



Foreword

Why a supplement on chronic hepatitis C, and why now? The answer boils down to two simple issues: hepatitis C is an increasingly relevant disease, and its management has been remarkably dynamic in recent years.

The disease's relevance stems from its prevalence and the potential for serious sequelae. Chronic infection with hepatitis C virus (HCV) remains one of the most common causes of liver disease worldwide and the most frequent indication for liver transplantation in the United States. Moreover, morbidity and mortality related to hepatitis C are projected to increase substantially over the next 2 decades.

But the most exciting story about this disease in recent years has been its management. Over the past decade, the treatment of chronic hepatitis C has evolved from thrice-weekly injections of interferon alfa monotherapy, which yielded sustained virologic response rates of less than 15%, to a combination of weekly injections of pegylated interferon alfa and daily ribavirin therapy, which produces sustained virologic response rates of approximately 55%.

Along the route to this progress we've learned many interesting lessons to further refine patient management. For example, we've discovered that a HCV genotype of 2 or 3 is the pretreatment viral factor that has consistently been associated with higher response rates to antiviral therapy. Additionally, the lack of an early virologic response (at 12 weeks) is generally an excellent predictor of nonresponse to antiviral therapy.

Recent years have also shown that delivering the optimal dose of antiviral therapy is associated with improved response rates. Delivering this optimal dose is especially important early in the course of antiviral therapy (during the initial 12 weeks), and its importance has been established most convincingly with regard to the dosing of ribavirin in patients infected with HCV genotype 1. Unfortunately, however, delivering this optimal dose of antiviral therapy has

also been associated with a number of side effects related to both interferon/peginterferon and ribavirin. These include development of neutropenia, anemia, and thrombocytopenia as well as interferon-induced neuropsychiatric side effects, a nonspecific flulike syndrome, dry cough, dyspnea, and itching.

In this supplement, our collection of internationally renowned hepatologists provide an up-to-date review of strategies for managing these side effects and guidance for enhancing adherence to the optimal antiviral regimen for chronic hepatitis C. These "adjuvant" strategies include the use of hematopoietic growth factors (epoetin alfa and darbepoetin alfa) for ribavirin-induced anemia as well as filgrastim for managing severe interferon-related neutropenia. Also discussed are strategies for addressing the neuropsychiatric side effects of interferon, including approaches to psychiatric assessment, monitoring, and treatment. The supplement's final article focuses on physician extenders and their increasingly crucial role in the management of HCV-infected patients, especially for managing the side effects of antiviral therapy.

We hope that presenting a number of strategies to improve patients' health-related quality of life (eg, treatment of anemia, patient education, simple interventions for side-effect management) may serve to improve adherence to treatment. Such an improvement in adherence may potentially increase the likelihood that antiviral therapy will be efficacious in a given patient. Regardless of what the next generation of antiviral therapy for chronic hepatitis C will be, strategies to improve adherence will remain helpful in optimizing outcomes for patients infected with HCV.

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