Preventing Vertical Hepatitis C Virus Transmission

To the Editor—Polis et al. [1] have conducted an excellent meta-analysis showing that the odds of vertical transmission of hepatitis C virus (HCV) infection are ∼90% higher for HIV–HCV–coinfected women than for HCV-monoinfected women. Because randomized trials are not feasible, methods such as meta-analysis and decision analysis are the best tools available to examine the risks of vertical transmission of HCV infection and inform clinical practice.

These results have important health policy implications. Current US guidelines do not recommend elective cesarean delivery for the prevention of mother-to-child transmission of HIV infection when HIV RNA levels are suppressed [2], but there are no recommendations about the use of cesarean delivery to prevent vertical transmission of HCV infection if these women are HIV–HCV coinfected.

We previously conducted a decision analysis and found that a recommendation for elective cesarean delivery among HIV–HCV–coinfected mothers in the United States with suppressed HIV RNA levels could avoid up to 90 perinatal HCV transmissions per year and incur a risk of 1 additional maternal death per 50 years [3]. In addition, the cost-effectiveness ratio for this intervention was well below the median for most clinical preventive services.

The findings of Polis et al. [1] are consistent with the high risk of vertical transmission of HCV infection among HIV–HCV–coinfected women that we considered in our study. On the basis of the findings from both of these studies, we believe that elective cesarean delivery to prevent transmission of HCV infection should now be offered to HIV–HCV–coinfected mothers who would not otherwise be offered this delivery option. As more evidence becomes available about the epidemiology and risk factors associated with vertical transmission of HCV infection, clinical guidelines should continue to be updated to reflect this knowledge.

Acknowledgments
Potential conflicts of interest. B.R.S. and K.O.: no conflicts.

Bruce R. Schackman1 and Kawai Oneda2
1Division of Health Policy, Department of Public Health, Weill Cornell Medical College, New York, New York, and 2Department of Family Medicine, University of Virginia Health System, Charlottesville

References

Reprints or correspondence: Dr. Bruce R. Schackman, Div. of Health Policy, Dept. of Public Health, Weill Cornell Medical College, 411 East 69th St., New York, NY 10021 (brs2006@med.cornell.edu).

Clinical Infectious Diseases 2007;45:802
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