

## Case Report

# Overcoming Medical Challenges for Hepatitis C and HIV Coinfection Treatment in Long-Term People who Inject Drugs: The External Jugular Puncture in Ambulatory Settings

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## Abstract

Chronic hepatitis C virus infection is a global epidemic affecting an estimated 2.35% of the world's population, with high disease burden among people who inject drugs (PWID). In addition, HIV coinfection has a high burden among PWIDs. Current HCV direct acting antiviral agents (DAA) are well tolerated and available in most western countries. However, routine limb venipuncture remains a medical barrier for treatment of HIV/HCV coinfection of long-term PWIDs. In fact, difficult venous access due to poor vascular health consecutive to years of intravenous drug injection is a common constraint. External jugular vein venipuncture is a simple and safe procedure, which can easily be performed in an ambulatory setting in patients with very poor peripheral venous capital. This technique proves useful for blood screening and medical follow-up of polymorbid PWIDs (HIV/HCV coinfection, non-infectious hepatic disorders, cardiovascular diseases, metabolic disorders, etc.)

The technique is used regularly by clinicians in Lausanne's addiction medicine clinic, and this article aims to review the practical aspects of the technique, its' possible complications, and the advantages it can offer long-term PWIDs in view of overcoming medical obstacles to gain access to HIV and new HCV efficient DAA treatments follow-up.

## INTRODUCTION

## Setting the problem

Chronic hepatitis C virus (HCV) infection is a global epidemic affecting an estimated 2.35% of the world's population, representing approximately 180 million infected individuals [1,2]. Overall, 90% of new HCV infections are related to injecting drug use [3-6].

In addition, HIV coinfection has a high burden among PWIDs with about 80% of people with HIV who inject drugs also have HCV [7]. Screening and further treatment of HIV and HCV infections presupposes frequent and large blood collections for evaluation of Direct Antiviral treatment (DAA) efficiency, as well

as monitoring for systemic side-effects of DAA therapy [8].

A good number of licensed rapid tests are currently available for antibody screening of HIV and HCV using capillary blood and saliva, respectively [9]. However, for diagnosis confirmation and viral load measuring we do not dispose of standardized algorithms based on capillary blood draw [10]. Peripheral venous access and limb phlebotomy can be challenging in long-term PWIDs due to poor vascular health as a result of years of intravenous drug injection and related medical complications [11,12]. Furthermore, femoral drug injection is a common practice among PWIDs [13-15].

In this context optional central blood draw from external jugular vein (EJV) is a simple procedure, which can easily be

performed in an ambulatory setting so as to circumvent the difficulty of obtaining large blood specimens in patients with very poor peripheral venous capital [16]. This technique proves useful for medical follow-up of HCV polymorbid PWIDs (HIV, non-infectious hepatic disorders, metabolic disorders, COPD, cardiovascular disease, etc.)

The technique is used regularly by clinicians in Lausanne's center for addiction medicine [17], and this article aims to review the practical aspects of the technique, its' possible complications, and the advantages it can offer long-term PWIDs in view of overcoming medical obstacles to gain access to HIV and new HCV efficient DAA treatments follow-up.

## Suitability of the technique : indications and contraindications to EJV venepuncture

Prior to performing an EJV blood collection, it is crucial to thoroughly assess the patient's peripheral venous capital, and identify any sites suitable for limb venepuncture. Difficult venous access can be established using both patient history (multiple failed attempts at peripheral venepuncture), and clinical examination.

Equally crucial is to assess and address the risk of reviving drug craving in PWID who have previously injected their external jugulars should this site be chosen to draw blood samples.

Check for coagulopathy and platelet level in the patient's record, and if abnormal, exercise precaution so as to minimize the risk of prolonged bleeding.

If no alternate suitability for blood collection from conventional peripheral sites is identified, proceed to bilateral EJV assessment for suitability for venepuncture. If the EJV is not clearly identifiable visually, or if there is the presence of local bruising or trauma to the neck, EJV venepuncture should not be attempted. Prior EJV injectors with important local venous scar tissue should also not undergo this procedure. Profound alterations in clotting or coagulation, or an agitated poorly cooperative patient (possibly under influence of psychoactive substances) are also general (yet relative) contra-indications to performing EJV blood collection.

## Advantages of the technique

Drawing blood samples from central veins as EJV presents no additional pain to the patient [16].

The EJV is a *superficial* vein, with little risk of provoking lesions to profound structures when collecting blood from it - unlike attempts to access the internal jugular which can be complicated by a pneumothorax for example.

The neck is a fairly "clean" site for blood sampling, unlike the groin, and may thus limit the risk of infectious complications related to blood sampling [18].

There is no adjacent artery to the EJV such as there is in the groin, which reduces the risk of arterial puncture and the associated complication of a compressive hematoma [6]. This consideration is especially relevant in patients who may have concurrent coagulopathy or thrombocytopenia as a result of HCV-related liver disease, HCV-treatment, alcohol misuse, etc.

In the case of patients who have particularly difficult peripheral venous access, EJV venepuncture presents an important risk-reduction strategy for blood collectors due to the reduction in the number of venepuncture attempts necessary to collect blood.

The EJV is a superficial vein which presents a relatively large caliber in comparison with peripheral limb veins, and thus the decent EJV blood-flow results in blood samples sufficient in volume for adequate analysis.

## The procedure

**Topographic anatomy:** The external jugular vein is a superficial vein situated on the lateral portion of the neck. It is easily identified visually, and runs obliquely from the angle of the mandible down to the middle of the clavicle. Its' diameter is roughly 5-10mm, but varies widely from one side to the other, between individuals, and seems inversely correlated to the diameter of the internal jugular vein on the ipsilateral side [19] as shown Figure (1).

**Preparation and positioning of the patient:** Clearly explain the procedure to the patient to obtain his informed consent, and reduce any anxiety.

Inform the patient about risks incurred through EJV drug injection, thus limiting the temptation for ulterior use of this venous route of access.

Make sure the patient is fully supine, with the head lying flat. Examine both left and the right neck sides to visually explore both EJVs. A slight Trendelenburg position if the examination table so allows, or asking the patient to perform a Valsalva maneuver can help to better identify the EJV by visualization and palpation (Figure 2a).

**EJV blood collection step-by-step:** Use an adequately equipped area to perform the procedure, so as to ensure patient security and reduce infectious risks.

Wash and/or disinfect hands, and wear gloves.

Ask the patient to lay down supine on his back, and to rotate his head to the side. The patient's head must lay in a relatively neutral position, neither extended nor flexed, as this could mask the EJV. Make sure the patient is in a comfortable position.

Ask the patient to perform a Valsalva manoeuvre so as to distend the EJV (Figure 2a).

If the EJV proves difficult to visually identify, slightly lower the head by elevating the neck by propping the shoulders up with a pillow (Figure 2b).



Figure 1 Topographic anatomy.

Clean the skin superficial to the EJV with cutaneous disinfectant. Allow the skin to dry.

Place a finger on the EJV on its' distal portion towards the clavicle.

Gently introduce the butterfly needle (22 G or 21 G) in the EJV following its direction.

Once the butterfly is introduced in the EJV lumen, reassure the patient by inviting him/her to breathe normally if the Valsalva maneuver is still being performed.

Attach the vacutainer adaptor to the butterfly needle, and collect blood samples as needed.

Withdraw the butterfly needle and apply some pressure to the site of venepuncture during 3-5 minutes to minimize the risk of ulterior bleeding.

Avoid multiple venepuncture attempts to the EJV to preserve the vein from damage, and avoid excessive discomfort to the patient.

**Post-procedural precautions and recommendations:** Help the patient to resume a seated position, and inform the patient of the possibility of feeling slightly dizzy. As for any other venepuncture, a vaso-vagal reaction is possible.

## CONCLUSION

EJV blood sampling is an easily and safely performed bedside technique which can prove useful in the clinical management of patients with poor peripheral venous capital, thus affording them the medical analyses required to treat them optimally.



**Figure 2a** Lateral supine head position.



**Figure 2b** Optional positioning of patient to better visualize EJV.

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