.

"I've lived with this virus for three decades. I've tried everything possible to treat it, including 14 years of injections with interferon, but it's still there," Mr Minty said.

"All I want is the opportunity to get rid of my hepatitis C, and these new drugs are my best chance of doing that. Why is the Australian Government denying me that opportunity?" Mr Minty added.

Phillipa, Len, Opi, Glenn and Jane are just five out of an estimated 230,000 people living with chronic hepatitis C.

80,000 Australians are already living with moderate to severe liver disease caused by their hepatitis C, and 630 people died of hepatitis C-related causes in 2013 alone.

"It is exciting that scientists have developed drugs that, in short timeframes and with few side-effects, can cure a potentially lethal virus in more than 9-in-10 people," Mr Loveday said.

"But it is incredibly frustrating that Australians living with chronic hepatitis C are being made to wait, and at this stage there is no end in sight."

"People like Len, and thousands of other Australians living with hepatitis C should be able to access these new treatments now, rather than potentially waiting years before getting the chance to have their hepatitis C cured," Mr Loveday said.

"It makes no sense to delay, or restrict access to, these new treatments – why should we expect people to have to get sick before they can have their hepatitis C treated?"

"That's why we are asking for members of the community to watch the Equal Treatment Access video, and sign the petition calling on Minister Dutton to take urgent action to ensure sofosbuvir, and other new drugs, are listed on the PBS as a matter of priority," Mr Loveday said.

To view the **#EqualTreatmentAccess** video, click here: **http://bit.ly/ETA2014**

For further information please contact Alastair Lawrie at Hepatitis NSW on 0411 203 440 or Stuart Loveday on 0410 488 144.

ENDS#

HEPAtidings

hepatitiswa Community Activities

A SNAPSHOT OF HEPATITISWA EVENTS

Hepatidings Contributors: Brenna, Amineh, Amanda and Nadia. | **Photographs by:** Amanda

From everybody at HepatitisWA, we would like to wish you a Merry Xmas and a Happy New Year!!!

HEALTH PROMOTIONS

During the past three months I have been kept very busy. I continue to provide educational sessions in various Alcohol and Drug services to people who are either living with hepatitis C or at risk of contracting the virus. These sessions are always well received and provide participants with the opportunity to gain knowledge around transmission and prevention of hep C, along with helping to breakdown a myriad of myths that continue to circulate about hep C. This is also an opportunity to let people know about current treatments and HepatitisWA's services.

I was also invited by the WA AIDS Council (WAAC) Youth Officer to provide information and resources on hep C and the risk of hep C through body art for the educational presentations that WAAC provides to approximately 7000 school leavers.

One of the biggest risks of transmission of hep C for young people is tattooing, in particular having backyard tattoos or travelling overseas and getting tattoos, so I am currently developing a youth friendly resource that will be focus tested by young people and youth services before being produced. Through our 'Play The Blood Rule' project our agency was invited to attend a couple of evening basketball events put on by the Police and Citizens Youth Club. We had a stall and did airbrush tattoos which provided us with the opportunity to interact with the young people in a fun and non-threating way on the risks of hepatitis C transmission.
- Brenna

SUPPORT SERVICES

The numbers of people accessing this service continues to increase. This is potentially due to the increase in the profile of hepatitis C within the community and media around availability of the new hepatitis C treatments. People are very keen to access Interferon-free based treatments and want to know when these new treatments are going to be available and what side-effects they will have. Unfortunately, we have no idea how long until they will be available and so most of the support I provide is talking to people about other options such as either waiting (if their hepatitis C is not too bad) for the new treatments, which could be a number of years away or what their options are with the current treatments available.

The Support Group continues to attract new members and the feedback from the group members is that they find the opportunity to discuss with peers the issues of living with hepatitis C very beneficial. A number of group members have commenced treatment and so they are finding the support from the other group members during this time to be very helpful. It is also an opportunity for those people who are contemplating treatments to discuss side-effects and coping skills.

I had the opportunity to attend the 1st World Indigenous Peoples' Conference on Viral Hepatitis and the 9th Australasian Viral Hepatitis Conference held concurrently in Alice Springs in September. I was able to connect with a number of national and international participants from varying services and organisations. The conference was very interesting and there was so much information on hepatitis B & C relating to epidemiology, virology, biology along with social and clinical research. It was also an opportunity for me to speak to people about HepatitisWA and what our agency is doing.
- Amineh

HEP B COMMUNITY ENGAGEMENT

"Liver Healthy Life" is a new hands on practical workshop that has been developed to provide hepatitis B information and promote liver health. The workshop is targeted towards Culturally and Linguistically Diverse (CaLD) communities and we have been lucky enough to have had a number of CaLD community groups already participate. The workshops are loads of fun with educational information on hepatitis B being given, along with practical information around promoting healthy juicing and raw salad making. The workshop participants really enjoy the opportunity to see how to make this healthy liver food (and taste), and to learn about hepatitis B. A number of the groups have provided interpreters (along with our own Support Officer who is able to speak a number of languages) to ensure that the participants don't miss out on what is being said.

Our evaluations thus far of this project has identified that participants are going away a lot more knowledgeable on transmission, testing and vaccinations of hepatitis B, and feel more confident in knowing what is healthy for their liver. Feedback has also been given that the participants really enjoy this format of learning. These workshops have also provided the opportunity to break down many myths that exist around hepatitis B.

If any CaLD community groups would like to find out more about this project please give me a ring at HepatitisWA on (08) 9227 9802.
- Amanda

Photo: Taken with permission at a "Liver Healthy Life" workshop.

NSP & VOLUNTEER PROGRAM

The NSP and Volunteer program has been full steam ahead during the last few months. We've enjoyed seeing new, enthusiastic faces in the office following our volunteer recruitment in August. These new recruits have experienced some mentoring from our long term volunteers which is has been great to see. The NSP has been busy with an increase in clients coming through the door to access sterile injecting equipment, utilise our clinical service, and to get information and referral from our NSP staff.

There have been a couple of exciting events that we've been involved in including 'Overdose Awareness Day' which fell on the 31st of August. HepatitisWA, WA Substance Users Association (WASUA) along with the Drug and Alcohol office held a BBQ in Hyde Park, (near the overdose memorial tree) on Monday the 1st of September. We had a great turn out, with over 100 clients and community members passing through for a hot dog and a chat on the grass. The aim of the event was to create awareness about drug overdose, both illicit and prescription, and to promote the Overdose Prevention And Management program (OPAM).

We also participated in 'Homeless Connect' on Wednesday the 12th of November in Russell Square Park. This was a huge event, with over 70 service providers offering their wares and services, free to community members who are currently homeless, or risk of homelessness. Three of our TAFE practicum students assisted at this event, offering information on hepatitis C prevention, testing and treatment, and HepatitisWA services. We also gave out free 'toiletry bags' containing a few personal hygiene items, along with the health message that sharing these items pose a risk of BBV transmission such as hepatitis C. There was a great turn out, with over 200 community members attending the event. Thank you to all the volunteers that assisted. It was a fantastic effort with great feedback received.
- Nadia ■

EQUAL TREATMENT

Whilst we are seeing significant progress in terms of treatment options for people with hep C, it does not appear we are seeing the same advancement with regard to knowledge and awareness, as well as attitude towards people living with hep C, with stigma, discrimination and fear still being a predominant reaction and response.

Both reports from consumers and research evidence suggest it is the people who are supposed to help us, treat us and be the most knowledgeable about hep C and other BBV's, that are in fact the group identified as demonstrating negative attitudes reflecting stigma and discrimination, namely the health/medical profession. Whilst there are a number of exceptional, non-judgemental practitioners working within the BBV and sexual health sector, there is still mind-sets reflecting the deserving and non-deserving in terms of access to treatment, often questioning the 'reliability' of consumers to complete treatment, that continue to inject drugs and those on pharmacotherapy programs. Whilst it is acknowledged that treatment is expensive and requires commitment, surely people, all people, should have the opportunity to demonstrate their ability to commit to treatment before being discarded as unsuitable, particularly if peer support is available to consumers who are having difficulties (anecdotal evidence suggests peer support improves treatment outcomes, including completion of treatment). It is difficult to attend an appointment if you believe the staff have already judged you and you may be feeling 'unworthy', particularly when you don't feel great already for a number of reasons, including possible depression associated with undergoing hep C treatment.

Fortunately, these attitudes are changing with current injecting drug use no longer being an exclusion criteria for hep C treatment. WASUA is working with a number of providers in an attempt to develop positive working relationships and referral pathways for our consumers. All key stakeholders (consumer, service providers, family members etc.) are welcome to contact WASUA for peer support, whether that be for further information, education, support (face-to-face or phone), assistance with appointments and other support as requested and required. Completing hep C treatment is not easy for anyone, particularly given the side effects from the drugs, as well as feelings of depression, isolation, stigma & discrimination. Unfortunately, too many consumers have not completed treatment for these very reasons, including lack of appropriate support and understanding. WASUA are committed to assisting & supporting consumers to get through these difficult times, so please do not hesitate to contact us.

As with general population trends those with hep C are an ageing population. Hep C is a progressive virus with people that contracted hep C 20-30 years ago, now potentially facing the possibility of various stages of liver disease. It is alarming to see the number of consumers attending WASUA that fall into this group with limited intention of seeking treatment for a variety of reasons including lack of support, stigmatized attitudes, lack of information and education sometimes with the fear of potential side effects from drugs like Interferon. WASUA is looking forward to the time when interferon is no longer required and/or part of a hep C treatment regime. Thankfully, treatment is now rapidly advancing in terms of shorter duration, reduction in side effects and increased rates of people clearing the virus. The discontinuing of Interferon in the future adds to a bright treatment horizon with increased numbers wanting to access treatment.

As WASUA's Hep C Educator, I recently visited a mainstream medical centre in the northern suburbs. There was nothing on hep C, resources or information on referral pathways. I was invited to change this and fill the gap with hep C information. This example demonstrates that there is a long way to go before hep C information and education via resources is strategically placed to reach every community. In the meantime, if you want or need support or just want to have a chat, please do not hesitate to give me a ring on (08) 9321 2877. ■

The WASUA clinic nurse is at WASUA on Tuesdays & Thursdays and at HepatitisWA every second Wednesday afternoon. Our clinic nurse can monitor your hep C and liver, free of charge, and offer confidential, expert specialist knowledge free from judgement, stigma and discrimination.

Written by Mikayla-Jay McGinley
Hepatitis C Educator, WASUA.

WASUA
WA's DRUG USER ORGANISATION
"if you would judge, understand" L.A. Seneca

PERTH
(08) 9321 2877
www.wasua.com.au

SOUTH WEST
Van Phone 0417 973 089
Office (08) 9791 6699

97 Spencer St, Bunbury (entry via Rose st)
Opening Hours: Monday to Friday 10am - 2pm.

Perth NSEP
Mon - Weds: 10am-5pm
Thurs - Fri: 10am-8pm
Sat & Sun: 11am-4pm

Clinic Hours
Tues & Thurs: 10am-4pm

Closed Public Holidays

WASUA provides a number of services on premises at 519 Murray Street, West Perth, including:

- NSEP (Needle and Syringe Exchange Program)
- Free hep A and B vaccinations for hepatitis C positive people
- Free blood testing in a friendly confidential environment
- Drug treatment support and referral
- Peer education and training
- Street-based outreach
- Advocacy and support for users
- Safe injecting and safe disposal education and resources
- Hepatitis C/blood borne virus information and resources

South West Mobile provides a mobile Needle Syringe Exchange Program (NSEP) at the following locations and times:

Margaret River	Tues: 1pm-2pm	Hospital Carpark
Busselton	Tues: 5pm-7pm	Kevin Cullen Community Health
Jaycee Park, Bunbury	Wed: 4:30pm-5:30pm	Jaycee Park
Hudson Road, Bunbury	Wed: 5:45pm-6:45pm	WA Country Health Service
Bunbury Hospital	Wed: 7pm-8pm	Dental Clinic Carpark
Manjimup	Thurs: 5pm-6pm	Hospital Carpark
Harvey	Thurs: 6pm-7pm	Hospital Carpark
Donnybrook	Fri: 4pm-5pm	Hospital Carpark
Collie	Fri: 6pm-7pm	Ngalang Boodja (Corner Forrest St & Atkinson St)

A confidential delivery service is also available throughout the southwest from Monday to Friday, for people who cannot attend the site locations. Phone **0408 946 762** to arrange a suitable time.

hepatitis*wa*

is facilitating a peer support service for people living with hepatitis.

The peer support group assists people to achieve better health and well being through discussions and activities. The monthly meetings are confidential, free and provide opportunities to share experiences and thoughts with peers in a friendly and non-judgemental way.

Healthy and tasty snacks will be provided.

For more information, please contact Amineh on 9328 8538 or support@hepatitiswa.com.au