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Re: Screening for Hepatitis C Virus: A Systematic Review

To Whom it may concern,

I am appreciative of the opportunity to provide feedback on behalf of Action Hepatitis Canada (AHC) on CADTH's *Screening for Hepatitis C Virus: A Systematic Review*.

I will begin my feedback by expressing my concern that the content of this review seems to be moving away from anything that we can hope might lead to the development of relevant Hepatitis C (HCV) screening guidelines for this country.

The AHC was concerned when the introduction section to CADTH's *Project Protocol* provided incomplete information regarding the ground-breaking progress of HCV treatment in recent years. We had hoped that expressing this concern in our February feedback would lead to subsequent CADTH reports in this review including a rounded summary of the current availability of highly effective treatments for HCV. Unfortunately, rather than having a more rounded summary describing the history of HCV treatment, this report has no summary of treatment progress at all.

New HCV treatments boast Sustained Virologic Reponse rates (SVR) of approximately 95% and come with minimal side-effects. Compared to previous treatments, this progress is monumental and changes the dynamic of discussions on all issues relating to HCV from prevention, screening and diagnosis through to discussions surrounding access to treatment and care. A diagnosis of HCV today could mean the provision of treatment leading to the viral clearance in a matter of 2-3 months.

These new treatments have the potential to contribute to the elimination of HCV in Canada. In order to achieve this goal, people need to be made aware of their viral status. The availability of highly effective DAAs should be a key influence in any discussion regarding patients' preferences and values; cost-effectiveness, or frequency of benefit associated with screening.

My second point reflects the absence of acknowledgement in the introduction section of this paper to the elevated infection rates among baby boomers. It is questionable to outline demographic groups who are associated with 'higher than average transmission risk' without similarly pointing to the disproportionate rates of infection among those in Canada born between 1946 and 1965.

As stated in the Public Health Agency of Canada's recent *Report on Hepatitis B and C in Canada: 2012*:

> *An analysis of cohort effects among reported cases of HCV found that those born between 1946 and 1965 contributed more than half of all HCV cases reported between 1991 and 2010 in Canada. While the rate of reported cases in Canada appears to be decreasing, the number of individuals, infected decades ago and now developing sequelae is anticipated to increase over time as individuals advance to more severe stages of disease progression. In addition, undiagnosed cases represent an unknown future burden of illness.*

Expanding on this, those born between 1945 and 1975 represent more than 75% of chronic HCV infections in Canada. It is estimated that at least 100,000 people living with chronic HCV infection are unaware that they are infected.

My last section of feedback is centered on the subjects of cost-effectiveness and patient perspectives. In recent years, Canada has been facing an increase in the rates of people accessing healthcare with advanced cases of HCV infection. Many of these people have been living with the virus for several decades and are now in need of extensive and expensive healthcare due to symptoms related to advanced liver disease including liver failure and liver cancer. Last year, the Canadian Liver Foundation revealed that 30-50% of all liver cancer can be attributed to HCV. Liver cancer is the only cancer for which mortality is increasing in Canada.

The AHC is interested in an examination of harm or cost-effectiveness associated with not screening for HCV. Late diagnosis increases the likelihood of advanced liver disease, liver cancer and need for liver transplantation. It also has the potential to increase costs associated with years of life lost, reduced functioning and health-adjusted life years. In addition to this, evidence has shown us that treatment is less effective when hepatitis C is diagnosed and treated late.

In terms of patient perspectives, I noted with interest that many of the studies referenced in this review took place prior to the advent of DAAs. The AHC would be interested to know what impact the availability and awareness of curative non-injected, short-term treatment, with minimal side effects has on peoples' viewpoints of the potential value of screening and diagnosis for HCV.

In order to thoroughly examine patients' perspectives of screening, we would also be interested in an examination of the viewpoints of people who have (or have had) HCV and were diagnosed later thereby allowing for unnecessary disease progression that might have been avoided had the illness been diagnosed sooner. We suspect that when asked, many of these patients would state that they would have preferred to have known about their status sooner.

It has been our understanding that this series of reviews by CADTH; PHAC and Toronto's Health Economics and Technology Assessment Collaborative is being conducted in order to update our country's Hepatitis C screening guidelines to better address our evolving understanding of the epidemiology of the virus as well as to better leverage the opportunity for viral clearance in those treated. We remain hopeful that when complete, this series of reviews will contribute to the establishment of new screening guidelines that make recommendations leading to the screening and eventual treatment of the estimated 100,000 people unknowingly living with HCV in Canada.

Sincerely,

Patricia Bacon
Chair, Action Hepatitis Canada