Guidance on the investigation and management of occupational exposure to hepatitis C

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Summary: This document updates previous PHLS guidance on the risks and management of occupational exposure to hepatitis C. In line with recent guidance from the UK Health Departments, the PHLS now recommends that all source patients, subject to appropriate consent, should be tested for evidence of hepatitis C infection. A baseline serum should be obtained from the exposed health care worker and stored for at least two years. Health care workers exposed to known infected sources should be followed up at six, 12, and 24 weeks after exposure. Serum taken at six and 12 weeks should be tested for hepatitis C virus (HCV) RNA and serum taken at 12 and 24 weeks for anti-HCV. Health care workers exposed to a source believed not to be infected do not require active follow up for hepatitis C unless requested or if they develop symptoms or signs of liver disease. Management of personnel exposed to a source whose hepatitis C status is unknown or a source unavailable for testing will depend upon a risk assessment by a designated doctor. Health care workers who are found to be positive for HCV RNA or antibody to hepatitis C should be referred to an appropriate consultant for consideration of early treatment.

Introduction
Guidance on the risks and management of occupational exposure to hepatitis C was last issued in 1993 by the PHLS Hepatitis Subcommittee. Since then, knowledge has increased about the prevalence of hepatitis C virus (HCV) infection in the United Kingdom (UK), the risks of occupational transmission, and the benefits of treatment. Guidance on the management of potential exposures to HCV was issued recently in the United States (US) and Canada and recommendations in these documents differ from those in the previous PHLS guidance. In addition, the UK Health Departments have issued recommendations on the management of significant exposures with regard to the potential risks of HIV, hepatitis B virus, and HCV infection. These developments provided an opportunity for the PHLS Advisory Committee on Blood Borne Virus Infections to reconsider and revise the recommendations of the PHLS group. This guidance is intended to supplement the detailed guidance on the management of blood exposure incidents produced by the UK Health Departments.

The evidence base
Risks of exposure to hepatitis C
Population based studies suggest that the prevalence of HCV infection in western Europe and North America is below 2.5%, lower than in many other parts of the world. The prevalence among new blood donors is currently 0.06% but a seroprevalence of 0.72% was found in UK organ donors. The prevalence in the West Midlands of anti-HCV among pregnant women was 0.14% but in a more recent PHLS study of pregnant women the prevalence was 0.33% in Greater London and 0.22% in Yorkshire (J Parry, personal communication).

Patients receiving health care in the UK are likely to have a higher prevalence of HCV infection than the general population. Known high risk exposures for HCV infection in the UK include injecting drug use, receipt of blood transfusion or blood products,
tattooing, and having been born abroad\(^9,10\). The prevalence of HCV among injecting drug users (IDUs) in studies in England and Wales was 46% in South Wales\(^11\), 59% in one area of rural England\(^12\), 59% among IDUs undergoing voluntary HIV testing in north west England (J Craske, personal communication), and 67% in IDUs attending a regional drug clinic in the north east\(^13\). In Scotland, studies of IDUs have found prevalences of anti-HCV between 77% and 90%\(^14,15\). People with haemophilia who receive untreated clotting factors\(^16-19\) and patients on renal dialysis in some units\(^20\) are also known to have a high prevalence, although the prevalence has been low in some renal units\(^21,22\). In some specialties and geographical locations, therefore, the risk of exposure to an HCV infected source may be high. Exposure to HCV positive sources in the UK is likely to be commoner than exposure to sources positive either for HIV or for hepatitis B surface antigen\(^23\).

**Risk of transmission to health care workers**

Health care workers may be at greater risk of hepatitis C than the general UK population\(^9,10\), but the prevalence of anti-HCV in such staff is lower than among health care workers in the US\(^22\), and western Europe\(^22,24\). In the UK, the overall prevalence of infection was estimated to be 0.23% among all health care workers and 0.28% in those at risk of occupational contact with blood and body fluids\(^25,26\).

In the US, a review of published studies in health care workers who received a needlestick injury from an anti-HCV positive source estimated the risk of transmission to be 1.8% (range 0%-7%)\(^2\). In a recent meta-analysis, the risk of transmission was shown to be greater if the source patient was known to be positive for HCV RNA; no transmission occurred from HCV RNA negative sources\(^27\).

**Risk of transmission from health care workers**

Only two episodes of transmission from an HCV infected surgeon to patients have been described to date\(^28,29\). In the UK, transmission from an HCV infected surgeon was implicated in a single case of acute hepatitis C detected after cardiothoracic surgery\(^28\). In the lookback investigation that followed, 277 patients were tested but no other infected individuals were identified\(^30\). This suggests that the risk of transmission from health care worker to patient is much lower than the risk of transmission from surgeons positive for hepatitis B e antigen\(^31\).

Based on this evidence, health care workers with HCV infection in the UK are not restricted from performing exposure prone procedures unless they have been shown to transmit hepatitis C to a patient\(^32\). Nevertheless, health care workers with HCV infection should be seen in occupational health departments to be advised on scrupulous adherence to the optimal precautions for control of bloodborne virus infections in order to reduce the potential risk of transmission during exposure prone procedures\(^4\). In addition, infected health care workers should be advised about the local arrangements for the reporting, assessment, and management of any incidents in which patients appear to have been exposed to a health care worker’s blood. Patients who sustain a significant exposure to blood (box 1) should be managed in the same way as exposed health care staff.

**Management of hepatitis C infection**

The UK Health Departments have concluded that there is no effective post exposure prophylaxis for hepatitis C\(^4\). The use of immunoglobulin has been suggested, but a US review in 1998 concluded that it did not prevent HCV infection\(^31\). Prophylaxis with alpha-interferon did not prevent transmission of hepatitis C after a needlestick injury in Japan\(^32\). No formal assessments of antiviral agents for post exposure prophylaxis have been performed, but their use has not been recommended in the US\(^2\).

Alpha-interferon is now commonly used to treat chronic hepatitis C infection\(^33,34\). Better response rates are likely to be seen with combination therapies that include ribavirin\(^35-37\). A recent European consensus statement recommended that combination therapy should be offered to all previously untreated infected individuals without contraindications\(^38\). Evidence based guidance on the management of patients with hepatitis C currently being developed by professional groups in the UK may involve the selection of patients on the basis of abnormal liver function, HCV RNA positivity, and grade of abnormality on a liver biopsy\(^35\). A decision about whether to continue treatment may depend upon demonstration of a virological response as assessed by genome detection.

Evidence on the optimal timing of treatment for acute and chronic hepatitis C infection is unclear. The use of interferon for acute hepatitis in a small number of patients suggested that early treatment might prevent chronic carriage\(^32\). A subsequent meta-analysis of the use of alpha- and beta-interferon in acute hepatitis C infection concluded that short term early treatment produced better response rates than treatment of chronic infections\(^39\). Control data on

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**BOX 1**

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<th>Definitions of occupational exposure(^1)</th>
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<td><strong>Percutaneous exposure:</strong> the skin of the health care worker is cut or penetrated by a needle or other sharp object (for example, scalpel blade, trochar, bone fragment, or tooth), which is contaminated with blood or other body fluid</td>
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<tr>
<td><strong>Mucocutaneous exposure:</strong> the eye(s), the inside of the nose or mouth, or an area of non-intact skin of the health care worker is contaminated by blood or other body fluid</td>
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<td><strong>Significant exposure:</strong> includes all percutaneous exposures and any mucocutaneous exposure to blood or bloody body fluids (but not mucocutaneous exposure to other body fluids).</td>
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untreated infections were limited, however, so the difference in response could reflect the natural clearing of acute infection. More recently, workers in Italy reported the results of a randomised controlled trial of beta-interferon in acute hepatitis C, in which the rates of chronic infection in treated (15/20) and untreated groups (16/20) were similar.\(^40\)

The US Centers for Disease Control and Prevention has concluded that there is insufficient evidence to suggest that treatment of acute hepatitis is more successful than early treatment of chronic hepatitis.\(^2\) In Canada, however, early treatment of health care workers who seroconvert following percutaneous exposures is now recommended.\(^1\) A recent consensus conference in Europe also stated that most experts now favour treating patients with acute hepatitis C infection.\(^38\)

**Recommendations**

The recommendations of the committee for the management of a significant exposure (box 1)\(^1\) are as follows:

**Investigation of source patients**

In most settings, most source patients are likely to be anti-HCV negative. The exclusion of HCV infection in the patient should reassure the exposed health care worker. Identification of a source patient who is positive for anti-HCV should prompt appropriate assessment of the patient and follow up of the health care worker. The advisory committee therefore recommends that, where possible, a baseline serum from the source patient should be obtained and tested for anti-HCV. Patients who are anti-HCV positive should be further investigated for HCV RNA (an EDTA plasma may be required by the local laboratory). In immunocompromised patients (including those on renal dialysis)\(^42\) or in patients with features suggestive of acute hepatitis C infection, the use of genome detection should be considered even if the source patient is found to be anti-HCV negative. These investigations will normally entail pre-test discussion and obtaining fully informed consent from the source patient.\(^4\) Specimens from the source patient must be stored in a secure archive at a temperature at or below 20°C for at least two years after the incident.

Source patients found to be anti-HCV and/or HCV RNA positive should be referred to an appropriate consultant with an interest in hepatitis C infection.

In the event that the source patient cannot be identified or if the patient refuses to be tested or is unavailable for testing, management should be based upon a risk assessment. This risk assessment should be conducted by one of the doctors designated to offer advice on the management of exposures to bloodborne viruses within the health authority or NHS Trust.\(^5\) Epidemiological and clinical information about the incident and/or the source patient should be obtained and reviewed. If the source patient is considered to be ‘high risk’ then the health care worker may be managed as if exposed to a source known to be positive. Such high risk exposures would normally be limited to sharps injuries contaminated with fresh blood from a member of a known high risk group (for example, an IDU). Because the risk of transmission of bloodborne viruses from dried blood is likely to be lower than from fresh blood, the advisory committee does not consider community needlestick injuries from discarded needles to be ‘high risk’ exposures.

**Investigation of the exposed health care worker**

Baseline serum should be obtained from the exposed person and stored in a secure archive at -20°C or below for at least two years (box 2). If the source patient is not infected with HCV, no further follow up with respect to HCV is required unless the health care worker develops liver disease. Information, counselling, and psychological support should be available for any employee who reports an exposure and a potential risk of any bloodborne viral infection.\(^4\) If, after the provision of information, the exposed person requests follow up, additional testing may be offered. At a minimum, this follow up should include testing for anti-HCV at six months.

For health care workers exposed to a source known to be positive for anti-HCV or HCV RNA (or a source whose hepatitis C status is unknown but who is assessed to be at ‘high risk’), serum should be obtained from the health care worker at baseline, six weeks, 12 weeks, and 24 weeks after exposure (box 2). Serum should be tested for HCV RNA at six and 12 weeks and for anti-HCV at 12 weeks and 24 weeks.

Early testing of the serum of the health care worker for HCV RNA will, if negative, give some reassurance at this stage. In a follow up study of individuals who sustained needlestick exposures to patients with non-A, non-B hepatitis, both of the health care workers who developed anti-HCV were HCV RNA positive one...
health care workers who have been exposed to an individual infected with hepatitis should be referred to the medical officer for assessment. We advise similar caution with respect to donations of other tissues. In studies of chronic HCV infection, the transmission of infection from mother to child is believed to occur in less than 10% of cases. Sexual transmission from chronically infected individuals occurs, but the risk appears to be low. The risk of transmission to infants and sexual partners may be higher in acute than chronic infections, but the magnitude of this increased risk is unknown. Discussion of the possible benefits of adopting safer sexual practices and the avoidance of pregnancy during follow up is therefore recommended.

Health care workers found to be anti-HCV and/or HCV RNA positive at any stage during follow-up should be referred to an appropriate consultant with an interest in hepatitis C infection. The evidence for the effectiveness of early treatment is limited, but referral will allow early assessment and a consideration of the potential role of treatment. As treatment options are likely to change over the next few years, early detection will enable recruitment into clinical trials and the early implementation of any treatment shown to improve outcome. Health care workers found to be anti-HCV and/or HCV RNA positive should also be referred to occupational health for advice.

References
12. Majid A, Holmes R, Desselberger U, Simmonds P, McKeeman...


Appendix I
PHLS Advisory Committee on Blood Borne Viruses
Dr P Mortimer (chairman), Dr T Wrehgitt (scientific secretary), Dr H Nicholas, Professor R Tedder, Dr W Irving, Professor M Bassendine, Dr C Teo, Professor P Morgan-Capner, Dr M Ramsay, Dr P Simmonds.