Assessment of Adherence to Guidelines for Hepatocellular Carcinoma Screening in HIV/HCV coinfected patients
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BACKGROUND

- Up to 40% of patients with HIV infection in US are coinfected with Hepatitis C (HCV).1–3
- Compared to HCV monoinfected patients, coinfected patients have:
  - Faster progression to cirrhosis1,2
  - Increased incidence of hepatocellular carcinoma (HCC)3
- Published AASLD guidelines recommend every 6 month ultrasound (US) as the preferred HCC screening strategy for patients with cirrhosis.4
- The majority of gastroenterologists are aware of the AASLD guidelines and apply them to clinical practice.5
- Real-world surveillance practices among primary providers have not been assessed for coinfected patients in the United States.

OBJECTIVE

Presuming that a large proportion of care of HIV/HCV coinfecteds is rendered by their primary providers, we aimed to determine their self-reported HCC surveillance adherence practices.

METHODS

- 25-question survey sent via US Mail.
- Study Cohort included all Primary Care and Infectious Diseases physicians in the US-census defined Philadelphia-Camden-Wilmington Metropolitan Statistical Area whose mailing addresses were publicly available (n=3,160).
- 1608 Family Medicine (FM), 1384 General Internal Medicine (IM), 168 Infectious Diseases (ID).
- 53 hospitals in 11 counties in four states (PA, NJ, DE, MD) had websites with a physician locator search function and were included in the study cohort.
- The survey measured provider demographics and likelihood of ordering liver imaging in coinfected patients, with and without known cirrhosis.
- Adherence was defined as reporting any imaging test (US, CT, or MRI) ordered at 6 month intervals.

RESULTS

- The overall response rate = 12.3% (n=387).
- The responding cohort included:
  - 208 FM, 142 IM, 34 ID, 3 Mac/Endo.
  - 34 (8.7%) self-identified as HIV specialists (28 ID, 6 IM).
- Respondent demographics are outlined in Table 1.

Table 1: Respondent Demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean ± SD</th>
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<tbody>
<tr>
<td>Median Age (range)</td>
<td>51.5 ± 11.8 (30-89)</td>
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<tr>
<td>Median Years in Practice</td>
<td>30 ± 12.2 (1-81)</td>
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<tr>
<td>University/Academic</td>
<td>17.4%</td>
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<tr>
<td>Private Practice</td>
<td>59.9%</td>
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<td>Median Total Patients/Month</td>
<td>320 ± 273.8</td>
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<tr>
<td>Median HIV/HCV Patients/Month</td>
<td>1 ± 7.24</td>
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- Only 42.3% were adherent to HCC screening guidelines using any imaging modality (every 6 months).
- No difference in adherence was observed between HIV specialists and non-HIV specialists (41.2% vs. 42.4%, p=0.12).
- No difference in adherence was observed between University and non-University physicians (39.1% vs. 43.1%, p=0.58).

Figure 1 delineates the percentage of respondents who reported being somewhat or very likely to order any liver imaging tests (US, CT, or MRI).

CONCLUSIONS

- Self-reported adherence with published guidelines for HCC screening is poor among primary providers for HIV/HCV coinfected patients, including HIV specialists and University-based providers.
- Unnecessary imaging is also frequently ordered on non-HCC patients, particularly by University-based providers.
- Improved adherence to guidelines is needed among primary providers as over 50% of HCC’s may be missed, and many patients may not be referred for subspecialty GI or Liver care, where screening practices may differ.

REFERENCES


Figure 1: Self-reported frequency of ordering imaging on coinfected patients without known cirrhosis

Figure 2: Self-reported frequency of ordering imaging on coinfected patients with known cirrhosis