E Renner, RA Schreiber. Re: The new Canadian Association for the Study of the Liver HCV guidelines. Can J Gastroenterol Hepatol 2014;28(3):164-164.

To the Editor:

The new Canadian Association for the Study of the Liver (CASL) guidelines for managing hepatitis C virus (HCV) infection were published in the January/February 2015 issue of the *Journal* (Can J Gastroenterol Hepatol 2015;29:19-34). This is a milestone for CASL, but also an opportunity for critical analysis and for preparing the next steps.

In Spring 2014, the CASL Executive tasked a small group of experts to draft new clinical practice guidelines for the management of hepatitis C that would take into account the progress of treatment and the specific Canadian context. The intent was (and is) to help treating physicians and patients make timely and educated treatment choices in the rapidly changing field of HCV care with new, highly effective and well tolerated direct antiviral agents becoming available in fast sequence. Based on an extensive review of the literature and their own experience, the HCV experts who authored the guidelines drafted a first version for review by the CASL Executive. A revised version was then sent for comments to the CASL membership. The final published version is the end product of this broad consultation process and proves to be of high quality when assessed using instruments such as the Appraisal of Guidelines for Research and Evaluation II (<http://www.agreetrust.org/resource-centre/agree-ii/>). Of note, everyone involved with the development of these guidelines did so on a purely voluntary basis, without external funding from any source, and any potential conflicts of interest of the authors (as per the date of submitting the guidelines for publication) were declared in the publication.

Yet, as with any effort of this nature, there is always room for improvement. The consultative process could have been more inclusive. Only one of the authors is an infectious disease specialist and some may argue that HCV-treating infectious disease specialists should have been consulted in a more systematic way. Moreover, other potential HCV treaters, including family physicians and nurses, patient advocacy groups and others, could have been included. However, a consultative process that is too broad or one that aims to be all encompassing may suffer from its ability to ever achieve consensus in a timely manner. In fact, in the case of HCV, in which the treatment options keep changing so drastically in so short a time, the balance of the extent of consultation and the need to opportune prompt production of an informative guideline is a fine line between too much and too little.

From the beginning, it was the intent of CASL to avoid real or perceived bias, and to be fully transparent about potential conflicts of interest (no external funding, full declaration by all authors at conclusion of the publication). After electronic publication and

while the guidelines were on press, we were informed by the first author of the guidelines that he had accepted a position with a pharmaceutical company starting in the immediate future. While this position is outside the HCV field, the company is heavily engaged in therapeutics for HCV. Immediately, an urgent teleconference was held with the authors of the guidelines. We learned that the first author's contact with the pharmaceutical company had started not before, but while working on the guidelines, that he had accepted the position only after the final version of the guidelines was submitted for publication to the *Journal* and, that he had felt, for confidentiality reasons, it was not possible to declare this potential conflict of interest earlier than he did. The co-authors confirmed that the content of the guidelines is based on the best available evidence, not biased by the aforementioned, and continues to have their full support. After considering several options to deal with the issue, it was decided the best approach was to be completely transparent and declare this potential conflict of interest – albeit after the fact because timelines did not permit its inclusion in/with the publication – by writing the present Letter to the Editor and asking for its immediate publication in the next available issue of the *Journal*. In the future, CASL will require all those involved in developing clinical practice guidelines to sign a contract regarding declaration of potential, perceived and actual conflicts of interest, be they pre-existing or arising during guideline development.

Where do we go from here with these HCV guidelines? Given the rapidly evolving HCV therapeutic domain, CASL is currently considering various options to assure that the current HCV guidelines are updated in a timely fashion as new therapeutic options become available. This will include having a most up-to-date electronic version of our HCV guidelines readily available on the CASL website (www.hepatology.ca) in a user-friendly, searchable format. Partnering with other national associations in developing updates, extending the coverage of the guidelines to special populations currently not covered and potentially developing practice guidelines in other areas will be important. Finally, transferring knowledge and having accurate 'state of the art' information readily available for the benefit of our patients does not end with developing/publishing practice guidelines. Monitoring the uptake of recommendations and, if necessary, removing obstacles to improve on it, are also essential to this effort. Indeed CASL, in collaboration with all stakeholders, will promote the development of sound policy to make modern anti-HCV therapy available to all those in Canada who need it.

Eberhard L Renner MD FRCPC
CASL President

Richard A Schreiber MD CM FRCPC FAASLD
CASL President-elect