Variation in Hepatitis C services may lead to inequity of health-care provision: a survey of the organisation and delivery of services in the United Kingdom.

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Author's response to reviews: see over
Variation in Hepatitis C services may lead to inequity of heath-care provision: a survey of the organisation and delivery of services in the United Kingdom.

Dear Editors,

Please find below responses to the reviewers’ comments of the above paper answered point by point with changes in the text in bold. We hope that they meet with your approval and look forward to receiving your reply in due course. Please do not hesitate to contact us should there be anything that you require clarification on.

With best wishes

Yours sincerely

Julie Parkes (on behalf of the authors)

Revisions to original submitted paper answering points raised by referees.

Reviewer 1 David Goldberg

- Page 2 The estimated number of patients –sentence completed

- Page 7 To clarify that the total estimated population given was taken from responding CSPs

“The total estimated prevalent population of patients with CHC managed by responding CSPs”

- Page 7 To clarify that those units managing >1000 patients with CHC refers to total number currently being managed by these CSPs

“three CSPs were managing over 1000 patients in total “
Table 1 simplified page 7

Table 1
Response rates and role in the care of patients with Chronic Hepatitis C by specialty

<table>
<thead>
<tr>
<th>Management role by specialty</th>
<th>Number in survey n (%)</th>
<th>Overall responding n (% total)</th>
<th>No role n (%)</th>
<th>DIP n (%)</th>
<th>CSP n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI</td>
<td>200 (58)</td>
<td>124 (52)</td>
<td>28 (64)</td>
<td>50 (51)</td>
<td>46 (47)</td>
</tr>
<tr>
<td>Hepatology</td>
<td>53 (15)</td>
<td>48 (19)</td>
<td>3 (7)</td>
<td>9 (9)</td>
<td>36 (37)</td>
</tr>
<tr>
<td>ID</td>
<td>43 (13)</td>
<td>30 (13)</td>
<td>1 (2)</td>
<td>14 (14)</td>
<td>15 (16)</td>
</tr>
<tr>
<td>GUM</td>
<td>48 (14)</td>
<td>38 (16)</td>
<td>12 (27)</td>
<td>26 (26)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Total</td>
<td>344 (100)</td>
<td>240 (70)</td>
<td>44 (100)</td>
<td>99 (100)</td>
<td>97 (100)</td>
</tr>
</tbody>
</table>

DIP= diagnostic & investigative provider  
CSP= comprehensive service provider  
* e.g. number (%) of management role provided by specialty

- Page 9 Clarification of number of CSPs with management strategies

“Co-ordinated management strategies for patients with HCV were reported by 45% (44) of CSPs, with formal collaboration between CSP and other services. The most common formal links were between the CSP and Drug and Alcohol Teams (n=37), GUM services (n=30), prisons (n=22), primary care (n=20) and homeless units (n=14). Other links included asylum seekers (2), other medical specialities (5) and a renal dialysis unit (1).”

- Page 10 To clarify that figures on proportions presented relate to responding CSPs

“Over 90% of responding CSPs used severity of hepatitis, more than 60% of respondents used age, and 90% used co-morbidity.”

- Page 11 Presentation of Table 3 revised to present question posed and answers to the question.

- Page 12 Child Pugh classification explained in footnote
Child Pugh is a clinical score to evaluate prognosis in cirrhosis using bilirubin, albumin, INR, ascites and encephalopathy which are awarded points depending on values, and allocated to three categories which indicate increasing severity of disease Class A (5-6 points) Class B (7-9 points) Class C (10-15 points). Class A has a better prognosis than B, which in turn has a better prognosis than class C.

- Table 4 simplified to promote clarity

**Table 4 Pattern of drug prescribing by CSP (2001)**

<table>
<thead>
<tr>
<th>Drug regime used by CSP</th>
<th>Interferon alone</th>
<th>Interferon &amp; Ribavirin</th>
<th>Pegylated Interferon&amp; ribavirin</th>
<th>Pegylated interferon alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients receiving a particular drug regime as a % of overall prescribing by CSP* (Median)</td>
<td>0-5</td>
<td>25-49</td>
<td>50-74</td>
<td>0-5</td>
</tr>
<tr>
<td>Number of CSPs using drug regime</td>
<td>20</td>
<td>64</td>
<td>57</td>
<td>24</td>
</tr>
</tbody>
</table>

- Page 17 To be more precise in phraseology
  “Further elaboration on the reasons for this attrition may contribute to more effective strategies aimed at increasing the number of people potentially eligible for treatment being seen by specialist services.”

- Page 17 to clarify what is meant by testing positive
  “….which suggests that even all those who have an antibody positive test are not being managed by specialist services”.

Reviewer 1 has suggested that the questions posed in the questionnaire be used as a template to frame presentation of results. However the authors feel that this would result in a very unwieldy document as the questionnaire involved 62 questions some with several parts. We agree that it is important to present the questionnaire to the reader so that they may refer to the actual question posed, and suggest that we include this as an Appendix 1.
Reviewer 2 Christian Trepo

- Current therapy recommendation and screening strategies in the UK and other countries

Mention of differences in therapy and screening are made on pages 16 and 17

“This contrasts with practice in Europe. 56% of positive subjects in France now know their serological status and 75,000 have been treated. 100,000 have been diagnosed in Germany, with 20-30,000 treated. Italy has treated approximately 100,000 patients, one third of diagnoses. In France through a wider screening policy (including prisoners, antenatal clinics, and social security medicals), reimbursement of private laboratories, and greater awareness, testing increased by 26% and 1.2 million tests were performed in France between 2000 and 2002. Testing is freely available anonymously in French universities, town centres and hospital family planning clinics in addition to prisons and drugs clinics. Germany has a similar screening strategy. There is no formal screening programme in the UK except for blood donors, although the Hepatitis C Action Plan plans a case finding strategy for named high risk groups”.

“NICE guidance in the UK recommends that interferon (pegylated and non pegylated) and ribavirin be used in moderate and severe CHC. A European consensus (1999) statement recommended that moderate/severe necroinflammation and/or fibrosis be treated, and in the USA treatment of moderate and severe disease is recommended.”

- Discussion of practice differences observed with those recommended. Addressed page 17 & 18

Despite the national guidance many CSPs found that funding for treatment was a barrier to care, leading to a persistence of postcode prescribing with regional variation in access to treatment.

“The variation in management strategies including treatment despite national standards of care may also be well served by increased cohesion of services locally and nationally, with the aim to have a consistent high quality evidence based service delivered to patients with CHC no matter where they live”.

- Liver histology waiting times as a barrier to care
This was explored page 14

Biopsy waiting times showed some differences between specialities, with 17 hepatologists and 4 ID physicians agreeing/strongly agreeing that biopsy times are a barrier to care, and 6 Hepatologists and 9 ID physicians disagreeing.

- Treatment of Child class B and C and waiting for liver transplant
Additional analysis of whether these groups were linked to transplant sites or those with close collaboration presented on page 12

Virtually all of the respondents definitely offered treatment to patients with moderate or severe hepatitis/cirrhosis (definition here Child-Pugh A), 48% (38) (and 9% (7) maybe treat) also treated those with Child-Pugh B, and 14% (11) treated patients with Child Pugh C cirrhosis¹. This was not linked in the majority of cases to whether the CSP treating HCV related end-stage liver disease with anti-virals were transplant centres or had close collaboration with transplant centres.

- Minor typo corrections

Table 3 column alignment corrected
Table 5 spelling corrected