

# HEPATITIS B

## MELBOURNE SEXUAL HEALTH CENTRE TREATMENT GUIDELINES

OCTOBER 2006

Hepatitis B is a viral infection affecting the liver. It is endemic in many Asian, Mediterranean and African countries. Common routes of infection include vertical transmission (mother to child), close contact (household contact, child to child infection), sexually and through blood products including injecting drug use, unsterile tattooing or piercing practices and needle stick injuries.

Acute hepatitis B infection ranges from asymptomatic to severe requiring hospitalisation. Approximately 90-95% of infections acquired perinatally and 5-10% of adult acquisitions go on to become chronic infections, which may eventually lead to cirrhosis and hepatocellular carcinoma. Australia commenced universal infant vaccination and an adolescent catch up program in 2000.

### DIAGNOSIS

	Anti-HBc	Anti-HBs	HBsAg	HBV* DNA	Action
Past resolved Hepatitis	+	+	-		No follow up required
Chronic infection	-	-	+	+/-	For Liver Clinic follow up
Past vaccination	-	+	-		

#### Comments

- \*DNA Hybridisation assay.
- Isolated anti-HBc (negative HbsAg/sAb) do DNA.

#### Disclaimer

The content of these treatment guidelines is for information purposes only. The treatment guidelines are generic in character and should be applied to individuals only as deemed appropriate by the treating practitioner on a case by case basis. Bayside Health, through MSHC, does not accept liability to any person for the information or advice (or the use of such information or advice) which is provided through these treatment guidelines. The information contained within these treatment guidelines is provided on the basis that all persons accessing the treatment guidelines undertake responsibility for assessing the relevance and accuracy of the content and its suitability for a particular patient. Responsible use of these guidelines requires that the prescriber is familiar with contraindications and precautions relevant to the various pharmaceutical agents recommended herein.

### MANAGEMENT

Routine serology screening in low risk clients is not recommended however it should be performed on clients:

- with family members with hepatitis B
- from high prevalence countries
- with high risk exposure including IDU and MSM
- with Hepatitis C
- from Aboriginal and Torres Strait Island Communities

For low risk clients who are unsure of their vaccination history clinicians must talk about the advantages of hepatitis B vaccination. They should discuss whether the client wishes to ascertain their vaccination history or whether they want to commence the vaccination schedule at this or a subsequent visit.

### VACCINATION

Hepatitis B vaccine should be recommended and commenced for anyone with no history of prior vaccination who is at risk to the infection.

Vaccination at the time of initial serology is recommended for clients:

- with family members with hepatitis B
- from high prevalence countries
- with high risk exposure including IDU and MSM
- from Aboriginal and Torres Strait Island communities

#### Administer by deep intramuscular injection into the deltoid muscle

*Children and adults up to 20 years*

- 3 doses of 0.5 ml paediatric formulation

*Adults over 20 years*

- 3 doses of 1 ml adult formulation

*HIV positive individuals*

- 3 doses of 1 ml adult formulation in each arm (6 doses in total)

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### VACCINATION SCHEDULE

Optimal interval: 0, 1 & 6 months.

Seroprotective response after each dose for adults under 40 are 50%, 70% and >90% for each dose respectively.

Alternate accelerated schedule: 0, 1, 2 & 12 months or 0, 7, 21 days & 12 months

Accelerated schedules should be considered where more rapid protection is required, eg vaccination to travellers or clients with partners with hepatitis B.

Continue vaccination if the course is incomplete – do not restart, just complete the course. Consider a person vaccinated if there have been 3 hepatitis B vaccinations within 1 year, or 2 vaccinations as part of school programme.

### POST VACCINATION SEROLOGY TESTING

(Anti-HBs) is not recommended routinely. It is recommended 4 weeks after the third dose in

- individuals at significant occupational risk
- immunocompromised individuals and those with pre-existing liver disease

If the antibody response <10mIU/mL, give booster then re-test after 4weeks, along with HBsAg, Anti-HBc and HIV serology. If these tests are all negative proceed to complete the second course then re-test. If there is still no response consider the client a non-responder and advise the client that they are still susceptible and will require HB immune globulin if they have a known future exposure.

### BOOSTER DOSES

Recommended for immunocompromised individuals, especially HIV positive individuals, and should be performed according to annual monitoring of anti-HBs levels.

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