Identifying those infected with hepatitis C virus

The new recommendations by the Canadian Task Force on Preventive Health Care for screening for hepatitis C virus (HCV) infection[1] strongly advise against screening those without apparent risks. This can only perpetuate Canada's low HCV diagnosis rates, leading to the late diagnosis of liver cancer, decompensated cirrhosis and extrahepatic illnesses.

These recommendations are based on the following assumption: patients are aware of their risks of aquiring HCV, can recall a remote circumstance that may have placed them at risk and would disclose that risk to their doctors. The task force recommendations overestimate the harms of screening but underestimate the benefits of screening and treatment. The task force expresses concern about the costs for one-time testing of an entire birth cohort, the potential for false positives and the potential stigma associated with a diagnosis of HCV. Yet, they did not comment on the obligation to inform people of a potentially fatal but curable disease, nor on the costs of not identifying disease at a treatable stage.

The task force admits that, in their analysis, 40 lives per 100 000 screened would be saved from cancer/cirrhosis (potentially an underestimate); yet, they argue that perhaps only 3 to 6 per 100 000 screened would be lost over 5 to 10 years. We suspect that most Canadians would choose to save 40 lives per 100 000 screened.

It is estimated that HCV infection remains undiagnosed in between 44% and 70% of those with HCV.[2,3] Age-based screening of adults born between 1945 and 1975 could identify about 77% of those living with undiagnosed HCV.[4] Age-based screening is cost-effective based on a reduction in deaths from HCV, and improved quality of life and reduced costs of acute care for those with advanced disease.[5–7] Importantly, the new agents for treatment of HCV have high cure rates with few adverse effects.[8]

Recent negotiations by the Pan-Canadian Pharmaceutical Alliance have reduced treatment costs, making it more affordable from the payer perspective. We note that the guideline states that screening will lead to "inequity," because only those screened who are "wealthier" or with private drug plans would receive treatment earlier in the course of disease. This statement is contrary to the intent of Canada's Health Act, which supports comprehensiveness of medically necessary services and universality of those services.

To reduce the death rate from HCV infection, we have to identify those infected. Risk-based screening alone has only been effective in identifying a small proportion of those affected. Although the screening guideline may encourage physicians to engage in more risk-based screening, they will not have a substantial impact on diagnosis rates, because they will not capture those patients without recognizable or disclosed risk factors and may falsely reassure some patients that screening is not recommended.

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