By Samantha Alleman

Sofosbuvir/Velpatasvir With or Without Ribavirin Effective for HCV in Patients With Any Genotype and Decompensated Cirrhosis

The combination of sofosbuvir/velpatasvir (Gilead) with or without ribavirin for 12 weeks and sofosbuvir/velpatasvir for 24 weeks produced high rates of sustained virologic response (SVR) in both previously treated and untreated patients with chronic hepatitis C virus (HCV) of any genotype and with decompensated cirrhosis, according to a phase 3, multicenter, open-label study. To date, no treatment regimen can be used for all HCV genotypes in patients with decompensated liver disease. The number of patients with decompensated cirrhosis is expected to grow as the population of patients with HCV ages.

For the study, which was released online on November 16, 2015 ahead of print publication in *The New England Journal of Medicine*, Dr Michael P. Curry and colleagues enrolled 267 patients infected with HCV genotypes 1 through 6 who had decompensated cirrhosis (defined as Child-Pugh-Turcotte class B). Of these, 207 patients (78%) had genotype 1, 12 patients (4%) had genotype 2, 39 patients (15%) had genotype 3, 8 patients (3%) had genotype 4, and 1 patient (<1%) had genotype 6; no patient had genotype 5. The patients were randomly assigned to 3 arms: sofosbuvir/velpatasvir alone for 12 weeks, sofosbuvir/velpatasvir with ribavirin for 12 weeks, or sofosbuvir/velpatasvir for 24 weeks.

At 12 weeks after the end of treatment, SVR was achieved by 83% and 94% of patients receiving sofosbuvir/velpatasvir alone or with ribavirin, respectively. Among patients receiving 24 weeks of sofosbuvir/velpatasvir, SVR was achieved by 86%. Response rates were similar among the 3 groups.

A total of 9 patients experienced adverse events that led to early discontinuation of treatment. Nine patients died, primarily owing to complications of end-stage liver disease.

The authors concluded that the combination of sofosbuvir/velpatasvir with or without ribavirin for 12 weeks and sofosbuvir/velpatasvir for 24 weeks is effective in patients with HCV of all genotypes and decompensated cirrhosis. However, they noted that more trials are needed to determine long-term clinical benefits and to evaluate patients with more advanced liver decompensation.

American College of Gastroenterology Updates Barrett Esophagus Guideline

The American College of Gastroenterology updated its guideline on the diagnosis and management of Barrett esophagus (BE) to recommend that routine screening be limited to men with gastroesophageal reflux symptoms and other risk factors, among other revisions. The screening of high-risk patients for BE continues to be endorsed.

According to Dr Nicholas J. Shaheen and colleagues, the new guideline, which was released online on November 3, 2015 ahead of print publication in *The American Journal of Gastroenterology*, is intended to provide an update of the definition and epidemiology of BE, as well as to review screening modalities, surveillance methods, and treatment approaches. The authors used the Grading of Recommendations Assessment, Development, and Evaluation system to determine the level of evidence and the strength of their recommendations.

According to the updated guideline, the use of endoscopic ablative therapy is no longer recommended in patients with nondysplastic BE owing to the complications and costs associated with this procedure as well as the low rates of progression of this type of BE to esophageal adenocarcinoma (EAC). However, endoscopic ablative therapy is preferred in patients with confirmed low- and high-grade dysplasia, as this treatment modality has been shown to significantly reduce progression to EAC both statistically and clinically.

The new guideline recommends endoscopic surveillance as an alternative treatment modality in patients with low-grade dysplasia, and surveillance intervals have been reduced in patients with nondysplastic BE. Because recent data have reported a low risk of malignant progression in this population, endoscopic surveillance should be performed no more than every 3 to 5 years.

The authors caution that these recommendations should not be considered to be practice standards or quality measures. They also note that the evolution of biomarkers, use of advanced imaging technologies, and development of less invasive and less costly screening modalities are likely to cause marked changes in subsequent updates. The authors also state that clinical circumstances should determine the best care for individual patients.

In Brief

A study reported that the risk stratification score AIMS65 proved superior to the Glasgow-Blatchford score and the pre-endoscopy Rockall score, and equivalent to the full-Rockall score, in predicting inpatient mortality for patients with upper gastrointestinal bleeding. In addition, AIMS65 was superior to all scores in predicting the need for intensive care unit admission and hospital length of stay. *Gastrointest Endosc*. 2015 Oct 26. Epub ahead of print. doi:10.1016/j.gie.2015.10.021.