SVR12 is higher than SVR24 in treatment-naïve hepatitis C genotype 1 patients treated with peginterferon plus ribavirin

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Background: Randomized clinical trials (RCTs) of interventions for the hepatitis C virus have historically used sustained virological response (SVR) at 24 weeks after treatment (SVR24) as the key effect measure. However, recent RCTs investigating the efficacy of new direct acting agents (DAAs) have used SVR at 12 weeks after treatment (SVR12). While there is evidence to suggest SVR24 and SVR12 are similar in patients receiving new DAAs, this is unlikely to be true for patients receiving backbone peginterferon-ribavirin control treatment. Establishing the difference between SVR12 and SVR24 for patients receiving peginterferon-ribavirin treatment is therefore necessary to avoid biased interpretations of the benefits of newer DAAs.

Methods: We searched the MEDLINE®, Embase™, and Cochrane CENTRAL for RCTs with a peginterferon-ribavirin arm that used SVR24 and/or SVR12. As no RCTs reported on both, we pooled SVR12 and SVR24 proportions using conventional meta-analysis. Proportions were pooled separately for peginterferon alpha-2a and alpha-2b. Further, a Bayesian meta-regression model was employed to estimate the difference between SVR12 and SVR24.

Results: Thirty-five RCTs including a peginterferon arm were identified. Twenty-four trials included a peginterferon alpha-2a plus ribavirin arms, of which 20 reported SVR24 and five reported SVR12. Seventeen trials included a peginterferon alpha-2b plus ribavirin arm, of which 16 reported SVR24 and one reported SVR12. Using Bayesian meta-regression, the pooled SVR12 was 6% higher than SVR24 with peginterferon alpha-2a (53% versus 47%) and 5% higher with peginterferon alpha-2b (45% versus 40%) and 95% credible intervals (CrIs) were only marginally overlapping. The meta-regression also demonstrated a marginally significant relative risk of 1.13 (95% CrI 0.99–1.26) of SVR12 versus SVR24. The conventional pairwise meta-analyses were consistent with these findings.

Conclusion: Considering the relatively large difference observed between SVR12 and SVR24, it seems reasonable to insist that future clinical trials report both to allow for complete transparency and clarity in their interpretation.

Keywords: sustained virological response, meta-regression, direct acting antivirals

Background
Historically, Phase II and Phase III clinical trials of hepatitis C virus (HCV) treatments have defined sustained virological response (SVR) as an undetectable HCV RNA 24 weeks after end of treatment (SVR24). This definition of SVR has been used in all key randomized clinical trials (RCTs) of peginterferon plus ribavirin, telaprevir, and boceprevir. However, due to the high efficacy of newer direct acting agents (DAAs) (eg, faldaprevir, simeprevir, and sofosbuvir), clinical trials assessing these treatments have used SVR at 12 weeks after end of treatment (SVR12). In patients receiving these...
newer agents, some RCTs have demonstrated nearly identical SVR12 and SVR24,1,2 and this has left trial researchers uncomfortable using SVR12 as the primary efficacy outcome. In addition, the impressively high SVRs observed in the recent clinical trials, along with the interferon-sparing properties of the newer agents, is surely sufficient to convince drug regulatory authorities. However, as the newer DAAs are slated to enter the market, decision-makers and clinicians will be faced with the challenge of deciding which agents are most likely to clear HCV, and for many Western countries, which agent(s) will be the most cost-effective to reimburse.

Since none of the newer agents have been compared head-to-head in RCTs, the best approach for establishing comparative efficacy between all agents is a technique commonly referred to as indirect treatment comparison (ITC) meta-analysis. ITC meta-analysis is a technique that is now widely recognized by health technology agencies worldwide. A key premise of ITC meta-analyses, however, is that all considered agents have been compared with the same control intervention using the same outcome measure. In the case of the DAAs, most newer agents have been compared with peginterferon plus ribavirin, but the efficacy of the first generation DAAs, telaprevir and boceprevir, have been established using SVR24; whereas the efficacy of the newer DAAs have predominantly been established using SVR12. Since decisions regarding the reimbursement of the newer DAAs will rely heavily on the results of ITC meta-analyses in most countries, and since the validity of ITC meta-analysis hinge on the similarity of SVR24 and SVR12, it is highly important to establish whether this similarity in fact holds true. Further, since peginterferon plus ribavirin is considerably less potent than newer DAAs, and the end-of-treatment response is typically substantially higher than SVR24, there is reason to believe that SVR24 and SVR12 differ importantly in patients receiving peginterferon plus ribavirin. The extent to which SVR24 and SVR12 may differ needs to be established so decision-makers can appropriately account for the potential difference in their decision-making processes. In Table 1, we illustrate the potential bias that can occur on the relative efficacy estimates between DAAs and control peginterferon-ribavirin, when assuming that SVR12 and SVR24 are equal.

Currently, no clinical trials including a peginterferon plus ribavirin arm have reported both SVR12 and SVR24. However, several trials have reported SVR24, and a number of trials investigating newer DAAs include a peginterferon plus ribavirin arm and report on SVR12. To compare SVR24 and SVR12 in patients receiving peginterferon plus ribavirin we therefore undertook a systematic review of clinical trials including a peginterferon plus ribavirin arm that reported either SVR24 or SVR12.

**Methods**

**Trial eligibility criteria**

We included RCTs involving standard doses of peginterferon alpha-2a or alpha-2b administered in combination with ribavirin for 48 weeks to treatment-naive patients. Standard doses were determined according to EASL (European Association for the Study of the Liver) (alpha-2b 1.5 µg per kg subcutaneously once weekly, alpha-2a 180 µg subcutaneously once weekly, ribavirin total daily dose of 600–1400 mg depending on patient weight). We included clinical trials that reported SVR for HCV genotype 1. We arbitrarily allowed for combined reporting for genotype 1 and 4 if the proportion of genotype 4 patients did not exceed 10%. We only considered studies conducted in North America or Europe and excluded trials administering non-standardized doses, including patients with co-infections (eg, HIV [human immunodeficiency virus]) or comorbidities (eg, cirrhosis).

**Search strategy**

A search strategy was developed in consultation with a medical librarian. The included search terms were peginterferon OR peg-interferon OR pegylated interferon AND ribavirin AND hepatitis C. The search was limited to randomized trials in humans. We searched the following databases (from inception to week 31 [July 29–August 4], 2013): MEDLINE®,
Our findings indicate that SVR12 is higher than SVR24 in HCV genotype 1 patients treated with peginterferon plus ribavirin. This difference holds true for both peginterferon alpha-2a and peginterferon alpha-2b. These findings do not come as a surprise as it has long been known that end-of-treatment response with peginterferon-ribavirin treatment is larger than SVR24, and that the loss of viral response in patients after end of treatment occurs gradually during the 24-week follow-up period.

Our findings have implications for the interpretation of current and future RCTs comparing new DAAs with backbone peginterferon-ribavirin alone. In particular, newer direct acting agents may erroneously be interpreted as only exhibiting moderate benefit over backbone peginterferon-ribavirin treatment if SVR is assessed at 12 weeks after treatment and the assumption is made that SVR12 and SVR24 are identical. ITC meta-analysis and network meta-analysis...
<table>
<thead>
<tr>
<th>Trial</th>
<th>No of patients</th>
<th>Genotype</th>
<th>Experimental intervention</th>
<th>Peginterferon arm</th>
<th>SVR12</th>
<th>SVR24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fried et al</td>
<td>298</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
<td>46.3%</td>
</tr>
<tr>
<td>Hadziyannis et al</td>
<td>271</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
<td>52.0%</td>
</tr>
<tr>
<td>Ferenci et al</td>
<td>95</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
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<tr>
<td>Diago et al</td>
<td>475</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
<td>47.8%</td>
</tr>
<tr>
<td>von Wagner et al</td>
<td>352</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
<td>52.8%</td>
</tr>
<tr>
<td>Zeuzem et al</td>
<td>114</td>
<td>I</td>
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<td>Alpha-2a</td>
<td>–</td>
<td>57.9%</td>
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<tr>
<td>Hezode et al</td>
<td>82</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
<td>46.3%</td>
</tr>
<tr>
<td>Roberts et al</td>
<td>438</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
<td>50.0%</td>
</tr>
<tr>
<td>Marcellin et al</td>
<td>212</td>
<td>I</td>
<td>Peginterferon alpha-2a</td>
<td>Alpha-2a</td>
<td>–</td>
<td>43.9%</td>
</tr>
<tr>
<td>Zeuzem et al</td>
<td>441</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>51.0%</td>
</tr>
<tr>
<td>Ascione et al</td>
<td>93</td>
<td>1,4</td>
<td>Both peginterferons</td>
<td>Alpha-2a</td>
<td>–</td>
<td>54.8%</td>
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<tr>
<td>McHutchison et al</td>
<td>1,035</td>
<td>I</td>
<td>Both peginterferons</td>
<td>Alpha-2a</td>
<td>–</td>
<td>40.9%</td>
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<tr>
<td>Rumi et al</td>
<td>91</td>
<td>I</td>
<td>Both peginterferons</td>
<td>Alpha-2a</td>
<td>–</td>
<td>48.4%</td>
</tr>
<tr>
<td>Yenice et al</td>
<td>40</td>
<td>I</td>
<td>Both peginterferons</td>
<td>Alpha-2a</td>
<td>–</td>
<td>45.0%</td>
</tr>
<tr>
<td>McHutchison et al</td>
<td>75</td>
<td>I</td>
<td>Telaprevir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>41.3%</td>
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<tr>
<td>Jacobson et al</td>
<td>361</td>
<td>I</td>
<td>Telaprevir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>43.8%</td>
</tr>
<tr>
<td>Bronowicki et al</td>
<td>11</td>
<td>I</td>
<td>Asunaprevir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>45.4%</td>
</tr>
<tr>
<td>Bronowicki et al</td>
<td>53</td>
<td>I</td>
<td>Asunaprevir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>52.8%</td>
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<tr>
<td>Sukowski et al</td>
<td>71</td>
<td>I</td>
<td>Asunaprevir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>45.0%</td>
</tr>
<tr>
<td>Manns et al</td>
<td>50</td>
<td>I</td>
<td>Asunaprevir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>62.0%</td>
</tr>
<tr>
<td>Jacobson et al</td>
<td>132</td>
<td>I</td>
<td>Asunaprevir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>50.0%</td>
</tr>
<tr>
<td>Lawitz et al</td>
<td>26</td>
<td>I</td>
<td>Sofosbuvir</td>
<td>Alpha-2a</td>
<td>–</td>
<td>57.7%</td>
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<tr>
<td>Benhamou et al</td>
<td>226</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>41.6%</td>
</tr>
<tr>
<td>Berg et al</td>
<td>225</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>48.0%</td>
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<tr>
<td>Brady et al</td>
<td>311</td>
<td>1,4</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>29.6%</td>
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<tr>
<td>Bui et al</td>
<td>86</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>43.0%</td>
</tr>
<tr>
<td>Jacobson et al</td>
<td>1,313</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>38.7%</td>
</tr>
<tr>
<td>Kumada et al</td>
<td>31</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>49.2%</td>
</tr>
<tr>
<td>Poordad et al</td>
<td>70</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>27.1%</td>
</tr>
<tr>
<td>Scotto et al</td>
<td>26</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>50.0%</td>
</tr>
<tr>
<td>Shiffman et al</td>
<td>48</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>29.2%</td>
</tr>
<tr>
<td>Sjogren et al</td>
<td>29</td>
<td>I</td>
<td>Peginterferon alpha-2b</td>
<td>Alpha-2b</td>
<td>–</td>
<td>41.4%</td>
</tr>
<tr>
<td>Ascione et al</td>
<td>93</td>
<td>1,4</td>
<td>Both peginterferons</td>
<td>Alpha-2b</td>
<td>–</td>
<td>39.8%</td>
</tr>
<tr>
<td>McHutchison et al</td>
<td>1,019</td>
<td>I</td>
<td>Both peginterferons</td>
<td>Alpha-2b</td>
<td>–</td>
<td>39.8%</td>
</tr>
<tr>
<td>Rumi et al</td>
<td>87</td>
<td>I</td>
<td>Both peginterferons</td>
<td>Alpha-2b</td>
<td>–</td>
<td>32.2%</td>
</tr>
<tr>
<td>Yenice et al</td>
<td>40</td>
<td>I</td>
<td>Both peginterferons</td>
<td>Alpha-2b</td>
<td>–</td>
<td>32.5%</td>
</tr>
<tr>
<td>Kwo et al</td>
<td>104</td>
<td>I</td>
<td>Boceprevir</td>
<td>Alpha-2b</td>
<td>–</td>
<td>37.5%</td>
</tr>
<tr>
<td>Poordad et al</td>
<td>363</td>
<td>I</td>
<td>Boceprevir</td>
<td>Alpha-2b</td>
<td>–</td>
<td>37.8%</td>
</tr>
<tr>
<td>Manns et al</td>
<td>80</td>
<td>I</td>
<td>Simprevir</td>
<td>Alpha-2b</td>
<td>–</td>
<td>42.5%</td>
</tr>
</tbody>
</table>

**Abbreviations:** SVR12, sustained virological response at 12 weeks after treatment; SVR24, sustained virological response at 24 weeks after treatment.

informing comparative efficacy of newer DAAs may also become biased if a mixture of SVR12 and SVR24 control responses are used in the analysis.

There are strengths and limitations to consider in our analysis. Strengths include the systematic inclusion of all relevant clinical trials allowing for a well informed analysis. Further, our analysis was designed specifically for this project using a Bayesian approach that recognizes differences in effect sizes across arms, thereby allowing greater precision to detect differences. Weaknesses of our study include the fact that publication bias inherently exists as the trials have been completed but do not report on both 12- and 24-week SVR. Newer DAAs in particular have had their trials completed but are, as yet, unavailable in published form. Lastly, our results are based on separated single-arm evidence, and while the considerable amount of data adds to the reliability of our results, confirmations of our findings will be required from randomized clinical trials that report both SVR12 and SVR24. In this vein, we should note that our findings stand in contrast to a recent retrospective observational study by Martinot-Peignoux which found a close to 100% agreement between SVR12 and SVR24 in patients receiving either of the two peginterferons. This study, however, included several genotype 2 and 3 patients.
as well and previous relapers and non-responders, and so, the populations are not fully comparable. The SVR24 in the study by Martinot-Peignoux was 71%, in contrast to the 35%–55% in all the RCTs included in our analysis. The study by Martinot-Peignoux used a highly sensitive assay with a lower level of detection of 9.6 IU/mL, and one can thus speculate that use of older less sensitive assays (eg, Copas Amplicor with 50 IU/mL lower level of detection) may be the cause of differences between SVR12 and SVR24. However, a subgroup analysis by RCTs using highly sensitive assays (defined as <20 IU/mL) versus “moderately” sensitive assays (actualized as 50 IU/mL or higher, although defined as >20 IU/mL) showed nearly identical SVR24 (results not shown). All trials reporting SVR12 used highly sensitive assays. In fact, the pooled proportions of highly sensitive assay SVR24 estimates were further from the SVR12 estimates than the pooled

Table 3 The pooled SVR12 and SVR24 proportions associated with peginterferon alpha-2a plus ribavirin and peginterferon alpha-2b plus ribavirin

<table>
<thead>
<tr>
<th>SVR time point</th>
<th>Peginterferon type</th>
<th>Conventional Meta-analysis</th>
<th>Bayesian Meta-regression</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVR12</td>
<td>Alpha-2a</td>
<td>54% (49%–59%)</td>
<td>53% (46%–59%)</td>
</tr>
<tr>
<td>SVR24</td>
<td>Alpha-2a</td>
<td>49% (46%–51%)</td>
<td>47% (45%–49%)</td>
</tr>
<tr>
<td>SVR12</td>
<td>Alpha-2b</td>
<td>43% (33%–53%)</td>
<td>45% (39%–53%)</td>
</tr>
<tr>
<td>SVR24</td>
<td>Alpha-2b</td>
<td>40% (38%–41%)</td>
<td>40% (38%–43%)</td>
</tr>
</tbody>
</table>

Notes: Proportions obtained with conventional pairwise meta-analysis of proportions, and with Bayesian meta-regression. The 95% confidence intervals and credible intervals are presented in parenthesis for the conventional meta-analysis and Bayesian meta-regression, respectively. 

Abbreviations: SVR, sustained virological response; SVR12, SVR at 12 weeks after treatment; SVR24, SVR at 24 weeks after treatment.

Figure 1 Study flow diagram.
Abbreviations: peg, peginterferon; SVR12, sustained virological response at 12 weeks after treatment; SVR24, sustained virological response at 24 weeks after treatment.

Figure 2 Forest plots of RCT peginterferon alpha-2a arms informing SVR12 (A) and SVR24 (B) proportions.
Abbreviations: RCT, randomized controlled trial; SVR12, sustained virological response at 12 weeks after treatment; SVR24, sustained virological response at 24 weeks after treatment.

proportions of the “moderately” sensitive assays. Considering that in the only RCT that reported both SVR12, SVR24, 51.8% and the SVR24 was 45.0%; and considering that our meta-analytic evidence is based on a large set of homogenous trials including a total of over 10,000 patients, it seems reasonable to suggest that limited confidence should be placed on the findings of the study by Martinot-Peignoux.

Considering the relatively large difference observed between SVR12 and SVR24, it seems reasonable to insist that future clinical trials report both outcome measures to allow for complete transparency and clarity in their interpretation.

Acknowledgments
We are grateful to Kabir Toor for his assistance with late-stage data extraction and proof reading of the manuscript.
Disclosure
Kristian Thorlund and Edward J Mills have previously consulted with Merck, Pfizer, Novartis, Janssen, and Gilead on systematic review issues. In addition, they have received grants from the Canadian Institutes of Health Research (CIHR) and consulted to the Canadian Agency for Drugs and Technology in Health and US Agency for Healthcare Research and Quality (AHRQ). Kristian Thorlund’s salary is supported by CIHR. Edward J Mills’ salary is supported by a CIHR Canada Research Chair. Eric Druyts does not have any potential competing interests. No funding was received for this study.

References
**Supplementary material**

WinBUGS code and data for the Bayesian meta-regression.

```r
## model begins

model{

###############################################
## Modelling of Peg-2a and Peg-2b SVR24 and SVR12 ##
###############################################

## Assigning priors for regression parameters
mu.peg ~ dnorm(0,.001)  # Mean logit peg-2a SVR12
coeff.pb ~ dnorm(0,.001) # Log OR offset from peg-2a to peg-2b
coeff.24 ~ dnorm(0,.001) # Log OR offset from SVR12 to SVR24

## looping over trial SVRs
for(i in 1:n.1)
{
  # Random effects logit link of SVR
  logit(p.p[i])<-mu[s[i]] + coeff.pb*p2b.p[i] + coeff.24*svr24.p[i]

  # binomial likelihood for number of patients with SVR
  r.p[i]~dbin(p.p[i],n.p[i])
}

## looping over trial baseline SVR (peg-2a SVR12)
for(j in 1:ns.1)
{
  # random-effects modelling of baseline Peg SVR
  mu[j] ~ dnorm(mu.peg, tau.b)
}

## Prior and deterministic equations for between-trial variance (random-effects term)
sd.b~dgamma(.01,.01)I(,1)
var.b<-pow(sd.b,2)
tau.b>-1/pow(sd.b,2)

## Conversions to effect measures of interest
logit(SVR2A12) <- mu.peg # back transform to proportions (SVR12 for peg-2a)
logit(SVR2B12) <- mu.peg + coeff.pb # back transform to proportions (SVR12 for peg-2b)
```
sVr12 is higher than sVr24 in patient receiving peginterferon plus ribavirin

\[
\text{logit} (\text{SVR2A24}) \leftarrow \mu.\text{peg} + \text{coef.24} \quad \# \text{back transform to proportions (SVR24 for peg-2a)}
\]
\[
\text{logit} (\text{SVR2B24}) \leftarrow \mu.\text{peg} + \text{coef.pb} + \text{coef.24} \quad \# \text{back transform to proportions (SVR24 for peg-2b)}
\]
\[
\text{RRAB12} \leftarrow \text{SVR2A12}/\text{SVR2B12} \quad \# \text{RR of peg-2a vs peg-2b for SVR12}
\]
\[
\text{RRAB24} \leftarrow \text{SVR2A24}/\text{SVR2B24} \quad \# \text{RR of peg-2a vs peg-2b for SVR24}
\]
\[
\text{RR1224A} \leftarrow \text{SVR2A12}/\text{SVR2A24} \quad \# \text{RR of SVR12 vs SVR24 for peg-2a}
\]
\[
\text{RR1224B} \leftarrow \text{SVR2B12}/\text{SVR2B24} \quad \# \text{RR of SVR24 vs SVR24 for peg-2a}
\]

## model ends
## Complete data set for Bayesian meta-regression ##

## number of trials and arms

\[
\text{list(ns.1=35, n.1=41)}
\]

## s[] is the study number
## p2b.p is in indicator function for whether the peginterferon is alpha-2b (=1) or alpha-2a (=0)
## r.p[] is the number of patients with SVR
## n.p[] is the number of patients
## svr24.p[] is an indicator function for whether SVR is SVR24 (=1) or SVR12 (=0)

<table>
<thead>
<tr>
<th>s</th>
<th>p2b.p</th>
<th>r.p</th>
<th>n.p</th>
<th>svr24.p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>51</td>
<td>93</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>37</td>
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25 1 19 70 1  ## Poordad 2010
26 0 40 71 1  ## Sulikowski 2013 — Faldaprevir (Hepatology)
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32 1 137 363 1  ## Poordad 2011 (boceprevir)
33 0 31 75 1  ## McHutchinson 2009 (telaprevir)
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35 0 15 26 0  ## Lawitz 2013 (sofosbuvir)
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