

Correspondence

The Forgotten Component in the Staging and Management of HIV/Hepatitis C Virus–Coinfected Patients

TO THE EDITOR—I read with great interest the recent article by Dr Martel-Laferrère and collaborators [1]. The study emphasized important messages for human immunodeficiency virus (HIV) and infectious diseases physicians who are increasingly treating hepatitis C virus (HCV) among HIV-infected patients [2]: promptly recognize cirrhosis, regularly screen for cirrhosis-related complications, avoid potential medical interactions, educate your patients regarding toxins or habits that may contribute to further liver damage, and consider referral of your HIV/HCV-coinfected patients for liver transplant evaluation when indicated.

However, an essential part of managing HIV/HCV-coinfected patients is identifying ongoing barriers to care. Our HIV/HCV-coinfected patients have a high prevalence of poverty, drug abuse, unstable housing, and neuropsychiatric diseases that affect their overall engagement in care [2]. They often have low health literacy, feel marginalized, and are uninsured [3]. Not surprisingly, only 5%–7% of HIV/HCV-coinfected patients are cured of HCV in the United States and Europe [4–6]. At the Owen Clinic at the University of California, San Diego, approximately 12% of our patients who attend an initial clinic visit for HCV treatment do not return for HCV care [7]. Furthermore, the main reason for not

initiating HCV therapy among those who completed HCV clinical staging is ongoing barriers to care [7]. Therefore, we teach medical students, residents, and infectious diseases fellows that complete staging and management of HCV in an HIV-infected patient requires 4 components: (1) assessment of HIV control and medical interactions; (2) liver staging status and prevention of cirrhosis-related complications; (3) addressing concurrent medical comorbidities; and (4) ascertainment of ongoing barriers to care.

I believe that the routine medical evaluation of any HIV/HCV-coinfected patient must include the assessment of potential ongoing barriers to care, which ultimately can preclude successful initiation and completion of HCV therapy in the forthcoming highly effective interferon-free era.

Notes

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