REPLY:

We are disappointed that the Cochrane group remains unconvinced that sustained virologic response (SVR) is a validated surrogate outcome and that direct-acting antiviral agents (DAAs) have been demonstrated to improve clinical as well as patient-reported outcomes in patients with chronic hepatitis C. Since our commentary in 2017, there have been many more studies supporting the benefits of SVR and DAA therapies, including a decline in patients added to the waiting list for liver transplantation for hepatitis C. We recognize that randomized controlled trial is the gold standard for showing the benefits of treatments, but given the robust evidence from clinical trials and observational studies all over the world, we do not believe that it is ethical to contemplate withholding clinically proven beneficial therapy. We stand by our associations' recommendations that all patients with chronic hepatitis C should be treated.

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Letter to Editor: Using Proper Methods to Identify Patients With Cirrhosis in Administrative Databases Is Crucial to Correctly Predict Outcomes

TO THE EDITOR:

We would like to congratulate Mumtaz et al.[1] for their important study attempting to develop and validate a risk score to predict 30-day hospital readmission in patients with decompensated cirrhosis using the US nationwide readmission database (NRD). Identifying patients with cirrhosis at high risk for readmission is critical for developing processes to effectively address this problem. However, flaws in patient identification challenge the utility of the risk score outlined in this study. Specifically, the authors failed to discuss their observed high readmission rates in the context of published data from the large multistate study by Tapper et al.[2] The NRD consists of patient data from multiple state inpatient databases (SID). Tapper et al. used SID data from five large geographically diverse states to describe 12.9% to 24.2% 30-day readmission rates in patients with 1-3 cirrhosis decompensation features, respectively. In contrast, Mumtaz et al. report a baseline 30-day readmission rate of 27%—an unexpected significant difference in readmission rates, given that the NRD is based on SID. This variation could be due to the case definition of decompensated cirrhosis. Specifically, the authors defined decompensated cirrhosis as the presence of cirrhosis plus any of the following: ascites, hepatic encephalopathy, variceal bleeding, or spontaneous bacterial peritonitis. However, in reviewing their coding, the International Classification of Disease Ninth Edition (ICD-9) clinical modification codes 348.30, 348.39, and 780.97 were included, which describe general encephalopathy or altered mental status. The authors cite two studies to support the use of these codes. However, no study has in fact validated these codes in patients with cirrhosis. Similarly, the authors used nonvalidated codes for coagulopathy. There are important studies describing the validity of ICD-9 codes to identify patients with cirrhosis.[3,4] The use of well-validated codes to identify patients