Hepatitis, Cholangitis and the RUQ

Key Points:
- Many patients with Hep B-associated HCC do not have cirrhosis, while nearly all patients with Hep C-associated HCC do.
- Hepatitis C RNA is the first biomarker to become positive in acute HCV. There is some evidence from uncontrolled trials and meta-analysis that interferon monotherapy may improve virologic clearance.
- Ultrasound has a sensitivity of 95% for gallstones, better than CT while both have a sensitivity of 75% for choledocholithiasis in the presence of dilated ducts.

1. What percentage of people with Hepatitis B and C go on to develop HCC and hepatocellular carcinoma, and what percentage of those patients are NOT cirrhotic?
   - Over 5 years, 12-20% of those with chronic hepatitis B will go on to develop cirrhosis. Of those patients, 6-15% will go on to develop HCC over 5 years.
   - Over 10-20 years, up to 50% of patients with chronic Hep C will develop cirrhosis, although rates vary widely depending on the study population.
   - 30-50% of HCC associated with HBV occurs in patients without cirrhosis. In contrast, nearly all HCC associated with HCV occurs in patients with cirrhosis, suggesting that the cirrhosis itself if the major risk factor in this setting.

2. What are the diagnostic and therapeutic options for acute Hep C?
   - HCV RNA is the first biochemical marker, often present within days of exposure
   - HCV Ab’s are usually present by the time symptoms are present but may be delayed for quite some time in patients with subclinical infection
   - A meta-analysis of four randomized trials involving 141 patients with acute transfusion-acquired HCV found that patients treated with interferon monotherapy had a greater likelihood of having an end-of-treatment virologic response (42 versus 4 percent) and a sustained virologic response (32 versus 4 percent). A more recent trial that was not included in the meta-analysis involved 44 patients identified within four months of acute infection who were treated with interferon alfa monotherapy. After 24 weeks of follow-up, 98 percent were HCV RNA negative, a rate of clearance that was much higher than would have been expected to occur spontaneously; note, however, that this was an uncontrolled trial. The efficacy of adding ribavarin has not been studied.

3. What is the best diagnostic test for choledocholithiasis?
   - Ultrasound has a 95% sensitivity for gallstones, which is superior to that of CT scan. Both CT and ultrasound, however, have about 75% sensitivity for choledocholithiasis in the presence of dilated ducts, 50% with non-dilated ducts. Other options include MRCP or ERCP, which in this case would be the gold standard.

4. When should the gallbladder come out?
   - Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones, with the exception of patients who are at increased risk for gallbladder cancer (anomalous biliary anatomy, porcelain gallbladder, Native American patients) or for those at increased risk for complications from cholangitis. Prophylactic cholecystectomy is not, however, routinely recommended in diabetic patients with gallstones, despite anecdotal evidence that diabetics may be at increased risk of complications. It is recommended for patients with biliary symptoms (not dyspepsia) and gallstones who are good surgical candidates.
References:

