



Identifying Stigma as a Key Initial Step to Equitable Hepatitis C Virus Care

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Hepatitis C virus (HCV) and alcohol use disorder (AUD) are leading causes of liver-related death in the United States.¹ Patients with both HCV and AUD have an accelerated progression of hepatic fibrosis and are at higher risk of morbidity and mortality compared with patients with HCV alone.² Fortunately, currently available HCV treatments or direct-acting antiviral agents (DAAs) are highly effective, safe, and curative therapies that significantly lower the risk of adverse liver-related outcomes for patients with HCV and AUD. As a result, guidance from the American Association for the Study of Liver Disease (AASLD) and the Infectious Diseases Society of America (IDSA) recommends DAA treatment for those with HCV and AUD without restriction based on alcohol use; however, these high-risk patients still face significant barriers to treatment.² Identifying and overcoming these barriers in vulnerable populations are a key step to our goal of eliminating HCV infection.

Haque and colleagues³ demonstrated lower DAA treatment rates for patients with HCV and AUD. They performed a retrospective cohort study analyzing 133 753 Veterans Health Administration (VHA) patients with HCV who were born between 1945 and 1965 and had completed an Alcohol Use Disorder Identification Test–Consumption (AUDIT-C) questionnaire. Patients were included in this study if they had at least 1 outpatient visit in the VHA from January 1, 2014, through May 31, 2017. Based on AUDIT-C data and an *International Classification of Diseases, Ninth Revision (ICD-9)* or *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)* diagnosis, all patients were stratified into 5 alcohol risk categories: current AUD (38%), abstinent with a history of AUD (12%), at-risk drinking (6%), lower-risk drinking (14%), and abstinent without a history of AUD (30%). The mean (SD) age of the study participants was 60.6 (4.5) years, nearly all were male (97%), and more than half were White (55%). For patients who entered the study in 2014, those with current AUD (hazard ratio, 0.72 [95% CI, 0.66-0.77]) and those who were abstinent with AUD history (hazard ratio, 0.91 [95% CI, 0.84-1.00]) were less likely to receive DAA treatment than those with lower-risk drinking. This trend continued for patients who entered the study from 2015 to 2017, where those with current AUD and those who were abstinent with a history of AUD again remained less likely to receive DAA treatment.

The AASLD-IDSA guidance recommending HCV treatment regardless of ongoing or prior AUD is supported by emerging data.² In 2016, Tsui and colleagues¹ reported outcomes of 15 151 patients who completed AUDIT-C screening and were treated with DAA-based therapy. Overall cure or sustained virologic response (SVR) rates were uniformly high regardless of alcohol use history. With these data and recommendations in hand, why are patients with AUD and HCV overlooked as candidates for therapy? First, we must look to ourselves as clinicians for answers. Prior to the DAA era, interferon-based therapy was often contraindicated for patients with ongoing alcohol use owing to frequent discontinuation of treatment and low SVR rates compared with those who were not drinking alcohol.⁴ Although interferon-based HCV therapy is no longer the standard of care, perhaps some clinicians are not aware of the improved safety profile and efficacy of newer DAA treatments for patients with HCV and AUD. Other clinicians may have concerns about adherence. Although it is true that decreased adherence to DAA treatment may result in poor treatment outcomes and even development of resistant strains of HCV, AUD is not necessarily associated with nonadherence. Treatments for other diseases, such as hypertension, diabetes, and HIV, are not typically withheld solely because of ongoing AUD or history of AUD. Finally, we are left with stigma. Are clinicians less

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likely to prescribe DAA treatment because behaviors surrounding alcohol use are considered self-injurious and hence the patient is less deserving? Do patients feel that their addiction makes them less worthy of liver-related care and are subsequently less empowered to educate themselves and request treatment? We would like to answer “no;” however, public stigma, self-stigma, and structural stigma surrounding AUD have been shown to contribute to restricted access to health care and poor patient outcomes.⁵ It is imperative that we identify and understand these types of stigma as a foundational step to overcome and improve health outcomes among patients with HCV and AUD.

In 2016, the World Health Organization set a goal for HCV elimination worldwide by 2030. This goal specified 80% of eligible patients with HCV treated and a 90% reduction in the incidence of new infections, with a subsequent 65% reduction of liver-related mortality. In the United States, the National Academies of Medicine outlined a similar plan for HCV elimination, which, if achieved, would save approximately 28 000 lives by 2030.⁶ Given the high prevalence of AUD and substance use disorder among patients with HCV, these goals will never be achieved unless these disparities (which are often rooted in stigma) are addressed.

There is no single solution to improve cure rates among patients with AUD and HCV. One limitation of the study by Haque and colleagues³ is that the reasons for withholding DAA treatment are unknown. Further qualitative and quantitative studies will be needed to gain insight into the specific reasons and circumstances that resulted in deferral of treatment and how these reasons can be better addressed by patients and clinicians. In addition, lower DAA treatment rates are only a single example of the breakdown of the care cascade for patients with AUD who remain untreated. Care for people with addiction and chronic illness often requires a multidisciplinary approach reaching beyond the patient-clinician dyad. Mechanisms to improve health care access and wraparound services to assist with addiction treatment and mental health counselling are essential to ensure equitable HCV care for our most vulnerable patients.² Finally, public policy on both a state and national level should reflect evidence-based guidance. For example, in 2022, 19 state Medicaid policies continue to limit access in some form to DAA-based therapies for patients with AUD.⁷ These policies restrict access to care without any evidence that they help improve patient safety or optimize outcomes.

The findings of Haque and colleagues³ are illustrative of how stigma among patients with addiction can result in limitations to accessing necessary treatment. Identifying, studying, and proactively working to overcome different types of stigma are essential to our efforts to reduce disparities in HCV care and ultimately reach our goals of HCV elimination.

ARTICLE INFORMATION

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