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Hepatitis C Virus and the Infectious Diseases Community

Scott D. Holmberg

Division of Viral Hepatitis, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia

It is a perfect storm for the chronic viral infection associated with the greatest morbidity and mortality in the United States. Of the 3 million Americans infected with hepatitis C virus (HCV), only 50% know they are infected. Infections acquired many years ago from parenteral exposures— injection drug use, transfusions received before screening assay availability (in 1992), or other healthcare exposures— have either no or nonspecific (but highly prevalent) symptoms, such as fatigue, arthritis, and depression. Clinicians tend to discount the extrahepatic effects of HCV infection, although HCV has been associated with diabetes and other serious morbidities. Now, after latencies of 20–30 years, there are rapidly increasing cases of cirrhosis, end-stage liver disease, hepatocellular carcinoma, and early deaths in the Baby Boom generation. The traditional bulwark for viral hepatitis care has been a small number of board-certified hepatologists— only about 2000— who are now overwhelmed. Although many never studied HCV in medical school, infectious disease and general clinicians are being called on for diagnosis and care for a rapidly increasing number of patients. In conjunction with World Hepatitis Day (28 July), this is an appropriate time to provide an overview of where we are and the immediate future for control and treatment of the HCV epidemic.

A generous grant from the Viral Hepatitis Action Coalition (VHAC) of the CDC Foundation has made this supplement possible. The first 2 articles establish some basic insight into the HCV epidemic in the United States (Klevens et al, pages S3–9) and worldwide (Averhoff et al, pages S10–5). The facts underlying current trends in this country and abroad are indeed sobering, but there is reason for cautious optimism. Fox and Jacobson (pages S16–24) describe the rapidly improving, if still expensive, curative therapies for HCV infection available now and in the near future; Feinstone, Hu, and Major (pages S25–32) outline prospects and problems in developing HCV prophylactic and therapeutic vaccines; and Taylor, Swan, and Mayer (pages S33–42) discuss the twin epidemics of and effective treatment for HCV and human immunodeficiency virus (HIV) infections. Laboratory tests are improving in their speed, reliability and specificity (Kamili et al, pages S43–8), and this work is vitally important to a major effort now underway to test and refer to care the many

Correspondence: Scott D. Holmberg, MD, MPH, Division of Viral Hepatitis, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 1600 Clifton Rd, Mailstop G-37, Centers for Disease Control and Prevention, Atlanta, GA 30333 (sdh1@cdc.gov).

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middle-aged HCV-infected persons who are, as yet, unaware they are infected (Smith et al, pages S49–53). Jorgensen and colleagues provide a unique insight into the relative lack of HCV knowledge among healthcare personnel who used the Centers for Disease Control and Prevention’s Division of Viral Hepatitis Web site for information (pages S54–7). Finally, Ward and Koh, the US Assistant Secretary for Health and Human Services, provide a policy roadmap for dealing with this burgeoning epidemic (pages S58–63).

Many with experience with both HIV and viral hepatitis often discuss how the HCV epidemic is time-shifted 10–15 years behind the HIV/AIDS epidemic. Just as morbidity and mortality from HIV infection have shown gratifying declines in recent years, following the introduction of HAART, so, too, is there cause for optimism that new therapies for HCV infection will encourage people to get tested and treated, reduce the infectiousness of HCV-infected persons, be used increasingly earlier in the course of infection, and obviate the need for liver biopsy and staging. Yet, while there is good news ahead, this will take a lot of work, with more patients than seen during the HIV/AIDS epidemic. Hopefully, this supplement will provide some helpful guidance as our infectious diseases community deals with this mammoth epidemic.

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