Journal Club Discussion of the Provisional USPSTF

HCV Birth Cohort Screening Recommendations

Friday, December 7, 2012

Summary

The U.S. Preventive Services Task Force (USPSTF) recently released provisional recommendations for HCV testing. USPSTF assigned a "B" grade recommendation for HCV testing of persons who inject drugs (PWID) and other persons with identified risks for infection (meaning that USPSTF recommends the service and there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial). This recommendation for risk-based testing is similar to that released by CDC in 1998. USPSTF also issued a recommendation for HCV testing of persons in the 1945-1965 birth cohort, assigning it a "C" grade. With a "C" grade recommendation, the USPSTF states that clinicians may provide this service to selected patients depending on individual circumstances, but for most individuals without signs or symptoms there is likely to be only a small benefit from this service. This recommendation is inconsistent with CDC's birth-cohort testing recommendation issued during August 2012, which calls for one-time testing for HCV without prior ascertainment of HCV risk for all adults born during 1945-1965. The USPSTF HCV testing recommendations are not considered final until the public has had a chance to provide input; USPSTF is soliciting comments through December 24, 2012.

This phone-based Journal Club discussion focused on highlighting areas of the USPSTF HCV testing recommendations in need of harmonization and those requiring additional clarification and/or research. The following bulleted statements represent comments made by participants during the December 7th call.

Modifications Needed to Harmonize CDC and USPSTF HCV Testing Recommendations for the Birth Cohort

- The rationale used by USPSTF in assigning a Grade C is unclear. Further, it does not acknowledge that most people living with HCV in the United States are unaware of their infection status.
- Recommendations did not acknowledge the effectiveness of non-treatment-related interventions recommended by CDC, such as counseling and alcohol use screening. Yet, the Task Force already recommends counseling for other conditions. Further explanation from USPSTF is needed to understand why this recommendation does not pertain to HCV-infected persons.

- USPSTF recommendations did not take into account cost-effectiveness; however, they are making recommendations based on prevalence, implying the importance of cost-effectiveness in recommending an intervention.
- The USPSTF rationale overlooks the comparison of HCV prevalence between the birth cohort and the general population. Rather, it focuses on comparing persons in the birth cohort to those at high risk, which is an inappropriate comparison.
- More information is needed on the methodology used to develop the USPSTF Grade C recommendation for HCV testing of the birth cohort.
- The recommendations failed to address people's "right to know" whether they are infected with HCV.
- The USPSTF recommendation does not mention the stigma associated with revealing risk factors or the challenges inherent in taking a risk-based approach to screening. With this approach, patients are required to admit to socially undesirable behaviors before they can receive preventive services. Many providers and patients are hesitant to engage in the discussions needed to determine level of HCV risk. No analyses were conducted to reveal the harms associated with not implementing the birth cohort recommendations.
- Electronic medical record prompts could be more easily incorporated into birth cohort approaches than risk-based approaches.
- USPSTF acknowledges SVR as a useful marker for treatment success and predictor of clinical outcome; however, they are hesitant to associated screening with SVR. Screening is a necessary first step in identifying infected persons and linking them to care and treatment as appropriate.
- The risk groups included in the USPSTF's recommendations have a similar HCV prevalence as the birth cohort.

Strength of the Evidence used by USPSTF

- Ideally, data from a long-term study examining the effects of screening vs. not screening would be available to help inform the USPSTF recommendations. However, in the absence of these data, retrospective data may be helpful.
- In one retrospective study of HBV-infected patients with hepatocellular carcinoma, 30% were not screening for HBV prior to HCC diagnosis; yet, having been screened and being identified as having HBV infection increased the rate of survival for these patients. Perhaps a similar study of HCV patients would be useful to the Task Force.

Type of Evidence Needed to Upgrade Recommendation from a "GRADE C" to a "GRADE B"

- Retrospective data from the VA study and a recent paper by CDC's Rebecca Morgan should be considered by USPSTF.
- All evidence, including peer-reviewed papers, abstracts, and unpublished data, should be provided to the Task Force for review.
- USPSTF should be informed about a new paper that used modeling to determine the effectiveness of identifying HCV-infected people using a risk-based approach. Data from this paper reveal that using this approach, approximately 500,000 people will be missed, almost all of

whom are in the birth cohort. Risk-based approaches are more effective in younger and older age cohorts.

- CDC's Viral Hepatitis Surveillance report for 2007 indicates that acute HCV infection cannot be identified for many cases because the case reports are either missing risk information; further, data from NHANES reveal that almost 50% of HCV-infected persons do not report a risk. These numbers are likely higher for chronic HCV infection.

Additional Comments:

- It would be useful to have one central repository where all USPSTF recommendation response activities are documented. NVHR has volunteered to maintain such a list of activities on its website; such information should be provided to NVHR via e-mail. This repository will not be used to communicate with the USPSTF; rather, it will serve to keep partners in viral hepatitis prevention informed about the types of response activities that are underway.