Therapies, included sustained virological response (SVR) as the study included if they were published in English, used FDA-approved antiviral types 1, 2 and 3. All studies between January 2009 and May 2014 were and Drug Administration (FDA)-approved regimens against HCV geno-

Interferon has been the backbone of anti-HCV therapy, but has been death. Antiviral treatment can prevent these complications and improve sur-

relapses (SVR of 41–86% vs 37–65% and 67–80% vs 36%, respectively). However, prior null responders fared poorly compared to partial responders and previous

inhibitor) was superior to peg-interferon plus ribavirin alone, both among first-generation NS3 inhibitors (telaprevir and boceprevir) were clearly more effective than the standard

treatment course to 24 weeks did not improve the SVR further.
The all-oral regimen of sofosbuvir and ribavirin for 12–24 weeks showed SVR of 68–84% among treatment naïve genotype 1 patients.

Among treatment naïve genotype 2 patients, 12 weeks of sofosbuvir plus ribavirin performed much better than 24 weeks of peg-interferon plus ribavirin (SVR 97% vs 78%). Genotype 3 patients, however, did not do well with 12 weeks of sofosbuvir and ribavirin (SVR~30%). However, SVR improved further with an extension of the treatment course to 24 weeks among both treatment naïve and treatment-experienced groups (95% and 80%, respectively). Of note, patients with cirrhosis or advanced fibrosis did less well compared to those without cirrhosis. Cirrhotic genotype 3 patients with prior null response fared the worst (SVR~33%).

The addition of telaprevir or boceprevir was associated with increased side effects and treatment discontinuation, while the addition of simepre-
vir or sofosbuvir was associated with minimal additional side effects beyond that expected with interferon. Although drug–drug interactions were a major problem with telaprevir and boceprevir, this was not the case with simeprevir or sofosbuvir.

While small numbers of well-compensated cirrhotics were included, studies involving patients with decompensated cirrhosis, renal failure, other comorbidities and minorities are lacking. Unfortunately, these are the most difficult and complex groups of patients in the clinical practice.

The field of HCV therapy is changing at such a rapid pace that any printed guidelines will likely be outdated by the time it hits the market. Keeping this in mind, and as the authors have pointed out in their discussion, the AASLD and Infectious Disease Society of America have jointly ventured a dynamic online clinical guidance that accommodates these rapid updates.1

Readers are encouraged to familiarise themselves with these updates as they will impact on the care they provide. With these new highly effective and safe interferon-free oral-only agents treating hepatitis C it is going to be easier than ever—except for their prohibitive costs.

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Reference