

# Hepatitis C

**Essential information** for professionals  
and guidance on testing



# Hepatitis C

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The purpose of this document is to inform health professionals about hepatitis C and assist them in offering hepatitis C testing to patients who may have been at risk of infection.

# Hepatitis C

## Essential information for professionals and guidance on testing

### DH INFORMATION READER BOX

<b>Policy</b> HR / Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
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# Hepatitis C

## Essential information for professionals and guidance on testing

### Introduction

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The hepatitis C virus was identified in 1989. It has since been shown to account for the majority of cases of post-transfusion non-A, non-B hepatitis.

Hepatitis C is now recognised as a significant public health problem world-wide, with the World Health Organisation estimating that some 170 million people are chronically infected. In England, it is estimated that there are approximately 200,000 people chronically infected and that the majority of these are unaware of their infection.

The purpose of this document is to inform health professionals about hepatitis C and assist them in offering hepatitis C testing to patients who may have been at risk of infection.

The document provides information and advice on:

- How the virus is transmitted;
- The natural history of hepatitis C infection;
- Groups who should be offered testing;
- Pre- and post-test discussion;
- Hepatitis C tests;
- Referral for specialist management and treatment for hepatitis C;
- Further sources of information.

This guidance is published to support implementation of the *Hepatitis C Action Plan for England*.\*

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\*Hepatitis C Action Plan for England, July 2004, Department of Health,  
[www.dh.gov.uk/publications](http://www.dh.gov.uk/publications) and [www.dh.gov.uk/cmo](http://www.dh.gov.uk/cmo)

# Epidemiology

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## How is hepatitis C transmitted?

The hepatitis C virus (HCV) is carried in the blood, which has been identified as the main vehicle of infection.

- The major route of HCV transmission in the UK is by sharing equipment for injecting drug use, usually via blood-contaminated needles and syringes. Drug injecting equipment (for example, spoons and filters) may also transmit the infection if it is contaminated with infected blood.
- There was a risk to recipients of blood transfusions (before September 1991), or blood products (before 1986) in the UK. For example, there is a high prevalence of HCV in people with haemophilia who received clotting factors before 1986.
- Mother to baby transmission does occur, but appears to be uncommon, with upper estimates of 6%. However, this is increased to around 14–17% when there is co-infection with HIV. There is no proven association, as yet, between breastfeeding and HCV transmission. Therefore, HCV infected mothers are not currently advised against breastfeeding.
- Sexual transmission of HCV is possible but uncommon. Studies suggest that less than 5% of the regular sexual partners of people with HCV infection will become infected.
- Transmission can occur through medical and dental procedures, in countries where HCV is common and where infection control may be inadequate.
- Health care workers (and, to a lesser extent, other workers, such as police, prison staff and social workers) may be at risk of HCV infection from occupational injuries, for example needlestick injuries.
- There is a risk from tattooing, ear piercing, body piercing and acupuncture if blood-contaminated equipment is re-used.
- There is some evidence that transmission may rarely occur through the sharing of razors or toothbrushes that are contaminated with blood.

There is no risk of HCV transmission from everyday social contact such as holding hands, hugging and kissing or through sharing toilets, crockery and kitchen utensils.

# Hepatitis C

## Essential information for professionals and guidance on testing

### Prevalence

In this country, injecting drug users are known to be at greatest risk of hepatitis C infection. Over 30% of injecting drug users attending specialist services have evidence of hepatitis C infection, and some studies have recorded levels up to 80%. Most cases of hepatitis C infection in which risk factors have been reported, are related to current or previous injecting drug use.

There has been no study of the prevalence of hepatitis C in the general population of this country, but information on the overall prevalence of infection can be derived from studies of low-risk populations, such as pregnant women. These studies suggest that 0.5% of the general population in England has been infected with hepatitis C. Some people clear the virus in the acute stage: this means that around 0.4% of the general population in England (200,000 people) may have chronic hepatitis C infection.

From surveillance of laboratory reports of hepatitis C infection, it is likely that the majority of those infected have not been diagnosed. Including provisional data up to the end of 2003, a cumulative total of around 38,000 infections have been reported in England to date. The majority of the reports have been in the 25–44 year age group. There have been around twice as many reports in males as in females, largely accounted for by the higher frequency of injecting drug use in males.



## Natural history

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HCV is a blood-borne RNA virus and, based upon differences in molecular structure, a number of different strains (genotypes) have been described. The incubation period of acute hepatitis C is usually between 6 and 9 weeks, with specific antibody usually present by 3 months from infection, although in some cases it may take up to 6 months before antibody is detected.

The majority of people suffer no symptoms when they become infected and for this reason there is little information about the incidence of new infections. Some people may feel briefly unwell, and in rare cases become jaundiced.

About 60–80% of people who acquire the infection become chronically infected. The rest clear the infection spontaneously. Many with chronic hepatitis C infection have no symptoms, while others feel unwell to varying degrees. Most people remain well for many years and this makes infection difficult to recognise.

The severity of symptoms does not necessarily equate to the extent of liver damage. Some patients report quite severe symptoms with no clinical signs of liver damage, while cirrhosis can be present without any obvious symptoms.

Most people who are chronically infected live out a normal lifespan, others only develop symptoms of chronic liver disease many years after initial infection. 5–20% of chronically infected people may develop serious liver disease (cirrhosis) after 20 years. A small proportion of these develop primary liver cancer.

Certain factors are associated with more rapid progression to severe liver disease. These include:

- being over 40 years old at the time of infection;
- alcohol consumption;
- male gender;
- co-infection with HIV or hepatitis B;
- immuno-suppressive therapy.

## Reasons to be tested for hepatitis C

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There are several important reasons for offering hepatitis C testing to a patient who may have been at risk of infection or who shows evidence of liver disease that may indicate infection.

### **Testing:**

- provides the opportunity to refer those infected to a specialist for further investigation and treatment, if appropriate;
- provides the opportunity for discussing current potentially harmful patterns of behaviour such as injecting drug use or excessive alcohol consumption;
- can allay anxiety.

# Hepatitis C testing

Testing for hepatitis C should form part of the investigation of patients with unexplained abnormal liver function tests, or with unexplained jaundice.

Current epidemiological evidence suggests that there are groups who should be offered hepatitis C testing and groups for whom testing is not recommended.

## Groups to whom hepatitis C testing should be offered

### QUICK REFERENCE SUMMARY

- People who have ever injected drugs in the past
- People who are currently injecting drug users
- People who have received transfused blood in the UK prior to September 1991 or blood products prior to 1986
- Recipients of organ and tissue transplants in the UK before 1992 or abroad in countries where hepatitis C is common and donors may not have been screened
- Those with a previous diagnosis of non-A, non-B hepatitis if not already tested
- Babies born to mothers known to be infected with HCV
- Children of mothers found to be infected with HCV
- Regular sexual partners of patients infected with HCV
- Health care workers accidentally exposed to blood where there is a risk of transmission of HCV
- Anyone who has received medical or dental treatment in countries where HCV is common and infection control may be poor (this will include blood transfusions and blood products where donations are not screened for HCV)
- People who have had tattoos, body piercing and other forms of skin piercing where infection control procedures are poor

#### ■ **People who have ever injected drugs in the past**

Individuals who experimented with drugs and perhaps injected on only a few occasions in the past, perhaps many years ago, may not be aware of this risk.

#### ■ **People who are currently injecting drug users**

The overall prevalence of anti-HCV among current injecting drug users in England is of the order of 30%,<sup>1</sup> although prevalence rates vary around the country. Higher levels, up to 80%, have been found among individuals with a long injecting career, and in those who started injecting before the introduction of needle exchange services in the mid-1980s, when sharing of equipment would have been more likely.

Any sharing of injecting equipment may present a risk, e.g. by anabolic-androgenic steroid injectors.

# Hepatitis C

## Essential information for professionals and guidance on testing

- **People who have received transfused blood in the UK prior to September 1991 or blood products prior to 1986**

In the past, hepatitis C was transmitted through the transfusion of contaminated blood or blood products. The introduction of donor screening in the UK, in September 1991, and of viral inactivation treatments of plasma products in the mid-1980s has largely eliminated these routes of transmission.

The prevalence of anti-HCV observed during the first four months of donor testing was around 1 in 1500 donors. Approximately 75% of confirmed anti-HCV positive donors have been found to be HCV RNA positive by PCR.<sup>2</sup> Thus, the risk of receiving a single unit of blood from an HCV RNA positive donor prior to September 1991 was probably around 1 in 2000. However, the risk rises in those who have received multiple transfusions, e.g. retrospective screening for hepatitis C of transfused children in a tertiary paediatric referral centre showed an anti-HCV prevalence of nearly 2%.<sup>3</sup>

In 1995 there was a look-back exercise to notify patients who had received blood from donors subsequently found to be anti-HCV positive (after the introduction of routine screening in 1991) and offer them counselling, further assessment and treatment where indicated. This exercise will not have identified all patients at risk, because some donors, unknowingly infected, may have ceased donating before September 1991, and also because incomplete records may have meant that not all recipients could be traced.

It is likely that the majority of patients who received products manufactured from pooled plasma in the UK prior to 1986 may have been infected with HCV. The majority have probably already been tested.

- **Recipients of organ and tissue transplants in the UK before 1992 or abroad in countries where HCV is common and donors may not have been screened**

The introduction of organ and tissue donor screening in the UK, in November 1991, has largely eliminated these routes of transmission. However, people who have had transplants pre-1992 or abroad in countries where HCV is common and donors may not have been screened for HCV, may have been exposed to HCV.

- **Those with a previous diagnosis of non-A, non-B hepatitis if not already tested**

Hepatitis C was only identified in 1989. However, a further blood-borne virus had been predicted as early as 1974, to explain cases of hepatitis not caused by hepatitis A or hepatitis B following the development of accurate tests for these viruses. This was known as non-A, non-B hepatitis. This diagnosis was given to some patients in the past, both to those who developed hepatitis following the receipt of blood or blood products (post transfusion non-A, non-B hepatitis), and also to community acquired infections. Hepatitis C has since been shown to account for the majority of cases of post-transfusion non-A, non-B hepatitis related to blood or blood products, and to a variable proportion of community acquired infections of other causes, including injecting drug use. Individuals with a history of non-A, non-B hepatitis should be offered a test for hepatitis C, if they have not already been tested.

- **Babies born to mothers known to be infected with HCV**

Babies born to mothers infected with hepatitis C are at risk of acquiring infection at or around the time of birth. The risk of mother to baby transmission

of hepatitis C is generally low and of the order of 5–6% in HIV negative mothers, but rises to around 14–17% when the mother is co-infected with HIV. Babies may be tested for HCV RNA at 4–6 weeks of age and at one year of age for HCV RNA and antibodies. Positive anti-HCV tests in such babies within the first year of life may be due to passively acquired maternal antibody and ideally such tests should be delayed until 12 months of age.

■ **Children of mothers found to be infected with HCV**

Where a mother is newly diagnosed with hepatitis C infection, consideration should be given to testing any of her children who may have been born subsequent to her acquiring infection with hepatitis C.

■ **Regular sexual partners of patients infected with HCV**

The role of sexual transmission of hepatitis C remains controversial. However, a low prevalence of hepatitis C infection (less than 5%) has been found among the regular long-term sexual partners of patients with hepatitis C infection where no other risk factors are reported.

■ **Health care workers accidentally exposed to blood where there is a risk of transmission of HCV**

Any occupational exposure to blood or body fluids should be followed up where there is a risk that the source of the blood or body fluids was a carrier of hepatitis C infection. Appropriate testing, in line with the guidance referred to below, should be offered. Reports suggest that the risk of transmission of hepatitis C following a single percutaneous exposure from a hepatitis C antibody positive source is probably between 1.2 and 3.0%. Guidance has been published on the management of occupational exposure to hepatitis C, including the place of early PCR testing<sup>4</sup>. Early referral to a specialist is recommended for workers found to have acute hepatitis C infection. Studies suggest that treatment in the acute phase can prevent chronic infection.<sup>5,6</sup>

■ **Anyone who has received medical or dental treatment in countries where HCV is common and infection control may be poor (this will include blood transfusions and blood products where donations are not screened for HCV)**

Patient to patient transmission of hepatitis C in the health care setting may occur though the re-use of blood-contaminated equipment. For example, in many developing countries unnecessary use of therapeutic injections and unsafe injecting practices (re-use of needles and syringes without sterilisation) are thought to account for a substantial proportion of new infections with hepatitis C.<sup>7,8</sup>

■ **People who have had tattoos, body piercing and other forms of skin piercing where infection control procedures are poor**

Some studies have found an association between tattooing and body piercing and hepatitis C infection, but the scale of the overall risk remains unknown. Whilst a potential route of transmission, the risk should be minimised where good infection control measures are in place (e.g. the use of sterile equipment for each client). Skin piercing businesses in England are regulated by Local Authorities. However, the risk is likely to be higher where these activities are carried out by non-professional practitioners or in venues where infection control procedures are poor, as may be the case when these activities are performed in prisons<sup>9</sup> or in some countries overseas.

# Hepatitis C

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## Groups for whom hepatitis C testing should take place as part of their health care

### QUICK REFERENCE SUMMARY

- Patients with renal failure on dialysis
- HIV infected patients

#### ■ **Patients with renal failure on dialysis**

Patients with renal failure on dialysis may be at risk of hepatitis C because of the potential for exposure to blood that can occur on renal units. The prevalence of infection in patients receiving dialysis on units in the UK is low in comparison to other countries. A survey indicated that, in England in 2002, the overall rate of patients with hepatitis C on dialysis or living with a kidney transplant was 1.8%.<sup>10</sup>

Advice on testing new patients on renal dialysis and renal transplantation units, on persons returning after dialysis abroad, on regular serological surveillance and on the place of HCV RNA detection is given in Good Practice Guidelines for Renal Dialysis/Transplantation Units: Prevention and Control of Blood-borne Virus Infection.

#### ■ **HIV infected patients**

All individuals found to have HIV infection should be screened for hepatitis C infection, since co-infection with these viruses may affect the prognosis for these patients and there are important implications for treatment.

## Groups for whom hepatitis C testing is currently not recommended

### QUICK REFERENCE SUMMARY

- Pregnant women not included within the groups outlined above
- All health care workers
- Individuals with multiple sexual partners
- Intranasal cocaine use

#### ■ **Pregnant women not included within the groups outlined above**

As there is currently no safe and effective intervention to prevent mother to baby transmission of hepatitis C, the National Screening Committee has not recommended routine antenatal screening for hepatitis C at this time. However, antenatal clinics provide a suitable place to offer opportunistic testing for hepatitis C to women in the risk groups above.

#### ■ **All health care workers**

The prevalence of hepatitis C infection among health care workers in England appears low, with overall rates between 0.23%<sup>11</sup> and 0.28%.<sup>12</sup> Routine screening for hepatitis C of all health care workers is therefore not recommended. Arrangements for limited testing of health care workers who are to perform exposure prone procedures are set out in the guidance document Hepatitis C Infected Health Care Workers [www.dh.gov.uk/assetRoot/04/05/95/44/04059544.pdf](http://www.dh.gov.uk/assetRoot/04/05/95/44/04059544.pdf) and the consultation document Health Clearance for Serious Communicable Diseases: New Health Care Workers [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthClearance/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthClearance/fs/en). A final version of the latter is due to be published during 2005.

Testing following needlestick injuries or other occupational exposure is dealt with above.

#### ■ **Individuals with multiple sexual partners**

The role of sexual transmission of hepatitis C remains controversial. Sexual activity is an inefficient route for transmission of hepatitis C. Nevertheless, studies have shown that individuals with multiple sexual partners have a slightly increased prevalence of hepatitis C compared to the general population. A survey among genito-urinary medicine clinic attenders in England and Wales has shown a prevalence of anti-HCV of 1.03% overall and 0.65% among those who did not report injecting drug misuse,<sup>13</sup> which is only slightly above the estimated prevalence in the general population.

# Hepatitis C

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### ■ Intra-nasal cocaine users

The role of intra-nasal cocaine in the transmission of hepatitis C is unclear. One study in the US has reported an association between a history of cocaine use and hepatitis C infection.<sup>14</sup> It has been suggested that transmission between individuals may result from the sharing of blood-contaminated straws used to inhale cocaine in the presence of damaged nasal mucosa. There have been no UK studies linking cocaine use with hepatitis C infection. Although the sharing of straws etc. should be discouraged, there is insufficient evidence currently to recommend that intra-nasal cocaine users, without other risk factors, should be tested for hepatitis C.

## Hepatitis C tests

The most widespread screening test for hepatitis C is a blood test for antibodies to the virus. A positive test, which should always be confirmed by testing a second blood sample, indicates whether a person has been infected with hepatitis C but it does not distinguish between previously resolved or current infection. About 20–40% of people who have been infected with hepatitis C will clear the virus at the acute stage. However, in general these people will still have positive antibody results.

It can take up to 3 months for antibodies to hepatitis C to become detectable following infection. Therefore, in patients whose exposure has been recent and whose first test is negative, the hepatitis C antibody test should be repeated 3 months after the last possible exposure in order to avoid misdiagnosis during this 'window period'.

If the antibody test is confirmed as positive, the next steps are to establish if the virus is still present, and if so to diagnose the extent of the underlying liver disease. To do this further tests are required, some of which may be carried out in primary or secondary care according to local arrangements.

An HCV RNA detection test (e.g. a PCR test) will identify current circulating virus. More sophisticated tests are available to identify the genotype of the virus and to assess the viral load. These latter tests are usually only carried out if a patient is to be offered antiviral therapy.

Liver function tests (LFTs) should be used to screen for evidence of hepatitis.



## Pre-test discussion

Pre-test discussion can be carried out by any suitably informed health professional. It need not be lengthy, subject to the needs of individual patients, as long as information is provided in a clear and concise way that the patient can understand. Pre-test discussion should cover the following areas:

- confidentiality of test results.
- modes of transmission.
- the nature of hepatitis C infection and the possible long-term implications of the disease.
- risk activities that the patient may have been involved in which have put them at risk of hepatitis C infection. Some attempt should be made to establish the date of the last risk activity (so that the 3 months antibody production 'window period' is taken into account).
- information about risk reduction and harm minimisation appropriate to the patient's circumstances.
- the implications of a positive or negative result for the individual and his/her family, e.g. the possible effect on relationships and the possible need for sexual partners to be tested. Establishing what support network the individual may have and giving information about national/local organisations that provide support. (For advice on insurance, see page 16).
- the testing procedures, including what the test involves, where it will be done, how long before the results come back, who will give the results and how, and what the results will mean; and the possible need for referral to a specialist for further investigations.
- treatment, when it is offered, its nature, possible duration, and likely success rate.
- informed consent.

Discussion before undertaking source patient testing after an accidental occupational exposure to blood may not need to cover all these matters unless the patient has independent risk factors for hepatitis C infection.

## Post-test discussion

Results should be given in person wherever possible.

### Negative results

- Where antibody test results are negative, patients should, where appropriate, be advised on ways of avoiding infection in the future.
- Repeat testing is recommended if the patient is believed to have been recently exposed to the virus, since HCV antibodies can take up to 3 months to develop.

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### Positive results

- A positive antibody test should be confirmed by testing a second sample. It is important that the patient clearly understands the result, and that further tests are required to establish whether there is current hepatitis C infection and identify the extent of any disease. These tests may be carried out in primary or secondary care according to local arrangements. **The patient should usually be referred to the appropriate specialist with an interest in hepatitis C.** Local referral protocols may vary.
- The patient may need support to come to terms with a positive test result and potential future implications. Referring practitioners should consider providing such support during the period that patients wait to see a specialist or exploring whether such support is available from the specialist department before the first appointment. (Sources of information that the patient may find helpful are listed at the end of this booklet).
- Reiterate natural history of HCV.
- Patients who are HCV positive should be advised not to donate blood or carry an organ donor card.
- If an HCV RNA detection test is done before referral to a specialist and is positive (indicating current infection has been diagnosed), patients should be advised:
  - To stop or reduce alcohol consumption. Continued alcohol consumption is associated with more rapid progression of liver disease. Patients may need to be referred for specialist alcohol support and counselling;
  - Not to share any injecting equipment (where appropriate);
  - To avoid sharing razors or toothbrushes, and to cover cuts and skin lesions with waterproof dressings;
  - To consider that, although uncommon, sexual transmission can occur, and that the use of condoms will minimise this risk;
  - To consider advising any regular sexual partners that they may wish to consider being tested for hepatitis C.
- Where a mother is newly diagnosed with hepatitis C infection, consideration should be given to testing any of her children who may have been born subsequent to her exposure to hepatitis C. Appropriate timings for testing should be included (explanation of presence of maternal antibodies, for example).

## Insurance

The Association of British Insurers ([www.abi.org.uk](http://www.abi.org.uk)) advises that insurance companies should not ask whether an applicant for life or health protection insurance has taken a hepatitis C test, had counselling in connection with such a test, or received a negative test result. Doctors should not reveal this information when writing reports and insurance companies will not expect this information to be provided.

Insurers may ask only whether someone has had a positive hepatitis C test result, is awaiting a test result, or is receiving treatment for hepatitis C.

Depending on disease progression and prognosis, there will be a range of insurance outcomes for those testing positive for hepatitis C from standard insurance premium rates to a small loading through to a larger loading or refusal of cover in some cases. Specialists should be able to provide the necessary information for insurance purposes either directly or via the GP.

## Hepatitis C ex gratia payment scheme (The Skipton Fund)

On 23 January 2004, the Secretary of State for Health announced the details of an ex gratia payment scheme for people inadvertently infected with hepatitis C as a result of NHS treatment with blood or blood products.

Every person in the UK who was alive on 29 August 2003 and whose hepatitis C infection is found to be attributable to NHS treatment with blood or blood products before September 1991 will be eligible for the payment scheme.

For further information about the payment scheme, including details of the eligibility criteria and how to take forward an application, please visit the Fund's website at [www.skiptonfund.org](http://www.skiptonfund.org)

### Treatment for hepatitis C

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The most accurate way of assessing liver damage in patients with chronic hepatitis C is by liver biopsy, where a very small piece of liver is removed using a special needle and examined under the microscope. This permits assessment of the grade, or activity, of the hepatitis (the degree of inflammation) and the stage of the hepatitis (the amount of scarring or fibrosis present). Current guidelines for the management of patients with chronic hepatitis C use the microscopic appearance of the liver to determine which patients should be offered treatment.

In recent years, increasingly effective treatments for chronic hepatitis C have become available. In January 2004, the National Institute for Clinical Excellence (NICE) recommended a combination of pegylated interferon alpha<sup>†</sup> and ribavirin for the treatment of patients with moderate to severe chronic hepatitis C, defined as histological evidence of significant scarring (fibrosis) and/or significant necrotic inflammation. [www.nice.org.uk/Docref.asp?d=102243](http://www.nice.org.uk/Docref.asp?d=102243)

Overall, this treatment is successful in clearing the infection (with no detectable virus in the blood 6 months after treatment has ceased) in up to 55% of patients. Success rates vary according to the infecting genotype, being up to 45% in those infected with genotype 1, but rising up to 80% in those infected with genotypes 2 and 3.

The recommended duration of treatment with pegylated interferon and ribavirin depends upon the infecting genotype, being 6 months for patients infected with genotypes 2 or 3, and 12 months for patients infected with genotypes 1, 4, 5 or 6. The treatment involves a subcutaneous injection of pegylated interferon alpha weekly, plus a daily dose of oral ribavirin. For patients in whom ribavirin is contraindicated or not tolerated, treatment for a year with pegylated interferon alpha monotherapy is recommended regardless of genotype. Response rates with pegylated interferon monotherapy are lower than when the drug is used in combination with ribavirin.

NICE guidance envisages possible treatment of current injecting drug users and people who have had an alcohol problem.

Treatment may be contraindicated for many patients, including those with pre-existing medical conditions and pregnant women. Side effects (fatigue, nausea, headaches, depression) can be intolerable for some. The development of haemolytic anaemia may limit the use of ribavirin.

Given that many patients with chronic hepatitis C remain well and that treatment can have considerable side effects and will not always be effective, it has been usual for patients with mild liver disease not to be offered treatment. Such patients are kept under ongoing observation to monitor disease progression and initiate treatment, if required. However, trials looking at the possible benefits of treating patients with mild disease are under way.

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<sup>†</sup> Combining interferon alpha with polyethylene glycol leads to delayed renal clearance and increases the plasma half-life resulting in more sustained antiviral activity and the need for less frequent injections.

## Further sources of information

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### NHS hepatitis C website

This new NHS website provides information and advice about hepatitis C for the public and professionals, including downloadable resources.

**Website:** [www.hepc.nhs.uk](http://www.hepc.nhs.uk)

### Hepatitis C Trust

The Hepatitis C Trust is a UK charity solely concerned with issues relating to hepatitis C. It was set up by people with the illness to provide information and support to those with hepatitis C, to raise public awareness and to initiate research. The charity maintains a website that will be continually expanded and updated to include the latest information on hepatitis C.

27 Crosby Row  
London SE1 3YD

**Helpline:** 0870 200 1200

**Fax:** 0207 089 6201

**E-mail:** [info@hepctrust.org](mailto:info@hepctrust.org)

**Website:** [www.hepcuk.info](http://www.hepcuk.info)

### British Liver Trust

The British Liver Trust (BLT) is concerned with raising awareness and providing information and education on all forms of liver disease. The charity produces a number of publications, for example '*Hepatitis C*' and '*Hepatitis C and injecting drug use*' patient leaflets. These are free to patients by sending an SAE to the address below, and for a small charge to primary care and other services. The BLT has expert advice on hand but is only able to respond to written medical enquiries by letter, fax or e-mail.

Portman House  
44 High Street  
Ringwood  
Hampshire BH24 1AG

**Tel:** 01425 463080

**E-mail:** [info@britishlivertrust.org.uk](mailto:info@britishlivertrust.org.uk)

**Website:** [www.britishlivertrust.org.uk](http://www.britishlivertrust.org.uk)

### UK Hepatitis C Resource Centre (A Mainliners Project)

The UK Hepatitis C Resource Centre is a specialist service that offers accessible advice and is an information point for people living with hepatitis C, healthcare professionals, members of the public and the media. The centre maintains a list of local support groups for people with HCV and provides information and leaflets. The centre also co-ordinates a national forum to represent the needs and views of people with HCV.

195 New Kent Rd  
London SE1 4AG

**Tel:** 0870 242 2467

**E-mail:** [admin@hepccentre.org.uk](mailto:admin@hepccentre.org.uk)

**Website:** [www.hepccentre.org.uk](http://www.hepccentre.org.uk)

# Hepatitis C

## Essential information for professionals and guidance on testing

### Children's Liver Disease Foundation

This organisation specialises in supporting children with liver disease.

36 Great Charles Street  
Birmingham B3 3YJ

Tel: 0121 212 3839

E-mail: [info@childliverdisease.org](mailto:info@childliverdisease.org)

Website: [www.childliverdisease.org](http://www.childliverdisease.org)

### Haemophilia Society

This organisation provides information and support for people living with or affected by haemophilia who are concerned about hepatitis C.

Chesterfield House, 385 Euston Road  
London NW1 3AU

Tel: 0800 018 6068

E-mail: [info@haemophilia.org.uk](mailto:info@haemophilia.org.uk)

Website: [www.haemophilia.org.uk](http://www.haemophilia.org.uk)

### Department of Health Substance Misuse Website

This website contains substance misuse guidance and resources for professionals and managers involved in preventing and treating drug misuse. May also be of interest to members of the public whose lives are affected by drugs. *'Hepatitis C – guidance for those working with drug users'* (published 2001), may be of particular interest, and can be downloaded from the website.

**Website:**

[www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SubstanceMisuse/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SubstanceMisuse/fs/en)

### Department of Health Sexual Health Website

This website contains general information about sexual health, FAQs and links to publications and other relevant websites.

**Website:**

[www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/fs/en)

### Playing Safely Website

Playingsafely.co.uk is the NHS guide to the symptoms, treatment and prevention of sexually transmitted infections (STI) and diseases (STD) including chlamydia, genital warts, herpes, syphilis and gonorrhoea. Details of sexual health/genito-urinary medicine (GUM) clinics can also be found on the website.

**Website:** [www.playingsafely.co.uk/](http://www.playingsafely.co.uk/)

### Talk to FRANK

Provides confidential information and advice to drug users and anyone concerned about drugs.

Tel: 0800 77 66 00

### Sexual Health Line

Tel: 0800 567123

### Drinkline

Provides free and confidential information and advice to anyone concerned about their own or someone else's drinking. They can put you in touch with local alcohol treatment agencies where help is available on a one-to-one basis.

Tel: 0800 917 8282

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