primary care providers. Health systems could target primary care settings for implementing operational interventions to improve overall coverage of birth cohort HCV testing in the United States. Additional evidence is needed to identify the optimal operational intervention and the potential yield from targeting the primary care setting. In addition, NHIS data lack generalizability to institutionalized populations, which have a high risk of HCV infection and barriers to care. These populations may require active case-finding approaches [5].

Note

Potential conflicts of interest. R. A. S. is on medical advisory boards for the American Liver Foundation, AbbVie, and Gilead and is on the speaker bureau for AbbVie. All other authors report no potential conflicts. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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Reply to MacDonald et al

TO THE EDITOR—We appreciate Dr MacDonald and colleagues’ [1] interest in our study [2] describing the limited coverage of hepatitis C virus (HCV) testing in the noninstitutionalized US civilian population, even among Baby Boomers, for whom there is a 1-time HCV testing recommendation. Our study was conducted using data from the 2013–2017 National Health Interview Survey. Using the same data source, the authors make an important point that, even in 2017, there were missed opportunities for HCV testing [1]. In particular, the authors highlight that 78% of untested Baby Boomers interacted with a primary care provider in the past year. We agree with MacDonald et al [1] that interventions to improve the uptake of HCV testing recommendations should be implemented in primary care settings (eg, provider and patient education programs, in combination with targeted electronic medical record best practice alerts for providers [3]).

We would also like to highlight additional opportunities and settings for improving the coverage of HCV testing. First, the emergency department (ED) is a key component of the traditional healthcare system. EDs commonly provide primary care to individuals who may not have a primary care provider, especially in underserved communities. Although it was less common for untested Baby Boomers to attend an ED in the past year, as compared to having an interaction with a primary care provider or specialist [1], the ED can be a high-yield venue for HCV testing in high-prevalence communities. We and others have previously documented a high burden of HCV infection in ED patients [4–7]. For instance, 25% of Baby Boomers attending the Johns Hopkins Hospital ED had antibodies to HCV [4]. Birth cohort–targeted, opt-out HCV screening and linkage to care (LTC) programs have been successfully implemented

in EDs [5], with some EDs also using nontargeted opt-out approaches to improve testing coverage in other high-risk populations [6].

Second, from a public health perspective, it is important to note that the implementation of birth cohort–based and risk-based HCV testing initiatives should not be limited to the traditional healthcare system. Nearly 1 in 5 untested Baby Boomers in 2017 reported no interaction with the traditional healthcare system in the past year [1]. Additionally, data from NHIS are not generalizable to institutionalized populations (eg, persons living in nursing homes and persons who are incarcerated). To reach Baby Boomers and younger high-risk individuals who are not engaged in the traditional healthcare system, it is imperative that HCV testing and LTC programs also be implemented in high-yield, nonmedical institutions and nontraditional healthcare settings, such as senior citizen centers [8], prisons [9], public health clinics [10], opioid treatment programs, and needle/syringe exchange programs [11]. Community- and faith-based organizations have also proven instrumental in expanding HCV testing and LTC programming [12].

Our study emphasizes the need to scale up and successfully implement HCV testing initiatives, particularly in the context of achieving HCV elimination by 2030 [2]. As highlighted by MacDonald and colleagues [1], systems-level interventions are needed to avoid missed opportunities for HCV testing. While we appreciate their settings-based perspective for the prioritization of implementing HCV testing programs, we believe a public health perspective and community-based approach are also needed to effectively improve coverage of HCV testing.

Note

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Tuberculosis and Dysglycemia

TO THE EDITOR—In our opinion, the extent to which dysglycemia is causally associated with tuberculosis (TB) remains unanswered. Ugarte-Gil and colleagues, with no control group, cannot answer that question [1]. We note that the prevalence of diabetes in, for example, their South African TB patients is not dissimilar to that reported in the general population of South Africans aged >30 years [2]. In fairness, their TB cohort is at the lower end of this age distribution.

However, it seems that the authors are in a position to remedy 2 problems with the diabetes-TB literature. First, they report collecting but, as is common, do not present data on dysglycemia at treatment completion. A hemoglobin A1c (HbA1c) measurement at this time point (ideally later) could unpick which of their patients with “newly diagnosed diabetes mellitus (DM)” have diabetes vs stress hyperglycemia. This assumes that, after few months of effective treatment, the stress response settles and patients regain most TB-associated weight loss. We note (Table 4 in their article [1]) that median HbA1c was already beginning to normalize in “new DM” patients after a fortnight of TB treatment.

Second, the diabetes-TB literature almost universally dichotomizes or (as here) aggregates dysglycemia into discrete categories. For an inherently continuous variable, this makes no sense. If dysglycemia is causally associated with TB, a substantial burden of attributable disease may be driven by the (larger) group of individuals with modest elevations in their blood sugar [3].

We would therefore be interested to see data both on dysglycemia at treatment completion and on the distributions of glycemic control in these TB patients from 4 very different settings. We encourage the authors to make this information available, either in their response to this letter or in future publications.

Note

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Reply to Yates and Barr

TO THE EDITOR—We thank Drs Yates and Barr for their valuable comments. In our article [1], we were not attempting to assess the extent to which dysglycemia is causally associated with tuberculosis (TB). A number of prospective studies exist, among a body of evidence, supporting probabilistic causation between diabetes mellitus (DM) and TB [2, 3]. Rather, the aim of our study was to identify age-adjusted prevalence and clinical characteristics of DM and intermediate hyperglycemia among those with newly diagnosed TB across 4 TB-endemic settings. In our South African population, the prevalence of DM (10.9% [95% confidence interval, 7%–14.9%]) was the lowest across all 4 study sites. However, as the smallest site, uncertainty around this estimate is greatest and the prevalence estimate was shown to increase after age standardization.