

Triangular Clinics: The Way of The Future

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Hepatitis C is not just a blood-borne disease, but a global threat, socially and economically. Every year, thousands of articles are written on this subject emphasizing the importance of urgent global efforts in reducing its incidence. World Health Organization (WHO) estimations suggest that up to 3% of the world's population (170 million) have been infected with HCV⁽¹⁾. About 85 percent of people with acute hepatitis C develop a chronic infection, an insidious disease whose barely discernible symptoms can mask progressive injury to liver cells over 2 to 4 decades. It is now the leading cause of liver cancer and results in more liver transplants than any other disease⁽²⁾.

Furthermore, injecting drug use (IDU) has been found the most common cause of HCV infection. IDUs contract hepatitis C by sharing contaminated needles and other drug injection paraphernalia. One recent study found that 64.7 percent of IDUs who had been injecting for 1 year or less were already infected with the virus. Overall prevalence of HCV was 76.5 percent among IDUs who had been injecting drugs for 6 years or less⁽²⁾.

Recently, HCV infection has drawn great attention due to similar risk factors and coinfectivity with human immunodeficiency virus (HIV) infection⁽¹⁾. Hepatitis C, HIV/AIDS, and hepatitis B share common risk factors for infection. IDUs have a high prevalence of co-infection with the viruses that cause these diseases. That is why it is important to test IDUs for all three viruses⁽²⁾.

About one quarter of HIV-infected persons in the United States are also infected with HCV⁽³⁾. HIV-HCV coinfection has been associated with higher titers of HCV, more rapid progression to HCV-

related liver disease, and an increased risk for HCV-related cirrhosis of the liver. Because of this, HCV infection has been viewed as an opportunistic infection in HIV-infected persons and was included in the 1999 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus. It is not, however, considered an AIDS-defining illness. As highly active antiretroviral therapy (HAART) and prophylaxis of opportunistic infections increase the life span of persons living with HIV, HCV-related liver disease has become a major cause of hospital admissions and deaths among HIV-infected persons⁽³⁾. Nonetheless, the effects of HCV coinfection on HIV disease progression are less certain. Chronic HCV infection seems to accelerate the course of HIV disease, resulting in a more rapid clinical and immunological progression⁽⁴⁾. However, the subject remains controversial. Since coinfecting patients are living longer on HAART, more data are needed to determine if HCV infection influences the long-term natural history of HIV infection⁽³⁾.

Generally speaking, it seems that the whole population prevalence of HCV infection is less than 1% in Iran, which is lower than that of other countries in the region⁽¹⁾. Islamic Republic of Iran borders Afghanistan, the major producer and distributor of illicit drugs. The fact that between 1,200,000 and 2,000,000 people are addicted in Iran and that roughly 280,000 are IDUs poses the extra risk of acquiring HCV/HIV. Although HIV prevalence is low (<0.1% of the adult population), with an estimated 20,000 people infected, the potential for rapid spread in the near future driven by injecting drug abuse is very high. Prison settings

are conducive to the sharing of contaminated needles and syringes, and many HIV (and HCV) infections have been reported from prison settings. The Rapid Situation Assessment (Razzaghi et al., 1999) and other reports indicate that sharing is not uncommon among IDUs. Given that there could be 1,200,000 to 2,000,000 IDUs in the country, a quarter of whom will have injected at least once, the potential for HIV transmission amongst and from them is very high⁽⁵⁾.

Having all the aforementioned facts in one hand and the fact that different approaches to control addiction had already failed on the other created the incentive to try something totally different. The Triangular Clinics, chosen the best practice for prevention and care for IDUs, started in Kermanshah in 2000, as a pilot study. The concept of the Triangular Clinic is to tackle three important issues: addressing IDUs through a harm reduction approach; the treatment of STDs; and care and support for People Living With HIV/AIDS (PLWHA). The problems of drug dependence, STDs and HIV are all behavioral in nature and hence the Clinic is a center for the treatment of behavioral diseases. By grouping the three together, it is possible to organize a comprehensive and integrated service to the patients⁽⁵⁾.

Such clinics deliver many services, integrating both prevention and care, as seen in figure 1. Services are provided by dedicated staff for drug

abusers, people seeking voluntary HIV counseling and testing, PLWHA and their family members, high risk populations, patients with STDs and people exposed to potentially contaminated body fluids (Fig. 1).

Harm reduction, as the core activity of Triangular Clinics, serves the infected ones well while other supportive services help healthy but at-risk population prevent the spread of HIV, HCV and other related ailments. We hope the already-in-place program of harm reduction gets national to cover all high risk populations including IDUs in and out of prison.

References

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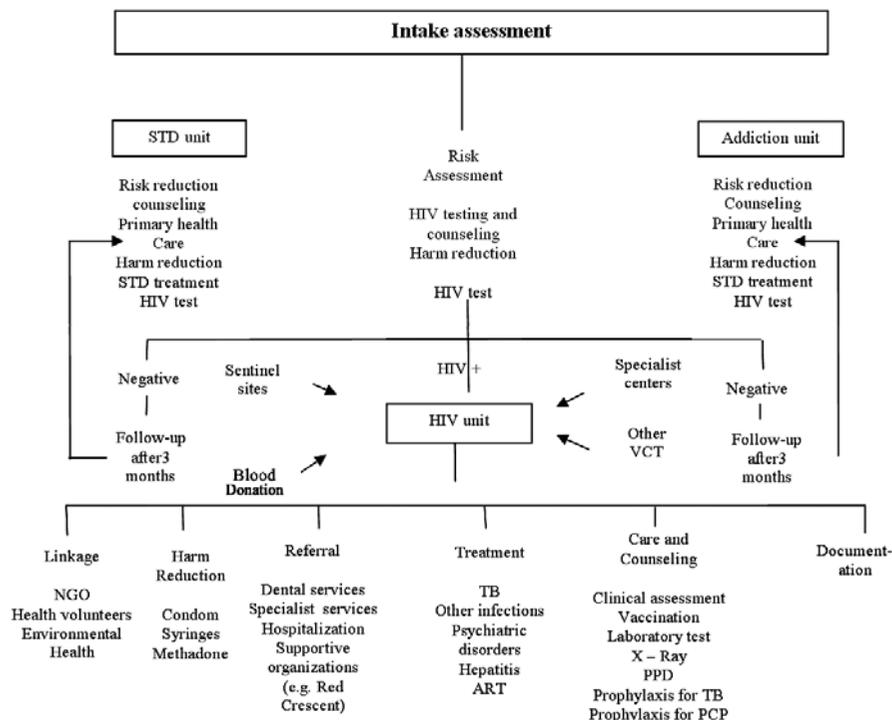


Fig 1. Triangular Clinics Services