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6 Article type : Letter

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9 In support of community-based hepatitis C treatment with triage of people at
10 risk of cirrhosis to specialist care

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This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as [doi: 10.1111/JVH.13391](https://doi.org/10.1111/JVH.13391)

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34 We read the article by Phillips and colleagues with interest (1). Phillips presents
35 a qualitative evaluation of hepatitis C care provided by a hepatitis nurse in a
36 community drug and alcohol treatment centre. The study found that providing
37 hepatitis C care in the community facilitated engagement in numerous ways,
38 including by mitigating previous negative hospital-based experiences. Most
39 people with hepatitis C have a history of injecting drug use, and many report
40 negative healthcare associated experiences (2).

41

42 We conducted a randomised study comparing community-based hepatitis C care
43 with hospital-based care (The Prime Study) in people who inject drugs (PWID),
44 which showed substantially higher treatment uptake in the community care
45 group (3). Current guidelines recommend that people with cirrhosis require
46 specialist care, therefore PWID at risk of cirrhosis were ineligible for the Prime
47 Study, and were referred to a hospital specialist (4). We were concerned that this
48 group may not attend and realise the benefits of hepatitis C treatment, because
49 of previous negative experiences of hospital care. Therefore, in the Prime 3+
50 cohort study, we prospectively followed participants at risk of cirrhosis and
51 ineligible for community-based treatment, to determine their uptake of hospital-
52 based treatment.

53

54 Of 103 Prime Study participants that underwent fibrosis assessment, 20 (19%)
55 were at risk of cirrhosis, defined as: FibroScan result >9.5 kPa, or platelet count
56 below the lower limit of normal, or aspartate aminotransferase to platelet ratio
57 index >1.0, or clinical features suggestive of cirrhosis.

58

59 Of 20 patients enrolled in Prime 3+ and referred for hospital care, 19
60 commenced DAAs: 15/19 (80%) via hospital-based specialists, 1/19 (5%) from a
61 specialist located in a community clinic, and 3/19 (15%) exited Prime 3+ and
62 obtained DAAs from their primary care provider. Overall, 19/20 (95%) of people
63 at risk of cirrhosis commenced treatment. Seventeen (89%) obtained sustained

64 virologic response 12 weeks post treatment, one obtained a virologic response at
65 9 weeks post treatment and the outcome for one is unknown.

66

67 There was high treatment uptake and cure in this small cohort of PWID with
68 hepatitis C at risk of cirrhosis referred for hospital-based specialist care.

69 Although Prime 3+ was small, the concern that PWID with hepatitis C at risk of
70 cirrhosis may not attend hospital-based specialist care appears unwarranted.

71 These data further support the benefit of models of care that provide hepatitis C
72 treatment in the community with referral of those at risk of cirrhosis to hospital-
73 based specialist care.

74

75 Funding

76 The Prime Study is an investigator-initiated study funded by AbbVie. The
77 investigators are responsible for the study design, data collection and analysis,
78 interpretation of data and preparation of manuscripts.

79 Acknowledgements

80 The authors gratefully acknowledge the contribution to this work of the Victoria
81 Operational Infrastructure Support Program's funding for the Burnet Institute.

82 JD, MH and AT acknowledge support from the National Health and Medical
83 Research Council. All authors contributed to the study design, data collection,
84 analysis and interpretation, and manuscript preparation.

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86 Conflict of interest statement

87 **BD & JH** – none; **AW** receives funding for investigator-initiated research from
88 AbbVie; **MH** receives funding for investigator-initiated research – Gilead, BMS
89 and AbbVie; **SR** reports advisory board member – Gilead, MSD, Bayer, AbbVie
90 and speaker: Gilead, Bayer and PI – Gilead, MSD, Bayer, AbbVie, BMS, Janssen,
91 Arbutus, Assembly Biosciences, Intercept, GSK, NGM pharmaceuticals; **WK**
92 receives funding from – Gilead, BMS, MSD, AbbVie and PI – DURECT, Arena
93 Pharmaceuticals, MSD; **JD** receives funding for investigator-initiated research
94 from Gilead, Merck, BMS and AbbVie and reports consulting for AbbVie, Merck,
95 BMS, Gilead; **DI** reports advisory board member – AbbVie, BMS, MSD, and

96 speaker – AbbVie, BMS, Gilead, MSD, and PI – Gilead, MSD; **AT** reports advisory
97 board member – Gilead, AbbVie, Bristol-Myers Squibb (BMS), and Merck, and
98 speaker – Gilead, Merck, BMS, AbbVie, Roche Diagnostics, and PI – Gilead, Merck,
99 AbbVie, BMS, Genfit, Arrowhead, Spring Bank, Sillajen, and research / grant
100 support – Gilead, Merck, BMS, AbbVie, Bayer.

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