



C-Gen 4 Hepatitis C

Maternal Hepatitis C virus (HCV) carriers in the community pose a small risk of HCV transmission to the newborn (5%) and a risk of parenteral HCV transmission to medical and para-medical staff exposed to maternal body fluids, especially blood. The incidence of HCV carriage in women of childbearing age is estimated to be 1-2% but may be as high as 80% in high risk behaviour groups such as injecting drug users and blood product dependent patients (the mean risk of transmission from a needle stick injury is 1.8%, range 0-10%). HIV co-infection is associated with a two-threefold increase in risk of neonatal transmission.

As a consequence, it is the opinion of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) that:

1. All medical and para-medical personnel who are parenterally exposed to the blood or other body fluids of HCV carriers should be screened and followed as part of standard occupational health procedures.
2. All pregnant women should be screened for the presence of antibody to HCV. The standard screening test is an anti-HCV enzyme immunoassay (EIA or ELISA), which must be confirmed by a second antibody test. It may take 3-6 months from the time of infection until antibodies are detected.

It is recommended that individuals who are HCV positive have PCR test for HCV RNA and liver function tests. The PCR detects the presence or absence of the virus in the blood, the viral load in the blood and the genotype. Liver function tests may be repeated every trimester.

The risk of perinatal transmission is dependant upon the presence of HCV RNA and whether there is a HIV co-infection. If the RNA is negative, the risk is negligible; if the RNA is positive, the risk is 6% and if both the RNA is positive and HIV co infection exists, the risk is 9-45%

3. Caesarean delivery has not been shown to reduce the transmission from mother to infant. Apart from standard precautions, there are no special measures advised to protect staff caring for a HCV positive patient.
4. Avoid fetal scalp electrodes and fetal scalp blood sampling. These procedures may increase the risk of neonatal infection.
5. Bath the baby to remove any maternal body secretions and blood prior to IM injections eg. Konakion.

6. HCV infection is not a contraindication to breastfeeding except in the presence of cracked or bleeding nipples. In this instance, expression and discarding of the milk is advised whilst waiting for healing of the cracked nipple.
7. All infants of HCV positive mothers should be screened between 12 and 18 months of age to determine whether they have been infected. (Screen by antibody and, if positive, test for HCV RNA by PCR)
8. Post natal management should be implemented and consider referral to a hepatology clinic when test indicate abnormal liver function.

References

NHMRC The Australian Immunisation Handbook, 8th Edition, 2003.

<http://www9.health.gov.au/immhandbook/>

Australasian Society for Infectious Diseases 'Management of Perinatal Infections' 2003.

<http://www.racp.edu.au/asid/resources.htm>

Hardikar W, Elliott EJ, Jones CA. The silent infection: should we be testing for perinatal hepatitis C and if so, how? Med.J.Aust. 2006;184:54-5.

Links to other related College Statements

[C-Gen 2 Guidelines for consent and the provision of information regarding proposed treatment](#)

[C-Obs 3 Antenatal screening tests](#)

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