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Need-adapted HCV-treatment setting for injection drug users

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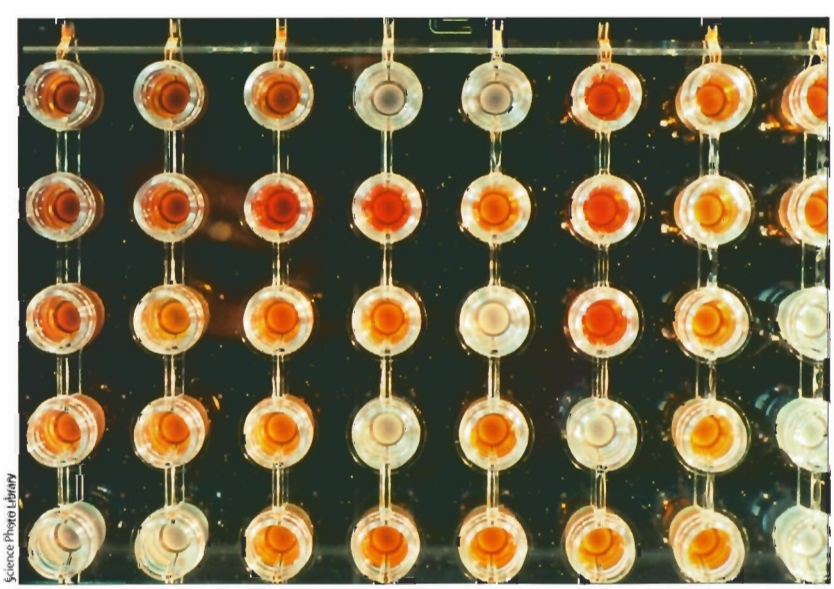
Although injection drug use has a crucial role in developed countries both as a transmission risk and as a reservoir for hepatitis C virus (HCV), access to antiviral treatment remains onerous for this marginalised population.[1] Two papers have outlined successful delivery of antiviral HCV treatment within a community-based and primary-care-based setting in previously unserved populations.

Mandy Wilkinson and colleagues[2] integrated a monthly hepatology outreach clinic in a specialised low-threshold addiction unit. Only basic medical criteria had to be fulfilled to qualify for antiviral HCV treatment, and rates of sustained virological response were above 50%. Criteria that otherwise would have led to exclusion from HCV treatment, such as homelessness and being an active injection drug user, were not associated with non-compliance. Kate Jack and colleagues[3] formed a partnership between general practices with a special interest in substance abuse and a secondary-care-based consultant in infectious disease. This working group also offered antiviral treatment at a low threshold after fulfilment of basic medical criteria; however, injection drug use had to be confined to three times weekly and stable housing was required. Sustained virological response was achieved by more than 60% of participants. In both studies, previous referral models proved unsuitable for integration of injection drug users in HCV treatment.



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Hepatitis C ELISA

Expanding HCV treatment to previously unreached populations who inject drugs is essential both from an individual's and a public-health perspective. Users often have comorbidities, such as alcohol dependence or HIV infection, which (accessorily to HCV) compromise liver function and increase mortality.[4,5] Among the liver-toxic agents and substance-use behaviours (alcohol, HIV, and HCV), only HCV can be cured. Alcohol use is often a contraindication for HCV treatment, but it does not have negative treatment outcomes unless associated with non-compliance.[6] Interestingly, Wilkinson and colleagues in their community-based treatment setting did not find an association between alcohol use and non-compliance. From a public-health perspective, HCV treatment is cost effective and might reduce the incidence of hepatocellular carcinoma.[7,8] In terms of secondary HCV prevention, data on the effect of successful HCV treatment on incidence rates in injection drug users would be of interest, but are missing due to low treatment numbers.[9]

Primary care models in the treatment of substance abuse are successful and well accepted by the

target population, if important principles of drug treatment specifically addressing psychosocial issues are considered and implemented. These measures comprise, among others, the establishment of a respectful and trusting relationship, a participative and professional approach in interactions with high emotional expression, care by a multidisciplinary team, setting of appropriate limits, and definition of responsibilities.[10,11] In secondary and tertiary care, more specialised medical interventions are delivered, while psychosocial aspects take a relative back seat. Injection drug users with impaired psychosocial functioning have an increased risk of getting lost in transfer from a need-adapted primary care setting to a medically centred secondary or tertiary care facility. This finding, also reproduced in their studies, encouraged Jack and Wilkinson, and their respective colleagues, to develop an integrated model. Stigmatisation often forms an additional obstacle.[12] It therefore is reasonable and promising to integrate secondary and tertiary care into primary care drug treatment as much as possible.

To further improve treatment access for injection drug users with severe somatic comorbidity, integrated community-based treatment settings should be implemented throughout the drug-treatment system as a first step. In a second step, principles of assertive community treatment developed for severe mental illness, such as rapid access to services, a high ratio of community-based to office-based appointments, assertive engagement, and a shared care approach, should be adapted to co-occurring drug dependence and physical comorbidity (eg, HCV).[13] Within the past decade, we have witnessed a shift from injection drug use as a contraindication for HCV treatment to verification of treatment feasibility in this group of patients. Within the next decade, we will probably see an extension of HCV treatment to even marginalised and severely affected injection drug users.

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Statistical reporting in Chinese biomedical journals

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Over the past 20 years, biomedical articles authored and published by Chinese researchers, especially in the science citation indexed journals, have improved greatly in quality, with biostatistics playing an important role. Use of statistical methods in biomedical research published in the leading Chinese medical journals is routine.[1] Scholars and/or practitioners in statistics are invited to join the editorial boards of some Chinese medical journals. China has come a long way and the gap between China and the developed countries in use of statistics in biomedical research is gradually narrowing.

Despite substantial effort made by many editors and authors, errors in statistics in biomedical journals remain common. As reported by Hu and colleagues,[2] the occurrence of statistical errors in Chinese medical journals was as high as 88%, with an incidence of