Response from Hepatitis C Trust, BASL, BIA, BVHG, BSG, and BHIVA to article asking whether widespread screening for hepatitis C is justified.
Foster, GR; Gore, C; Hudson, M; Moss, P; Ustianowski, A; Ryder, S; Bhagani, S

For additional information about this publication click this link.
http://qmro.qmul.ac.uk/spui/handle/123456789/7743

Information about this research object was correct at the time of download; we occasionally make corrections to records, please therefore check the published record when citing. For more information contact scholarlycommunications@qmul.ac.uk
Response from Hepatitis C Trust, BASL, BIA, BVHG, BSG, and BHIVA to article asking whether widespread screening for hepatitis C is justified

Graham R Foster professor of hepatology, Queen Mary’s University of London, 1 Charles Gore chief executive, 2 Mark Hudson consultant hepatologist, Freeman Hospital, Newcastle, and president, 3 Peter Moss consultant in infectious diseases, Hull and East Yorkshire Hospitals NHS Trust, and president, 4 Andrew Ustianowski consultant in infectious diseases, North Manchester General Hospital, and president, 5 Stephen Ryder consultant hepatologist, Nottingham University Hospitals NHS Trust, and vice president hepatology, 6 Sanjay Bhagani consultant physician, Royal Free Hospital, and chair. 7

1Queen Mary’s University of London, London E1 4AT, UK; 2Hepatitis C Trust, London, UK; 3BASL (British Association for the Study of the Liver), Lichfield, UK; 4British Infection Association (BIA), Knutsford, UK; 5British Viral Hepatitis Group (BVHG), Lichfield, UK; 6British Society of Gastroenterology (BSG), London, UK; 7BHIVA Hepatitis Society, London, UK

Koretz and colleagues argue that hepatitis C virus (HCV) screening should be delayed. 1 We disagree. HCV transmission was common in the 1960s-80s, and because mortality occurs 30-40 years after infection deaths will rise exponentially over the next decade. 2 Delaying effective intervention will have a massive impact. The authors argue that because a community study showed an increase in liver and non-liver mortality most infected people will not die from HCV. Infection can cause or exacerbate renal disease, diabetes, and dyslipidaemia and treatment reduces all cause mortality, 3 indicating that both liver and non-liver related deaths are caused by HCV and reversed by treatment. Disease outcome is improved by lifestyle changes, but this requires diagnosis. Identification also allows action to reduce transmission, and because chronic infection is associated with treatment reversible neurocognitive dysfunction, the detection of infection has additional benefits. 4

The benefits of viral elimination can be shown by comparing mortality in treated patients who respond to treatment with those who don’t. 5 The authors argue that these benefits are due to “differences in people who respond”—people who respond don’t develop liver disease. If this were true, patients with cirrhosis wouldn’t respond, but many are successfully treated, with disease regressing. 5 The authors compare different studies with different underlying cancer rates and imply that cancer incidence is the same in successfully and unsuccessfully treated patients. This is misleading—comparisons within the same cohorts show reduced liver cancer rates in treated patients. It is not valid to take the highest cancer rate from a treated population and compare it with a selected untreated population with a strikingly low rate of cancer and conclude that treatment has no effect.

Current standard of care for HCV no longer involves interferon but uses oral drugs that eliminate virus in more than 90% of cases. 6 Telaprevir (with many side effects) has been replaced by drugs that are virtually free from side effects—most side effects in the pivotal trials of oral drugs were not drug related. Independent European and US experts have reviewed the data on HCV treatment and screening and conclude that increased testing and screening is the right response. The development of new highly effective drugs gives us an opportunity to eliminate the harm caused by this virus. To delay a process with clear benefit in order to satisfy demands for more data would expose thousands of undiagnosed treatable patients to the risks of cancer and cirrhosis. This must not be regarded as acceptable.

Competing interests: GRF: speaker and consultancy fees from AbbVie, Gilead, BMS, Janssen, and MSD. CG: the Hepatitis C Trust receives support from AbbVie, Janssen, MSD, Roche, and Gilead. MH: advisory boards and speaking commitments for Janssen and Gilead. PM: consultancy and paid speaking engagements for MSD, Gilead, Janssen, AbbVie, and BMS. AU: consultancy and paid speaking engagements for AbbVie and Gilead. SR: advisory boards Gilead, Abbvie, Janssen, g.r.foster@qmul.ac.uk
and MSD. SB: speaker engagements and advisory boards Abbvie, BMS, Gilead, Janssen, and MSD.

Full response at: www.bmj.com/content/350/bmj.g7809/rr-9.

3 Van der Meer AJ. Association between antiviral treatment and extrahepatic outcomes in patients with hepatitis C virus infection. Gut 2015;64:495-503.

Cite this as: BMJ 2015;350:h998
© BMJ Publishing Group Ltd 2015