

The Treatment of Hepatitis C: Emerging Evidence of the Need for Change

Hepatitis C viral infection is a serious global health problem. As this issue's lead article on hepatitis C explains, an estimated four million Americans (1 in 65) are infected — only one-half million of whom have been diagnosed. The global picture is higher with 170 million affected worldwide. While the prevalence of hepatitis C in the United States is only 1.8 percent, rates in African, Asian, and Indonesian countries are significantly higher; for example, 17 percent in Rwanda, 18 percent in Egypt, 5.6 percent in Thailand, and 6.1 percent in Vietnam. Prevalence rates among incarcerated populations are also very high - 25 percent in Hindelbank prison in Switzerland, for example. The spread of the virus through blood transfusions, intravenous drug use, and the medical use of infected blood products in the 60s and 70s is only now becoming apparent, revealing the effects of a viral disease that has a latency period of 20-30 years. Hepatitis C infection is now the leading cause of liver transplants and is responsible for 8-10 thousand deaths per year in the United States. This figure, expected to triple in the next ten years, will generate mortality figures which will rival HIV.

Because hepatitis C is a silent disease, it may not be diagnosed until significant hepatic fibrosis has occurred and treatment for cirrhosis or hepatocellular carcinoma is necessary. The current standard of care for hepatitis C is combination therapy: ribavirin, a nucleoside analogue that has no apparent antiviral activity in hepatitis C, and interferon, a drug that is only 15 percent effective when used alone. The efficacy of both medications used together is significantly improved, but the side-effect profile is disconcerting: hemolytic anemia, constant fatigue, suicidal ideation, and severe depression.

The current protocols are costly and not available to everyone. Pregnant women (ribavirin is a teratogen and pregnancy is not advised until six months after the therapy is finished) and those with a history of significant depression are not eligible. Since HIV+ individuals have been excluded from the Rebetron (a drug which combines interferon with ribavirin) trials, the effect of these drugs in HIV+ populations and their interactions with HIV antiviral combination protocols is still largely unknown.

Botanicals have been used by the majority of the world's population to treat acute and chronic hepatitis for decades. The evidence of lowered viral loads and improved liver histology with botanical extracts such as glycyrrhizin, catechin, and silymarin begs the question: Are costly pharmaceuticals with high side-effect profiles the only areas that deserve the attention of federal research agencies? Might the mechanism of ribavirin be duplicated by plant substances like phyosterols without the toxicity and the cost? These and other questions may be asked and possibly answered in August at the National Institutes of Health's conference: Complementary and Alternative Medicine in Chronic Liver Disease. The need to seriously consider the benefits and, in some cases, necessities of alternative medicine has never been stronger or more urgent. Hepatitis C may be the test case for governmental acceptance of alternative medicine in the United States. This country cannot afford, and the global economy cannot bear, the economic burden of treating up to 170 million people with a drug such as Rebetron which costs \$2,000 per month, for 6-12 months of treatment, and will require extensive support systems to prevent discontinuation of treatment due to intolerable side-effects.

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