

SARS-CoV-2 massive testing: A window of opportunity to catch up with HCV elimination

To the Editor:

The 69th World Health Organization's assembly approved in 2016 a global strategy for eliminating viral hepatitis, as a threat to public health, by 2030.¹ Since then, great progress has been made in reducing the impact of viral hepatitis, particularly in relation to HCV.

The effects of achieving viral cure are countless, at both individual and population levels. In this regard, we read with great interest the work published by Calvaruso & Craxi,² explaining precisely the present, long-term and expected benefits induced by direct-acting antivirals (DAAs). Furthermore, as a consequence of the massive treatment with DAAs, Forns' group foresees a very optimistic scenario: cirrhosis related to HCV will be a marginal cause of hospital admissions in the near future.³ Unfortunately, the pandemic caused by SARS-CoV-2 endangers these remarkable advances. In fact, the first wave of the COVID-19 pandemic overwhelmed healthcare systems around the world, with far-reaching consequences.⁴ Along this line, Blach *et al.*⁵ modeled the devastating consequences of delaying HCV elimination programs. This delay will be reflected in an increase of HCV-related mortality, both as consequence of cirrhosis complications and hepatocellular carcinoma (HCC) development. A single-year delay may result in an excess of 70,000 liver-related deaths and 44,000 excess HCC diagnoses.

The COVID-19 crisis has forced the diversion of the majority of healthcare resources towards the care of infected patients, impacting the management of those with other conditions. A clear example is patients infected with HCV.⁶ Unfortunately, the closure of harm reduction centers, cancellation of elimination programs and medical consultations, as well as reduced access to healthcare centers, is decreasing the rate of HCV diagnoses. In fact, in a recent survey evaluating the impact of COVID-19 on viral hepatitis, up to 64% of participants reported it being impossible to access viral testing, with the closure of testing facilities being the main cause in the United States.⁷ Consequently, this diagnostic delay will be translated into a delay in treatment initiation, whose consequences have been predicted by Blach *et al.*,⁵ and have been seen in the past.⁸

Nowadays, asymptomatic carriers appear to be the most likely spreaders of the SARS-CoV-2. Thus, massive population-level testing is warranted, since home confinement – and re-confinement – cannot be long-lasting measures. Therefore, the vast majority of people should probably undergo SARS-CoV-2 testing. This provides a golden opportunity to catch up with HBV control and HCV elimination. Patients that must already attend healthcare facilities for SARS-CoV-2 testing, could also be screened for HCV and HBV, in a single visit. Integrating HCV detection programs⁹ into SARS-CoV-2 testing will likely have a

very small economic cost, with the potential to be hugely profitable down the line. Since COVID-19 may induce liver damage, albeit rarely, and the current viral armamentarium includes multiple potentially hepatotoxic drugs, HBV and HCV screening could be important in the management of patients with suspected SARS-CoV-2 infection. Furthermore, SARS-CoV-2 and hepatitis tests could be easily performed at the same time by means of point-of-care techniques, using saliva assays or dried blood spots, preventing further redundant analyses. Thus, establishing integrated diagnostic circuits may prevent unnecessary repeat sampling.

We are aware of the enormous resource burden caused by the pandemic. However, it is our duty to provide adequate care for non-COVID-19 patients. In fact, if their conditions remain undiagnosed as a consequence of the reintroduction of restrictive policies, their prognosis may be dismal. For this reason, and in agreement with adapting the cascade-of-care to the new coronavirus situation recommended by the EASL-ESCMID in their last position document,¹⁰ we believe that mass and combined detection of SARS-CoV-2, HBV and HCV would allow us to respond simultaneously to several public health problems with minimal cost. As a matter of fact, this policy would keep us on track for viral elimination by 2030.

Therefore, in accordance with Wingrove *et al.*,⁹ we consider that i) HCV and HBV status should be assessed in every patient undergoing SARS-CoV-2 testing; 2) HCV elimination programs should be restarted as soon as possible, especially in vulnerable populations, where the impact of the interruption of HCV elimination programs will be shocking. This way we will avoid the direct consequences of the paralysis of HCV elimination programs and, simultaneously, we send an optimistic message to people: public health programs can be maintained, even in these uncertain times.

Finally, we acknowledge that we are facing another SARS-CoV-2-related wave. However, the upcoming waves will be the consequences of the delayed diagnosis of other conditions resulting from the temporary suspension of many health programs. In the setting of liver diseases, this could be prevented by population-level anti-HCV and HBV testing in every patient undergoing SARS-CoV-2 testing.

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Conflict of interests

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Letter to the Editor

Authors' contributions

All authors contributed equally.

Supplementary data

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Javier Crespo^{1,2,3}

Álvaro Díaz-González^{1,2}

Paula Irizubietra^{1,2}

Susana Llerena^{1,2}

Joaquín Cabezas^{1,2,*}

¹Gastroenterology and Hepatology Department, Marqués de Valdecilla University Hospital, Santander, Spain

²Research Institute Valdecilla (IDIVAL), Santander, Spain

³School of Medicine, University of Cantabria, Santander, Spain

*Corresponding author. Address: Gastroenterology and Hepatology Department, Marques de Valdecilla University Hospital, Research Institute Valdecilla (IDIVAL), Avda. de Valdecilla s/n. Santander, 39008 Cantabria, Spain. Tel.: +34 942 20 25 20; fax: +34 942 20 25 44.

E-mail address: joaquin.cabezas@scsalud.es (J. Cabezas)