

Management of dialysis patients with hepatitis C virus in the era of direct-acting antiviral therapy

We read with interest the recent comprehensive review on the “management of dialysis patients with hepatitis C virus in the era of direct-acting antiviral therapy” by Toyoda and Kikuchi. The authors are to be congratulated for this detailed timely review [1]. [Correction added on 13 September 2023, after first online publication: ‘Toyoda and Kikuchi, 2023’ has been added in the References section and its citation was inserted in the preceding sentence.]

We would like to comment on two points.

First, the authors rightly stress the substantial risk of cirrhosis and hepatocellular carcinoma in dialysis patients infected with HCV. We would like to stress that HCV infection also contributes to a higher cardiovascular risk and that DAA therapy reduces this risk [2]. Thus, the benefits of treating HCV infection are systemic and not limited to the liver-related risks.

Second, the authors state that “it may remain controversial whether dialysis patients with cured HCV should be managed as non-infected patients or whether strategies to prevent HCV transmission should be continued or stopped.” This wording is surprising. According to the 2022 update of the Hepatitis C and CKD KDIGO Guideline, hygienic precautions are key to prevent HCV transmission in dialysis and should be thus always be continued [3]. The authors probably implicitly allude to an isolation strategy of HCV-RNA positive patients. In that respect, first, it should be stressed that such a strategy is not recommended by KDIGO. Second, if an isolation strategy is nevertheless used, the only reliable test to detect HCV infectivity in dialysis patients who had a sustained viral response after DAA therapy is nucleic acid testing (NAT) for HCV-RNA. The KDIGO guideline [3] recommends to test such patients by NAT every 6 months. Indeed anti-HCV antibodies may persist for years after a resolved infection and cannot be used as a marker of infectivity. This NAT testing is part of the quality control assessing the yearly infection rate in the dialysis unit. In addition, it would be unethical to dialyze a patient cured from HCV, even though he still has anti-HCV antibodies (which are not protective) in a room

reserved for HCV infected patients. This would put him at higher risk of HCV reinfection with another HCV strain or isolate. Indeed, the risk of nosocomial transmission persists in HD units globally [4], although it is reduced as compared with decades ago [5].

CONFLICT OF INTEREST STATEMENT

Prof. M Jadoul has cochaired the KDIGO HCV in CKD guidelines and is KDIGO cochair. No other relevant disclosure.

PATIENT CONSENT STATEMENT

No patient is reported in this letter to the editor. Thus no need for a patient consent statement.

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