Asymptomatic hepatitis C infection

Be cautious with liver biopsy

EDITOR,—In her review of hepatitis C Carol A Seymour arrives at a confusing conclusion about the value of liver biopsy in infected asymptomatic blood donors.[1] Liver biopsy "seems essential" once the condition has been diagnosed because patients respond to antiviral treatment. Seymour later admits that therapeutic trials are required in this group of patients but then advocates a nationwide policy to identify, follow up, and treat asymptomatic people infected with hepatitis C virus. The two important issues she fails to address are sampling bias in the estimation of the frequency of liver disease in asymptomatic donors and the lack of evidence that treatment affects the long term outlook in hepatitis C.

It is wrong to make statements about the prevalence of disease in selected populations. The careful documentation of the North London Blood Transfusion Centre shows how selected the group who undergo liver biopsy can become.[2] In contrast, the investigators in Trent region gave no indication of how many patients did not have a biopsy or what the indications for biopsy were.[3] Only studies of unselected or randomly sampled populations will give reliable estimates of the prevalence of histological disease in asymptomatic subjects that are generally applicable. Sampling bias has probably led to an overestimation of the frequency of liver disease associated with hepatitis C in Trent.

The consensus reached both in a recent issue of *Drug and Therapeutics Bulletin*[4] and at a conference on hepatitis C in Edinburgh late last year was that antiviral treatment can normalise hepatic enzymes and improve the appearances on liver biopsy. There is no evidence, however, that it affects long term prognosis.

With so much uncertainty about the prevalence of liver disease related to hepatitis C and the long term benefits of treatment it is irresponsible to advocate liver biopsy in all asymptomatic infected patients.

ROLAND VALORI
Consultant physician

JOHN CHRISTIE
Registrar in general medicine

Gloucestershire Royal Hospital,
Gloucester GL1 3NN

1 Seymour CA. Asymptomatic infection with hepatitis C virus. *BMJ* 1994;**308**:670-1. (12 March.)
2 Ryan KE, MacLennan S, Barbara JAJ, Hewitt PE. Follow up of blood donors positive for antibodies to hepatitis C virus. *BMJ* 1994;**308**:696-7. (12 March.)
3 Irving WL, Neal KR, Underwood JCE, Simmonds PN, James V. Chronic hepatitis in British blood donors infected with hepatitis C virus. *BMJ* 1994;**308**:695-6. (12 March.)
4 Managing patients with hepatitis C. *Drug Ther Bull* 1993;**31**:61-2.

More questions, few answers

EDITOR,—Unfortunately, the editorial[1] and papers on asymptomatic infection with hepatitis C virus[2-4] created more questions than answers for me. I work in an inner city practice that has many intravenous drug users on its list. Over the past few years a proportion of these patients have requested HIV tests. The virology laboratory has been telling us these patients' hepatitis B and C status even though we have generally not asked to know this. I now realise that we are in the middle of an epidemic. About 80% of the intravenous drug users on our list who have been tested are positive for hepatitis C virus. So far, none of these patients has shown any abnormal results of liver function tests.

Many of the early patients were not counselled before having the test. When I received the positive results nobody seemed to know what I should do with the information. As knowledge of hepatitis C virus infection has grown among intravenous drug users more patients have come forward requesting to have their hepatitis C status checked. Before the test is performed I have tried to explain the current thinking on monitoring and available treatment. Few of these patients have chosen to go for further investigations in hospital, and none have chosen to have liver biopsies or to receive interferon.

Although it may be reasonable to suggest that a liver biopsy is essential, what are we hoping to achieve by this and what do we have to offer these patients after the biopsy?

CHRIS FORD
General practitioner

London NW6 6RY

1 Seymour C. Asymptomatic infection with hepatitis C virus. *BMJ* 1994;**308**:670-1. (12 March.)
2 Irving W, Neal K, Underwood J, Simmonds P, James V, on behalf of Trent Regional Hepatitis C Virus Study Group. Chronic hepatitis in United Kingdom blood donors infected with hepatitis C virus. *BMJ* 1994;**308**:695-6. (12 March.)
3 Ryan K, MacLennan S, Barbara J, Hewitt P. Follow up of blood donors positive for antibodies to hepatitis C virus. *BMJ* 1994;**308**:696-7. (12 March.)
4 Bruno S, Rossi S, Petroni M, Villa E, Zuin M, Podda M. Normal aminotransferase concentrations in patients with antibodies to hepatitis C virus. *BMJ* 1994;**308**:697. (12 March.)

Hepatitis C can be sexually transmitted

EDITOR,—It was disappointing that Carol Seymour and Kate Ryan and colleagues failed to mention the sexual transmission of hepatitis C virus.[1,2]

For some time there has been epidemiological evidence that hepatitis C can be sexually transmitted.[3] Other studies have not shown a risk,[4] indicating that the risk is low. This overall view is supported by other large scale studies suggesting that there is a cumulative risk with time.[5] Epidemiological evidence of sexual transmission is supported by case reports of horizontal transmission in couples with no other known transmission risk, in whom nucleotide sequencing has shown concordance of virus type.[6] Osmond *et al* concluded in their paper that although they found the likely risk of sexual transmission in an individual case to be low, because of the large pool of asymptomatic carriers within the population sexual transmission could account for thousands of new infections in the United States each year.[5]

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

This has two important implications. Firstly, Seymour supports the view that wider screening should occur. Tedder *et al*[3] found that 2·2% of homosexual men attending a sexually transmitted disease clinic in central London had positive results for hepatitis C antibodies on second generation antibody tests. As this figure is considerably higher than that in the blood donor population, if a policy of wider screening is to be introduced then those attending such clinics represent a group at least deserving further study.

Secondly, with respect to counselling of patients positive for hepatitis C, sufficient evidence exists for it to be negligent not to counsel patients regarding possible sexual transmission. Sexual partners of patients with hepatitis C virus should be screened, and if they are discordant they should be advised to have protected intercourse as there is a small risk of sexual transmission. If long term partners are not willing to do this, they should be aware that there is a cumulative risk with time, so that they can make an informed decision. This should form part of the nationwide policy to prevent the spread of hepatitis C in the population that Seymour has called for.

SIMON CURTIS
Senior registrar

Harrison Department of Genitourinary Medicine,
Radcliffe Infirmary,
Oxford OX2 6HE

1 Seymour CA. Asymptomatic infection with hepatitis C virus. *BMJ* 1994;**308**:670-1. (12 March.)
2 Ryan KE, MacLennan S, Barbara JAJ, Hewitt PE. Follow up of anti-HCV positive blood donors. *BMJ* 1994;**308**:696-7. (12 March.)
3 Tedder RS, Gilson RJ, Briggs M, Loveday C, Cameron CH, Garson JA. Hepatitis C virus. Evidence for sexual transmission. *BMJ* 1991;**302**:1299-302.
4 Bresters D, Mauser-Bunschoten EP, Reesink HW, Roosendaal G, van der Poel CL. Sexual transmission of hepatitis C. *Lancet* 1993;**342**:210-1.
5 Osmond D, Padian N, Hayes W, Sheppard E, Glass S. Risk factors for hepatitis C positivity in heterosexual couples. *JAMA* 1993;**269**:361-5.
6 Rice PS, Smith DB, Simmonds P, Holmes E. Heterosexual transmission of hepatitis C virus. *Lancet* 1993;**342**:1052-3.

Failure in community care

Inpatient care is part of the integrated approach

EDITOR,—Jeremy Coid's editorial[1] contains sentiments about supervision registers and the government's response to proposals for community supervision orders, which will find broad agreement within the profession. It also contains misrepresentations of the research findings and aims of community psychiatry.

Despite Coid's protestations about "professional dogma," not one of the research studies he quotes suggests that community services can exist without admission beds or that "mental hospitals can close and that seriously mentally ill people can be conveniently and easily managed in the community." All of these studies report inpatient spells as part of an integrated approach to their patients' needs. What they do show is that admission is less often needed and discharge more prompt when community services are adequately developed.

Coid suggests that community services research has sinned by either excluding too many patients[2]