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Title	Commentary on Zeremski et al. (2016): Improvements in HCV-related Knowledge Among Substance Users on Opioid Agonist Therapy After an Educational Intervention
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Publication date	2016-10
Publication information	McCombe, Geoff, Anne Marie Henihan, Dorothy Leahy, Jan Klimas, John Lambert, and Walter Cullen. "Commentary on Zeremski et Al. (2016): Improvements in HCV-Related Knowledge Among Substance Users on Opioid Agonist Therapy After an Educational Intervention" 10, no. 5 (October, 2016).
Publisher	Lippincott, Williams and Wilkins
Item record/more information	http://hdl.handle.net/10197/8234
Publisher's statement	This is not the final published version.
Publisher's version (DOI)	10.1097/ADM.0000000000000244

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Sir,

Zeremski et al highlight how improving patients' knowledge about Hepatitis C virus (HCV) care can enhance adherence to treatment plans and improved treatment outcomes (Zeremski et al. 2016). In this regard we believe that patients' knowledge of HCV care can best be optimised through community based approaches to HCV treatment as supported by recent findings from Wade et al and Grebely et al (Wade et al. 2015, Grebely et al. 2016).

The advent of such models of care provide an opportunity to embed HCV treatment within a holistic approach that also addresses related issues, especially problem alcohol use. This is especially the case in Ireland, where problem alcohol use is common among people who inject drugs (Ryder et al. 2009). This increases the risk of complications related to chronic HCV infection as alcohol can exacerbate HCV infection and the associated liver damage by causing oxidative stress and promoting fibrosis, thereby accelerating disease progression to cirrhosis (Batchelder et al. 2015).

To examine the prevalence and treatment of HCV and problem alcohol use among patients attending primary care for opioid agonist treatment (OAT) (Klimas et al. 2014, Klimas et al. 2015), we have conducted secondary analysis of data collected during a feasibility study of an alcohol brief intervention for patients attending primary care for OAT. The study, whose methodology has been described previously, involved 106 patients attending general practice in two of Ireland's four health regions (East and Midwest respectively, with data collected during interviews with patients.

Of 106 patients, 105(99%) had been tested for HCV, 54(51%) were HCV positive and 20(19%) reported they 'had been treated for' HCV. Forty nine patients (46%) were identified to have problem alcohol use and 20(37%) were both HCV positive and had problem alcohol use.

Though HCV seroprevalence remains comparable with that reported previously (Cullen et al. 2003), the high rates of problem alcohol use (46%) and especially the proportion of patients who both drink heavily and are HCV positive (19%) are concerning (Klimas et al. 2015). Compared to a sample of patients attending general practice for OAT in 2009, we observed comparable age of first drug use, gender HCV testing rate, HIV testing rate and

HIV prevalence (see Table 1). While known HCV seroprevalence was comparable (51% v 55%), we observed a higher proportion of patients to be drinking heavily (46% v 35%).

As healthcare systems endeavour to facilitate access to new treatments for HCV infection, it is also important to minimise the risk of further liver damage by developing educational interventions which also identify and treat problem alcohol use in at-risk groups. In this regard, primary care is well placed to address complex needs among this group.

< Table 1 about here >

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Table 1. Bloodborne virus status and problem alcohol use among patients attending general practice for opioid agonist treatment - comparison of 2013 v 2006.

	2013 (Klimas et al 2013, 2015)	2006 (Ryder et al, 2009)
Age (years)	40.9 (8.9)	33.4 (7.1)
Age at first heroin use (years)	19.6 (5.1)	18.9 (5.4)
Age at first injecting (years)	20.9 (4.9)	19.9 (4.5)
Gender (male)	69 (65%)	133 (68%)
HCV status known (self-reported)	104 (99%)	188 (96%)
HCV positive	54 (51%)	107 (55%)
HCV treated	21 (20%)	N/A
Problem alcohol use	49 (46%)	68 (35%)
HCV positive with PAU	20 (19%)	N/A
HIV status known (self-reported)	103 (98.2%)	187 (95%)
HIV positive	6 (5.7%)	10 (5%)
HBV status known (self-reported)	88 (83.8%)	N/A
HBV positive	3 (2.7%)	N/A