LETTER FROM THE EDITOR

Recently, I saw a sign stating that only 1 in 4 people infected with hepatitis C virus (HCV) know that they are infected. This advertisement encouraged readers to get tested for HCV. Given the large number of undiagnosed HCV-positive individuals and the availability of new, more effective therapies, increasing public awareness about HCV testing is an important step in reducing HCV infection rates and preventing the sequelae of chronic HCV infection.

According to the Centers for Disease Control and Prevention, HCV testing is recommended for a number of at-risk groups. For example, patients should be tested if they have ever injected illegal drugs; if they received a clotting factor transfusion prior to 1987; if they received a blood transfusion or organ transplantation prior to July 1992; or if they have signs or symptoms of liver disease. (For more information on screening criteria, go to http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm#section3.) While such risk-based screening can effectively target individuals who are more likely to be HCV-positive, this strategy has several limitations. Patients may be hesitant to confess to illegal drug use, they may not remember that they received a blood transfusion over 20 years ago, or they may have early-stage infection that is not yet causing symptoms. Thus, risk-based screening may cause a significant percentage of infections to be missed.

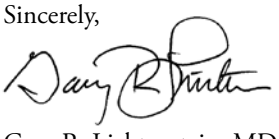
Birth-cohort screening has been suggested as an alternative screening strategy. As described by Lisa McGarry during a presentation at Digestive Disease Week 2011, birth-cohort screening would involve testing all adults born during a certain period [Abstract 477: The Impact of Birth-Cohort Screening for Hepatitis C Virus (HCV) Compared With Current Risk-Based Screening on Lifetime Incidence of and Mortality From Advanced Liver Disease (AdvLD) in the United States (U.S.)]. Specifically, the Markov model developed by McGarry and colleagues assessed the impact of testing all individuals born between 1946 and 1970, as individuals in this age group have a particularly high rate of HCV infection (http://www.medscape.com/viewarticle/742322). When compared to risk-based screening, this birth-cohort screening strategy would result in more individuals being tested, more individuals being diagnosed with HCV, and more individuals being treated. While the need for additional testing would increase overall costs, McGarry and colleagues estimated that birth-cohort screening would reduce costs associated with advanced liver disease, as well as reduce HCV-associated morbidity and mortality.

While birth-cohort screening is not yet recommended, the results of this study confirm that additional screening could be beneficial. By testing more individuals, we can diagnose and treat more cases of HCV, and in many cases, we can cure patients of this disease. With the addition of protease inhibitors to peginterferon and ribavirin therapy, rates of sustained virologic response (SVR) are now approaching 75% in patients with genotype 1 HCV infection, and patients with genotype 2 or 3 HCV infection show similar or higher SVR rates when treated with peginterferon and ribavirin alone. Thus, we are no longer faced with an incurable disease for which a diagnosis has limited value. Instead, diagnosis can often lead to treatment and cure.

For clinicians, the presence of advertisements about HCV testing can serve as a reminder that we need to remain vigilant in identifying individuals who meet existing screening criteria. In addition to ordering an HCV test for patients who present with signs or symptoms of liver disease, we may also need to question asymptomatic patients about risk factors and offer testing as appropriate.

Moving on to other topics, this issue of *Gastroenterology & Hepatology* offers several interesting articles. Our features this month include a review of serogenomics in ulcerative colitis and a discussion of bloating, and our 2 case studies describe a patient with rheumatoid arthritis in whom etanercept was used to enable clearance of HCV and a cardiac transplant recipient who developed a fatal *Strongyloides* infection. This month's columns address the diagnosis of eosinophilic esophagitis, treatment of *Clostridium difficile* infection in immunosuppressed patients, endoscopic approaches to nutritional support, and the underdiagnosis of hepatitis E virus infection. As always, I hope you find these articles useful and informative.

Sincerely,



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