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## Current and Future Therapies for Hepatitis C Virus Infection

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### To the Editor

In their review of drug therapy for chronic hepatitis C infection, Liang and Ghany (May 16 issue)<sup>1</sup> summarize boceprevir- and telaprevir-based regimens. Figure 2 of the article describes the regimens according to the response to the previous therapy, the response-guided therapy, and the stopping rules. The boceprevir regimen they describe represents the labeling information in the United States.<sup>2</sup> However, the information about boceprevir in European regimens has some differences<sup>3</sup> — the duration of therapy for patients who have not had a response to previous therapy (whether the patient had a relapse, a partial response, or no response) is 48 weeks (peginterferon alfa and ribavirin for 4 weeks, then all three drugs through week 36, and then peginterferon alfa and ribavirin through week 48). For the readers of the *Journal* in Europe, our comments might be useful.

### Appendix

**The Authors Reply:** In our review, we used the Food and Drug Administration (FDA) labeling information<sup>1</sup> as the basis for the approved regimens for boceprevir and telaprevir. Ozaras et al. point out that the European Medicines Agency (EMA) labeling information<sup>2</sup> for boceprevir for patients who have had a relapse differs from the FDA labeling. The recommended regimen for patients who have received previous treatment was based on a subgroup analysis comparing rates of sustained virologic response between patients with an early response (undetectable level of HCV RNA at weeks 8 through 24) and those with a late response (detectable level of HCV RNA at week 8 but undetectable at week 24) who were receiving response-guided therapy (peginterferon alfa and ribavirin for 4 weeks, then all three drugs through week 32) or standard-duration therapy (peginterferon alfa and ribavirin for 4 weeks, then all three drugs through week 44).<sup>3,4</sup>

There was a difference of 6 percentage points in the rate of sustained virologic response in favor of response-guided therapy for patients with a late response and a difference of 7 percentage points in favor of standard-duration therapy for those with an early response (neither difference was significant). The FDA reasoned that these differences were probably due to chance, and it recommended response-guided therapy for patients with an early response who had previously had a relapse or a partial response. The EMA highlighted the fact that the higher rate of sustained virologic response among patients with an early response in the standard-duration group than among patients in that group with a late response was entirely due to a higher relapse rate in the group that received response-guided therapy than in the standard-duration group, and it therefore recommended that all patients who had received previous treatment undergo standard-duration therapy.

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Since publication of their article, the authors report no further potential conflict of interest.

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