Scope and Objectives
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Chronic HCV is a major cause of liver-related morbidity and mortality. The World Health Organization (WHO) considers HCV an epidemic. Because a patient living with HCV can be infected for decades before being discovered, it is often called the "silent" epidemic. According to the Center for Disease Control (CDC), 20 - 30% of people with chronic HCV will eventually face life-threatening symptoms. In India, where most health-care visits include one or more therapeutic injections, (Vishnu Priya and Lee 2001 & Lakshman and Nichter, 2000) there is great potential for exposure to infected blood. Individuals seeking health care from providers with little or no medical training are at particularly high risk when injections are administered with reused, unsterilized needles and syringes (Anand et al., 2001 & Singh et al., 2000). Among Indian blood donors, the seroprevalence varies from 0.48% in Vellore (Issar et al., 1995) to 1.85% in New Delhi (Panigrahi et al., 1997). Presently, determination of the seroprevalence of HCV in general population is a priority. Community based seroprevalence studies are difficult to conduct in developing countries like India because of socioeconomic hurdles and logistic difficulties.

In rural Maharashtra only one of 1054 apparently healthy persons tested was positive for anti-HCV (Chadha et al., 1999). Pondicherry has a heavy load of migrant population due to tourism and industrial activities. It is an important destination for tourists, labourers and truck drivers. Some of the areas of the city and that of the neighboring state of Tamil Nadu is socio-economically backward where education and access to health information is limited. Safe practices like use of disposable syringes is restricted to privileged sections. Persistent endemic state of HCV infection within a community can be due to medical injections (Sun et al., 2001). A recent survey in the city of Chennai, over two-thirds of the general population reported receiving at least one injection in the past six months averaging four injections per year (Vishnu Priya and Lee, 2001).

Presently, there is no vaccine or other means for preventing hepatitis C infection. The most effective therapy for chronic hepatitis C is combination therapy
with interferon alpha (IFN α) and ribavirin (Kjaergard 2001a). Furthermore, IFN and ribavirin are connected with a plethora of adverse events such as anorexia, nausea, dry skin, and leukopenia and are costly (Kjaergard 2001a). Therefore new medications and approaches to treatment are needed. Complementary therapies are being used increasingly (Eisenberg, 1998 and Vickers, 1998).

Herbs have made a significant contribution to medicine. Herbal practice has been around for centuries and has produced some sound observations. Clearly more information and research needs to be conducted in this area in order to understand better and incorporate the use of botanical products into current health practices.

There are wide range of herbs that can promote liver health. No complementary medicine or alternative medicine has been scientifically proven to cure or even ease symptoms of HCV. Thus most people are turning to herbs for relief. They use herbs either to clear hepatitis itself or to deal with side effects of interferon. Use of herbal drugs in the treatment of liver disease has a long tradition, especially in Eastern medicine. Reducing the incidence of blood-borne infections due to health-care related exposures would be an important step in controlling the spread of HCV infection in developing countries such as India.

The present study aims to explore the prevalence pattern of HCV in the study area depending upon their demographic characters, clinical condition and risk factors which helps in the establishment of awareness on HCV risk among the liver disease patients and general population. The potential use of medicinal plants in curing viral infection has gained new attention world wide. This study also focuses on the paradigm of approach in treating HCV, with an emphasis to search for a new herbal product and exploring them for its antiviral activity. Thus the efficacy of the selected medicinal plants for antiviral activity will pave way as a supportive or an alternative therapy for HCV. Recent anti-HCV treatment algorithms suggest that tailoring antiviral therapy based on HCV genotype (European Association for the Study of the Liver, 1999), hence genotyping of HCV was done.

With available information and scarcity of work done in south Tamil Nadu the study was planned with following objectives,
• To look for the incidence of HCV in liver disease patients in and around Tiruchirappalli
• Genotyping of HCV
• To see the coinfection of other blood borne viruses/silent killer viruses-HBV, Delta agent and HIV
• To assess the Liver Function Tests of the study group
• To study the anti-HCV property of the plants chosen
• To assess the immunomodulatory nature of the plants chosen
• To rule out the toxic nature of the plants chosen
• To assess the hepatoprotective nature of the plants chosen
• To find out the phytoconstituents of the plants chosen