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ORIGINAL ARTICLE

Hepatitis C and 2025: Our Observation

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ABSTRACT

Background: Hepatitis C virus (HCV) remains an important cause of chronic liver disease, cirrhosis and hepatocellular carcinoma (HCC). Hospital-based data describing the clinical spectrum, routes of case detection and reported exposure histories of HCV seropositive adults in northern Bangladesh remain limited.

Materials and Methods: This hospital-based descriptive cross-sectional study was conducted among adult patients attending the outpatient and inpatient services of the Department of Hepatology, Shaheed Ziaur Rahman Medical College Hospital, Bogura, from 1 January to 31 December 2025. Sixty-five adults with reactive anti-HCV by ELISA were included by consecutive sampling. Sociodemographic characteristics, reason for HCV testing, recorded diagnosis, selected exposure histories, SGPT, Child-Pugh class and BCLC stage where applicable were analyzed. Categorical data were expressed as frequency and percentage; age as mean±SD, and SGPT as median (IQR).

Results: The mean age was 45.6±12.6 years (Age range 19 to 70 year); 53.8% (35) were female, 29 44.6% (29) male and one 1.5% (01) third gender. Evaluation of elevated liver enzymes was the commonest reason for testing 36.9% (24). Liver cirrhosis was the most frequent recorded diagnosis 32.3% (21), followed by chronic hepatitis C 26.2% (17) and chronic liver disease (F1-F3) 20.0% (13). Cirrhosis with or without HCC was recorded in 41.5% (27) patients, while one additional patient had HCC without cirrhosis. Blood/blood-product transfusion 72.3% (47) and previous surgery 61.5% (40) were common reported exposure histories. Median SGPT was 120 U/L (IQR 73-165). Among 26 patients in whom Child-Pugh classification was applicable, 73.1% (19) were in class C.

Conclusion: The hospital cohort showed a broad spectrum of HCV associated liver disease, with a substantial proportion presenting Cirrhosis and HCC. Transfusion and previous surgery were frequently reported exposures. Earlier case detection, virological confirmation of current infection and linkage to curative treatment may reduce progression to advanced liver disease.

Keywords: hepatitis C; anti-HCV; cirrhosis; hepatocellular carcinoma; exposure history; Bangladesh.

INTRODUCTION

Hepatitis C virus (HCV) infection is a major cause of chronic liver disease, cirrhosis and hepatocellular carcinoma worldwide. The World Health Organization (WHO) continues to identify viral hepatitis as an important cause of preventable liver-related morbidity and mortality, with major gaps in diagnosis and treatment remaining in low- and middle-income countries[1]. HCV is principally a blood-borne infection. Important routes include unsafe healthcare procedures, transfusion of unscreened blood or blood products, and sharing of injection equipment. A reactive anti-HCV antibody test indicates previous or

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current exposure but does not by itself establish active viremic infection; WHO recommends confirmatory nucleic acid testing for HCV RNA (or an appropriate virological alternative) after a reactive antibody result[2]. The epidemiology of HCV varies considerably across populations. A systematic review of the WHO South-East Asia Region estimated a pooled anti-HCV seroprevalence of 0.84% in low-risk populations, with substantially higher prevalence among maintenance hemodialysis patients and people who inject drugs [3]. Studies from Bangladesh have also demonstrated heterogeneous HCV seroprevalence across community and selected clinical populations, with greater burden in particular risk groups [4–6].

Hospital-based observations cannot estimate community prevalence, but they can describe how patients are detected, the spectrum and severity of liver disease at presentation, and commonly reported exposure histories. This study therefore aimed to describe the sociodemographic profile, indications for HCV testing, recorded clinical spectrum, selected exposure histories, biochemical and liver disease severity profile, and distribution of recorded diagnoses according to age, sex, district and occupation among HCV seropositive adults attending a tertiary hospital in Bogura during 2025.

MATERIAL AND METHODS

Study design, setting and period:

This hospital-based descriptive cross-sectional study was conducted among adult patients attending the outpatient and inpatient services of the Department of Hepatology, Shaheed Ziaur Rahman Medical College Hospital, Bogura, Bangladesh, from 1 January to 31 December 2025.

Study population and sampling:

Adult patients aged 18 years or above with reactive anti-HCV antibody by ELISA who attended the study department during the study period and had the required clinical information were eligible. Patients without anti-HCV seropositivity were excluded. Consecutive sampling was used, and all eligible participants available during the study period were included.

Sample size:

The expected proportion used for sample-size estimation was 20%, based on Spearman et al., who reported that approximately 10-20% of individuals with chronic HCV develop major liver complications, including cirrhosis, liver failure and hepatocellular carcinoma, over 20-30 years[7]. With a 95% confidence level and 10% absolute precision, the minimum required sample was 62. During the study period, 65 eligible anti-HCV-seropositive adults were included.

Data collection and variables:

Data were recorded using the study data-collection form. Variables included age, sex, district of birth, occupation, reason for HCV testing, recorded clinical diagnosis, history of blood/blood-product transfusion, previous surgery, dialysis or kidney-transplant-unit association, injection street-drug needle use, occupational contact with human blood, SGPT, Child-Pugh class and BCLC stage where applicable. Child-Pugh classification was summarized only for patients in whom it was clinically applicable, and BCLC stage only for patients with HCC; BCLC is an established staging framework for hepatocellular carcinoma [8]. Exposure variables are presented as reported histories and were not interpreted as causal risk factors because no anti-HCV-negative comparison group was included.

Statistical analysis:

Data were analyzed using SPSS version 29.0. Categorical variables were summarized as frequency and percentage. Age was presented as mean±SD and median (range), while SGPT was summarized as median and interquartile range (IQR). Recorded clinical diagnosis was described according to age group, sex, district of birth and occupation. Only descriptive analyses were performed.

Ethical considerations:

Ethical approval for the parent viral-hepatitis study was obtained from the Institutional Review Board of Shaheed Ziaur Rahman Medical College, Bogura, Bangladesh (Memorial No. 59.14.1020.135.000.25.0001.25.1364; IRB meeting 30 December 2024; approval letter dated 31 December 2024). The approved protocol specified written informed consent and confidentiality

RESULTS

A total of 65 anti-HCV-seropositive adults were included. Mean age was 45.6±12.6 years and median age was 45 years (range 19-70). The largest recorded age group was 41-50 years 21 (32.3%). Females accounted for 35 (53.8%), males for 29 (44.6%) and one (1.5%) participant was recorded as third gender. Bogura was the most frequent district of birth 36 (55.4%) and housewife was the largest occupational category 29 (44.6%) (Table I).

Table I. Sociodemographic distribution of participants (n=65)

Characteristic	n	%
Age (years)		
Mean±SD,	45.6±12.6	
Median (range)	45 (19–70)	
18 to 30 year	8	12.3
31 to 40 year	15	23.1
41 to 50 year	21	32.3
51 to 60 year	14	21.5
61 to 70 year	7	10.8
Sex		
Female	35	53.8
Male	29	44.6
Third gender	1	1.5
District of birth		
Bogura	36	55.4
Joypurhat	18	27.7
Naogaon	4	6.2
Sirajganj	3	4.6
Natore	2	3.1
Dinajpur	1	1.5
Gaibanda	1	1.5
Occupation		
Housewife	29	44.6
Service (Not related to patient)	10	15.4
Businessman	10	15.4
Farmer	7	10.8
Student	5	7.7
Service (Related to patient)	3	4.6
Foreign garment worker	1	1.5

Evaluation of elevated liver enzymes was the commonest recorded reason for HCV testing 24 (36.9%), followed by evaluation for liver cirrhosis 8 (12.3%), dialysis screening 7 (10.8%) and blood donor screening 6 (9.2%) (Table II).

Table II. Recorded reason for HCV testing (n=65)

Recorded reason for testing	n	%
Evaluation of elevated liver enzymes	24	36.9
Evaluation for liver cirrhosis	8	12.3
During dialysis screening	7	10.8
Blood donor screening	6	9.2
Asymptomatic patient with risk factor	5	7.7
Blood-recipient/thalassaemia-related screening	4	6.2
Preoperative screening	3	4.6
Ascites evaluation	2	3.1
Overseas screening/health check	2	3.1
Asymptomatic patient with risk factor and ascites evaluation	1	1.5
Evaluation of liver SOL	1	1.5
Prenatal screening	1	1.5
Symptoms of acute hepatitis	1	1.5

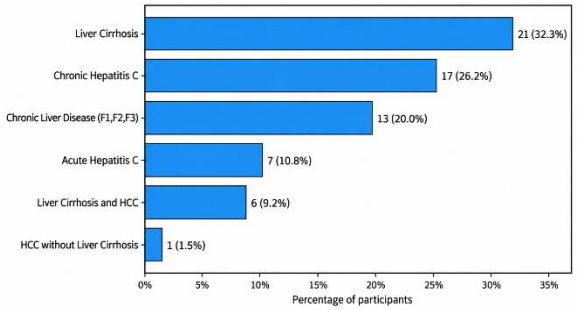


Figure 1. Recorded clinical diagnosis among anti-HCV-seropositive adults (n=65).

Blood/blood-product transfusion was recorded in 47 (72.3%) patients and previous surgery in 40 (61.5%). Seven (10.8%) had an association with a dialysis/kidney-transplant unit, six (9.2%) reported injection street-drug needle use, and three (4.6%) reported medical, dental or other work involving human blood contact (Table IV). These are reported exposure histories and should not be interpreted as causal determinants.

Table IV. Selected recorded exposure histories (n=65)

Recorded exposure/history	n	%
Blood/blood-product transfusion	47	72.3
Previous recorded surgery	40	61.5
Dialysis/kidney transplant unit association	7	10.8
Injection street-drug needle use	6	9.2
Medical/dental/other work involving human blood contact	3	4.6

Median SGPT/ALT was 120 U/L (IQR 73-165). Child-Pugh classification was available for 26 of the 27 patients with cirrhosis; 19 (73.1%) were class C, 6 (23.1%) class B and one (3.8%) class A. BCLC staging was available for all seven HCC cases; 6 (85.7%) were recorded as BCLC D and one (14.3%) as BCLC C (Table V).

Table V. SGPT/ALT and recorded Child-Pugh/BCLC fields

Finding		n/statistics	%
SGPT/ALT (U/L)	Median (IQR)	120 (73-165)	
Child-Pugh classification available (n=26)	Child-Pugh A	1	3.8
	Child-Pugh B	6	23.1
	Child-Pugh C	19	73.1
BCLC staging among HCC cases (n=7)	BCLC C	1	14.3
	BCLC D	6	85.7

Mean age was highest among patients with liver cirrhosis and HCC (56.5±2.1 years) and liver cirrhosis (52.9±10.0 years). Acute hepatitis C occurred only among male participants in this dataset, whereas liver cirrhosis was more frequently recorded among females (Table VI). Figure 2 shows the distribution of diagnoses across the recorded age groups.

Table VI. Age and sex distribution according to recorded clinical diagnosis

Recorded diagnosis	n	Age, mean±SD (years)	Female, n (%)	Male, n (%)	Third gender, n (%)
Acute Hepatitis C	7	45.1±12.7	0 (0.0)	7 (100.0)	0 (0.0)
Chronic Hepatitis C	17	39.9±12.6	9 (52.9)	7 (41.2)	1 (5.9)
Chronic Liver Disease (F1,F2,F3)	13	37.5±10.6	8 (61.5)	5 (38.5)	0 (0.0)
Liver Cirrhosis	21	52.9±10.0	15 (71.4)	6 (28.6)	0 (0.0)
Liver Cirrhosis and HCC	6	56.5±2.1	2 (33.3)	4 (66.7)	0 (0.0)
HCC without Liver Cirrhosis	1	35.0	1 (100.0)	0 (0.0)	0 (0.0)

The distribution of recorded diagnoses varied descriptively across districts of birth. Bogura contributed 36 patients, with liver cirrhosis the largest diagnostic category 12 (33.3%). Joypurhat contributed 18 patients, among whom chronic hepatitis C 8 (44.4%) and liver cirrhosis 7 (38.9%) were the most frequent categories. Small cell counts in the other districts precluded meaningful inferential comparison (Table VII).

Table VII. Recorded clinical diagnosis according to district of birth (n=65)

District of birth	n	Acute Hepatitis C n (%)	Chronic Hepatitis C n (%)	Chronic Liver Disease (F1,F2,F3) n (%)	Liver Cirrhosis n (%)	Liver Cirrhosis and HCC n (%)	HCC without Liver Cirrhosis n (%)
Bogura	36	6 (16.7)	6 (16.7)	8 (22.2)	12 (33.3)	3 (8.3)	1 (2.8)
Joypurhat	18	1 (5.6)	8 (44.4)	1 (5.6)	7 (38.9)	1 (5.6)	0 (0.0)
Naogaon	4	0 (0.0)	0 (0.0)	3 (75.0)	1 (25.0)	0 (0.0)	0 (0.0)
Sirajganj	3	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)
Natore	2	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Dinajpur	1	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)
Gaibanda	1	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)
Total	**65**	**7 (10.8)**	**17 (26.2)**	**13 (20.0)**	**21 (32.3)**	**6 (9.2)**	**1 (1.5)**

Percentages are row percentages.

Occupation-wise distribution also showed descriptive differences. Among housewives (n=29), liver cirrhosis was recorded in 15 (51.7%). Among businessmen (n=10), acute hepatitis C and chronic liver disease (F1,F2,F3) were each recorded in four (40.0%), while among farmers (n=7), chronic hepatitis C was the largest category 3 (42.9%). These patterns are descriptive and should not be interpreted as occupation-related risk estimates (Table VIII).

Table VIII. Recorded clinical diagnosis according to occupation (n=65)

Occupation	n	Acute Hepatitis C n (%)	Chronic Hepatitis C n (%)	Chronic Liver Disease (F1,F2,F3) n (%)	Liver Cirrhosis n (%)	Liver Cirrhosis and HCC n (%)	HCC without Liver Cirrhosis n (%)
Housewife	29	0 (0.0)	6 (20.7)	5 (17.2)	15 (51.7)	2 (6.9)	1 (3.4)
Service (Not related to patient)	10	1 (10.0)	4 (40.0)	1 (10.0)	4 (40.0)	0 (0.0)	0 (0.0)
Businessman	10	4 (40.0)	0 (0.0)	4 (40.0)	0 (0.0)	2 (20.0)	0 (0.0)
Farmer	7	1 (14.3)	3 (42.9)	0 (0.0)	1 (14.3)	2 (28.6)	0 (0.0)
Student	5	1 (20.0)	2 (40.0)	2 (40.0)	0 (0.0)	0 (0.0)	0 (0.0)
Service (Related to patient)	3	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)
Foreign garment worker	1	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Total	**65**	**7 (10.8)**	**17 (26.2)**	**13 (20.0)**	**21 (32.3)**	**6 (9.2)**	**1 (1.5)**

Percentages are row percentages.

DISCUSSION

This one-year hospital-based study describes the clinical and sociodemographic spectrum of 65 anti-HCV-seropositive adults attending a tertiary hepatology service in northern Bangladesh. The cohort was middle-aged overall, with a slight female predominance. Elevated liver enzymes were the most frequent indication for HCV testing, while dialysis and blood-donor screening also contributed to case detection. Liver cirrhosis was the most frequent recorded diagnosis, and HCC was present in 10.8% of patients. These findings reflect the profile of patients who reached a tertiary hospital and should not be interpreted as the prevalence of HCV in the surrounding community. In the WHO South-East Asia Region, pooled anti-HCV seroprevalence has been estimated at below 1% in low-risk populations, while substantially higher rates have been reported among hemodialysis patients and people who inject drugs [3]. Bangladesh-based studies similarly show that HCV occurrence varies according to the population studied, with relatively low seroprevalence in community samples but higher levels in selected clinical and high-risk groups [4–6].

The age distribution across diagnostic categories was clinically relevant. Patients with liver cirrhosis and cirrhosis with HCC were older on average than those recorded with chronic hepatitis C or F1-F3 chronic liver disease. This pattern is consistent with the natural history of chronic HCV, in which fibrosis may progress over many years before cirrhosis or hepatocellular carcinoma becomes clinically evident. Approximately 10-20% of individuals with chronic HCV may develop major liver complications over 20-30 years, although progression varies between individuals [7]. Long-term progression to cirrhosis and HCC is also recognized in international HCV guidance[2].

Blood/blood-product transfusion and previous surgery were the two most frequently recorded exposure histories in this cohort. Unsafe healthcare procedures, inadequately screened transfusion and sharing of injection equipment are recognized routes of blood-borne HCV transmission [2]. However, all participants in the present study were anti-HCV seropositive and no anti-HCV-negative comparison group was included. Therefore, the observed frequencies describe exposure histories only and cannot establish causation or quantify the association of individual exposures with HCV acquisition.

The liver disease severity profile was also notable and likely reflects tertiary-care referral. Among patients for whom Child-Pugh classification was applicable, nearly three-quarters were class C. In a 2025 tertiary-hospital study from Bangladesh, 58% of patients admitted with decompensated chronic liver disease were reported to be Child-Pugh class C, and anti-HCV seropositivity was identified in 17.2% of that population [9]. That study involved a different source population and is therefore not directly comparable with the present cohort, but it provides relevant local

context for the burden of advanced liver disease in hospital practice.

Interpretation of anti-HCV positivity also requires distinction between antibody exposure and active infection. Anti-HCV antibodies can remain detectable after spontaneous viral clearance or successful treatment; therefore, HCV RNA or another validated virological test is required to confirm current infection before treatment decisions are made [2]. Modern direct-acting antiviral regimens can achieve sustained virological response in the great majority of appropriately treated patients, which reinforces the importance of timely confirmation of viraemia and linkage to care[10].

Recent tertiary-care data from Bangladesh suggest that the relative contribution of different aetiologies to the chronic liver disease caseload has changed over time, including changes in the contribution of chronic viral hepatitis [11]. Contemporary hospital-based surveillance and careful characterization of HCV-positive patients therefore remain useful for understanding changing patterns of presentation and for planning diagnostic and treatment services.

A strength of this study is that it provides a one-year, real-world description of consecutive HCV seropositive adults attending both outpatient and inpatient Hepatology services in northern Bangladesh. By integrating sociodemographic characteristics, indications for HCV testing, recorded clinical diagnoses, exposure histories and measures of liver disease severity, the study offers a practical snapshot of contemporary tertiary-care presentation in a setting where recent local HCV data remains limited.

Limitations

This study has several limitations. First, it was conducted at a single tertiary Centre with a relatively small sample, which may limit generalizability and may over-represent patients with more advanced liver disease because of referral patterns. Second, the absence of an anti-HCV-negative comparison group precluded estimation of associations between reported exposures and HCV seropositivity. Third, exposure histories were based on recorded patient information and may be subject to recall or documentation bias. Fourth, several clinical and sociodemographic subgroups contained small numbers, limiting meaningful subgroup analysis. Finally, the descriptive cross-sectional design did not permit assessment of temporal relationships, treatment response or longitudinal disease progression.

CONCLUSION

Among anti-HCV-seropositive adults attending this tertiary hospital during 2025, liver cirrhosis was the most frequent recorded diagnosis, and HCC was present in about one in ten patients. A large proportion of those with applicable Child-Pugh assessment were class C, indicating substantial liver disease severity in the referred cohort. Blood transfusion and previous surgery were commonly reported histories, while screening through dialysis, blood donation and other clinical pathways contributed to case detection. Strengthening timely HCV testing, confirmatory virological assessment and linkage to curative treatment may help reduce late presentation and HCV-related complications in Bangladesh.

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Conflict of interest

The authors declare no conflict of interest.

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