



COMMENTARY

HCV Infection in Pediatric Population A Current Brief Synopsis

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Pediatric hepatitis C virus (HCV) infection represents a major health problem that has a prevalence ranging from 0.05%-0.36% in the United States and Europe to 1.8%-5.8% in certain developing countries [1]. Pediatric dialysis patients are at high risk of HCV infection with a proportional relationship with the transfusion number as well as dialysis time and cross contamination within dialysis units was considered a very important factor [2, 3]. In children, HCV infection tends to be asymptomatic with normal or near-normal alanine aminotransferase levels. Children younger than three years should not be treated as there's a possibility for spontaneous resolution during the first few years of life in infants born to HCV-infected mothers, yet if the infection persists, the frequency of development of fibrosis is similar to that in adult population [4, 5]. As disease progression is slow, severe disease is rare, and interferon based therapy has an efficacy of only little more than 50% with significant adverse effects have been reported in up to 52% of those treated, thus a conservative approach has generally been adopted and treatment of children aged 3 to 11 years with chronic HCV was advised to be deferred until interferon-free regimens are available [1, 5]. In 2017, the European Medicines Agency and the Food and Drug Administration approved the use of the fixed-dose combination of ledipasvir/sofosbuvir and of the combination of sofosbuvir and ribavirin for treatment of adolescents (12–17 years or weighing >35 kg) with chronic hepatitis C virus [6].

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