

LETTER FROM THE EDITOR



Just as this issue of *Gastroenterology & Hepatology* was being prepared for publication, the Centers for Disease Control and Prevention announced a major change to their hepatitis C virus (HCV) screening recommendations: In addition to risk-based screening, one-time testing for HCV is now recommended for anyone born between 1945 and 1965 (www.cdc.gov/nchstp/newsroom/HepTestingRecsPressRelease2012.html). This age group was selected for universal screening because individuals in this group—the “baby boomers”—are 5 times more likely to be HCV-infected than those in other age groups. Among baby boomers, the rate of HCV infection is 1 in 30, but the majority of infected individuals remain undiagnosed.

By significantly increasing the number of people who are tested for HCV, this new screening strategy will hopefully allow more patients with HCV infection to be identified. Under the previous screening recommendations, individuals were only tested for HCV if they were in a high-risk group—such as intravenous drug users or those who had blood transfusions prior to the mid-1980s—but many at-risk individuals were never identified and thus never tested. As Paul Y. Kwo discusses in this month’s *Advances in Hepatology* column on page 398, some high-risk individuals may not remember engaging in risky behavior many years before, or they may not realize such behavior increased their chances of becoming infected with HCV. Because such individuals can “fall through the cracks” of a risk-based screening strategy, estimates suggest that at least half of HCV-infected individuals remain undiagnosed.

Screening all baby boomers will eliminate the need for risk assessment, which should widen the pool of individuals who are offered HCV testing; however, other barriers to testing remain and will need to be addressed. As Kwo discusses, HCV screening needs to be firmly linked to treatment: All individuals who are tested for HCV need to know that therapy is available, and HCV-infected individuals need to be evaluated for treatment after they are diagnosed. Also, access to healthcare is necessary in order for individuals to be offered HCV testing, even under

a birth-cohort screening strategy, so barriers to care will continue to hamper the implementation of any screening program.

With more widespread testing and earlier diagnosis of infected individuals, patients will hopefully be able to avoid many of the negative consequences of HCV infection, including cirrhosis, decompensated liver disease, and need for liver transplantation. Earlier diagnosis and therapy are particularly beneficial in the current era of HCV treatment, as protease inhibitor-based therapy allows up to 75% of patients to achieve sustained virologic response, sometimes with only 24–28 weeks of therapy. Indeed, as HCV therapy continues to improve, effective screening programs will become even more important.

Moving on to this month’s issue of *Gastroenterology & Hepatology*, I invite you to read more about HCV screening in the column by Kwo, and I also encourage you to explore the topics covered in this month’s other columns, including gastroesophageal reflux disease and asthma, techniques for performing endoscopic retrograde cholangiopancreatography in Roux-en-Y gastric bypass patients, and parenteral nutrition in patients with inflammatory bowel disease. In addition, this month’s feature articles address 2 topics that will be of particular interest to gastroenterologists and endoscopists—drug interactions and natural orifice transluminal endoscopic surgery (NOTES)—and our case studies present a life-threatening variceal hemorrhage in a woman with severe pulmonary arterial hypertension, as well as a small series of patients with esophageal injury following radiofrequency ablation for atrial fibrillation.

Sincerely,

A handwritten signature in black ink that reads "Gary R. Lichtenstein". The signature is written in a cursive, flowing style.

Gary R. Lichtenstein, MD, AGAF, FACP, FAGC