RESEARCH LETTER

Changes in Testing for Human Immunodeficiency Virus, Sexually Transmitted Infections, and Hepatitis C Virus in Opioid Treatment Programs

Opioid dependence is a risk factor for human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and hepatitis C virus (HCV) infection.1 Opioid treatment programs, which provide treatment to more than 300,000 opioid-dependent individuals in the United States,2 are well-positioned to offer testing for these infectious diseases to a high-risk population. They were among the first venues to offer HIV testing and are more likely to offer HIV, STI, and HCV testing than other drug treatment programs.3 Private for-profit opioid treatment programs are increasingly widespread and such programs offer on-site HIV testing less often than nonprofit and public programs.3 However, with the 2006 national recommendations for routine opt-out HIV testing,4 we hypothesized that the percentage of programs offering on-site testing for HIV, STIs, and HCV would increase.

Methods | To determine the percentage of opioid treatment programs offering on-site testing over time, we analyzed the National Survey of Substance Abuse Treatment Services.5 The survey is sent to directors of all known drug treatment facilities (response rate, 91.4%-96.5%); survey questions had minor wording changes over time. We tabulated the percentage of opioid treatment programs offering on-site HIV, STI, and HCV testing from 2000 to 2011; there was no survey in 2001. We compared the percentage of for-profit, nonprofit, and public (owned and operated by local, state, tribal, or federal government) programs offering on-site testing over time. Programs with missing data (0.2%-3.9% per year) were excluded. We calculated the relative difference in programs offering on-site testing in 2000 and 2011 using SAS version 9.3 (SAS Institute Inc). P values were calculated using χ2 tests for trend. A 2-sided P≤.05 was considered significant. Because the survey is publicly available and contains no patient-level data, the Albert Einstein College of Medicine institutional review board determined this study was not considered human research.

Results | The number of US opioid treatment programs increased from 849 in 2000 to 1175 in 2011. The percentage of programs operating as for-profit businesses increased from 43% to 54%, nonprofits decreased from 43% to 36%, and public programs decreased from 14% to 10%. From 2000 to 2011, the absolute number of programs offering testing for HIV, STIs, and HCV increased but the percentage offering on-site testing for HIV declined by 18% (95% CI, 13%-23%; P < .001) and for STIs by 13% (95% CI, 7%-18%; P < .001). There was no significant change for HCV testing (P = .63; Figure 1).

More than 75% of public programs offered on-site testing for each infection, with no significant change over time. Offering on-site HIV testing declined by 20% (95% CI, 10%-29%; P < .001) among for-profit programs and by 11% (95% CI, 6%-17%; P < .001) among nonprofit programs (Figure 2). Offering on-site STI testing declined by 23% (95% CI, 16%-30%; P < .001) in for-profit programs. Offering HCV testing declined by 13% (95% CI, 3%-22%; P = .002) in for-profit programs and increased by 14% (95% CI, 4%-25%; P < .001) in nonprofit programs.

Conclusion | The proportion of US opioid treatment programs offering on-site testing for HIV and STIs declined substantially between 2000 and 2011, despite guidelines recommending routine opt-out HIV testing in all health care settings, including substance abuse treatment facilities. Declines were most pronounced in for-profit programs, suggesting that persons enrolled in these programs may be at increased risk for delayed diagnosis and continued transmission of HIV, STIs, and HCV.

This study had limitations. Referral-based testing was not recorded; however, referral-based services often do not translate into patient use.6 Testing for STIs may be limited...
Intraoperative Cholangiography During Cholecystectomy

To the Editor: Dr Sheffield and colleagues1 found that on a patient level, intraoperative cholangiography was associated with reduced risk of common bile duct injury during cholecystectomy, presumably by laying out a roadmap for the surgeon. This is consistent with other appropriately powered studies of the topic. A secondary, instrumental variable analysis was performed to control for the unmeasured confounding in this study based on administrative data, but it is unclear whether this was appropriate.

To justify this approach, the authors cited 3 studies using clinical data that have not shown a benefit with intraoperative cholangiography, but these studies were either underpowered or included minor common bile duct injuries that are expected when intraoperative cholangiography helps to avoid a major common bile duct injury. More recently, Törnqvist et al2 used only clinical data and found the same protective relationship of intraoperative cholangiography, including a survival benefit.

The instrumental variable analysis was also problematic. Intraoperative cholangiography is used for different reasons by routine vs selective users, the former using it for a road map or safety-first approach and the latter using it to look for an injury once it is suspected. As the Editorial3 pointed out, hospitals where surgeons are routinely using intraoperative cholangiography may be hospitals where surgeons are doing other safety-first activities, including the use of trained assistants and better visualization technology that may be associated with lower risk of common bile duct injury.

Marcus A. Bachhuber, MD
Chinazo O. Cunningham, MD, MS

Author Affiliations: Division of General Internal Medicine, Albert Einstein College of Medicine, Bronx, New York.

Corresponding Author: Chinazo O. Cunningham, MD, MS, Albert Einstein College of Medicine, 111 E 210th St, Bronx, NY 10467 (ccunning@montefiore.org).

Author Contributions: Dr Bachhuber had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Bachhuber.

Acquisition of data: Bachhuber.

Analysis and interpretation of data: Bachhuber, Cunningham.

Drafting of the manuscript: Bachhuber, Cunningham.

Critical revision of the manuscript for important intellectual content: Bachhuber, Cunningham.

Statistical analysis: Bachhuber.

Obtained funding: Cunningham.

Study supervision: Cunningham.

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Cunningham’s husband was recently employed by Pfizer Pharmaceuticals and is currently employed by Quest Diagnostics. No other disclosures were reported.

Funding/Support: This study was supported by grants R34DA031066, R01DA032110, R25DA023021, and AI-51519 from the National Institutes of Health.

Role of the Sponsor: The National Institutes of Health had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.


COMMENT & RESPONSE

Copyright 2013 American Medical Association. All rights reserved.