Hepatitis B Prescriber Forum Q&A

This resource outlines the questions asked during the Hepatitis B Prescriber Forum run Friday 24th February 2023. Answers to questions have been provide however many were answered live, to watch the live recording click here.

Session: Hepatitis B Trends in your area

Q. In this version of the mapping project, what measure was used to define "engaged in care"? Any limitations in the data?

A. Thanks Daniel, good question - a person was “engaged in care” if they who had either treatment or a viral load test in the past year (through Medicare/PBS). It’s intended to be a simple metric, and so it doesn’t track ongoing care over time, but we do report on more complex measures in the Mapping Report (https://ashm.org.au/vh-mapping-project/ - see p38). Medicare data provides high coverage but obviously will not include everyone, such as those ineligibles for Medicare (estimated to be around 5% of those with CHB).

Q. What post code has the highest prevalence of hepatitis b carrier?

A. Thanks for the question Jay - we don’t report prevalence data specifically by postcode, but the regions with the highest prevalence include the West Arnhem, Katherine, and Barkly regions of NT; Kimberley in WA; and Fairfield in Sydney. All of these areas have prevalence higher than 2.5%. If anyone would like to look up their postcode to see what statistical area 3 it is in (to compare with the report), there is a resource here: https://maps.abs.gov.au/index.html.

Q. What is the link for local info?

A. The online portal is available here: https://public.tableau.com/profile/nationalhepmapping#!/. For background information about data sources and instructions for the portal, you can visit https://ashm.org.au/vh-mapping-project/. Thanks!

Session: Perspectives of individuals living with hepatitis B: patient-centered care

Q. Has Rachel checked her four children for their HB status?

A. Answered live

Q. Is her father on reg HCC screen?

A. Answered live

Q. Great to have your insights today. Thank you, Rachel. Can you give us some ways you think clinicians could do better with communicating with patients about hepatitis B?

A. Answered live

Q. This question is around diagnosis, Marilou what have you found to be helpful when giving patients a positive diagnosis?

A. Answered live

Q. With her four pregnancies did she have TDF prophylaxis?

A. Answered live

Q. I have seen a pt with CHB but not having regular checkups. there is still concept of Hep B carrier in some CHB patients. Any tips to encourage the pt to involve in regular checkups. or do we require to promote the available and accessible treatment of CHB like Hep C treatment?

A. Answered live

Q. Do the panelists think that some people might be reluctant to undergo HBV screening due to future applications for Permanent Residency? If so, how do they approach this?

A. Answered live

Q. Cost of medications for non-Medicare card holders is always an ongoing issue. Is there compassionate access to such medications as in HIV medications?

A. Rolf - agree. We are speaking about Medicare issues in a session at 2.15pm. There is some compassionate access but much more limited than HIV context. Noting the costs of generics, while still expensive for patients, has come down significantly.

Session: Case Study on providing culturally appropriate care to patients from a migrant background

Q. Dr Capati, which hep B resources do you find best for our Indigenous communities. I'm based in Papanya, NT. Pintupi Luritja language group.

A. Answers from chat:

- HepBHelp has a list of resources for patients that clinicians can use/download from (including links to all hep orgs across Australia) - http://www.hepbhelp.org.au/index.asp?PageID=7
- Another great resource developed in NT is the Hep B Story - https://www.menzies.edu.au/page/Resources/Hep_B_Story/

Q. A question for Prof Cowie in his session: now that our medical software can directly access the AIR it is generally easy to see hepatitis B vaccination histories for young adults who grew up in Australia. Working in sexual health and in general practice I screen widely with triple serology, and I look at the AIR where it is recorded for many young adults that they received two Hepatitis B vaccines as teenagers. Many (I do not know how many) of these are negative for Hep B surface antigen and antibody and core antibody. Is this a failure of the two-vaccine regimen? Thank you.

Session: Perspectives of NP Prescribers: Models of care and how nurses can support the management of care

Q. Hi Tracey, fascinating presentation, great to hear what you do - thank you! Is there a care plan for inmates with hepatitis B when they leave custodial settings and return to the community?

A. All patients are provided with a release summary which contains all the information and investigations that have been conducted whilst they are in custody. They are also provided with a referral to their existing healthcare provider (or new referral if require linkage to care) detailing the specific HBV management plan and timeline of when further investigations are required.

Q. When patients come into custody, with perhaps partial treatment or treatment that needs to be escalated, are there any special barriers to overcome? do you think it's the same as any transition from community to institutional care?

A. Hi Kelly, if the patients identify that they are on treatment prior to incarceration then we contact the healthcare provider who prescribed the medication to obtain a summary of their care. The patient is assessed thoroughly and any patients on treatment or to be considered for treatment are reviewed in our weekly liver clinic. The HBV NLMC reviews routinely occur every 6 months and we use the ASHM Decision making in HBV resource to guide our practice.
A barrier in this scenario to continuity of care is the delay in accessing a healthcare summary from the external care provider. This is why we attempt to provide the clear summaries as the patient exits custody- and arrange linkage to care.

Session: Case study on hepatitis B seroconversion
Q. Can we get quantitative sAg in Australia?

A. Answered live

Q. What would you do if the patient has HbcAb positive only? You would give Hep B vaccination or will check PCR/ viral load?

A. Answered live

Q. What level of AFP is it considered significantly elevated?

A. I think any AFP above the normal range should be investigated. The cutoff varies between labs. It should be accompanied by an ultrasound. Sometimes active flare of hepatitis may cause it to be elevated in the absence of HCC. But if it is elevated above normal range or newly rising, you may consider a more sensitive scan such as a multi-phase CT if the ultrasound is negative.

Q. I recently had a CHB who seroconverted. HBsAg was negative but VL was 13. Repeat testing HBsAg was negative and VL undetectable. There was difficulty asking the laboratory to test VL when sAg was negative. Is this common? Or does VL usually become undetectable prior to loss of sAg?

A. This is an uncommon situation. Yes the VL should become negative if you seroconvert HBsAg. So it may be that your patient was in the process of seroconverting. The other option is that the patient has occult HBV infection (HBsAg negative but still positive viral load). But in that setting, their HBsAg should have been negative all along, rather than seroconverted from positive to negative.

Q. Does vaccination to hep B, help increase the HepbSAb level in this case of seroconversion? Therefore, promoting them to stay hepbSAg neg?

A. No, if they have naturally seroconverted, the addition of vaccination would not help boost HBsAb and does not help prevent reactivation.

Q. Hi Ken, thanks interesting thoughts. That approach to HCC surveillance in those who seroconvert makes me wonder if we should consider it for people who are diagnosed with "cleared HBV" for the first time (i.e never enter care when they are sAg +ve but only picked up after they are sAg -ve sAb +ve cAb +ve). This would be a big cohort of people to consider HCC screening for I presume.

A. Answered live

Q. Who will decide whether before treatment of chemo etc of the patient, patient need to be given prophylaxis treatment?

A. This decision is probably best made in conjunction with a gastroenterologist/hepatologist as it depends on their type of chemo regimen.

Q. Does patient occult hepatitis b need to be treated?

A. Answered live

Q. How high is anti HB sAb after one dose of the HB vaccine to be considered anamnestic response?

A. Sorry, I don't actually know the answer to this one. In clinical practice, we/staff health are happy as long as it is detectable (>10).

Q. Thanks so much Ken, great talk! My understanding of the Yip paper was that HCC incidence in non-cirrhotic patients after HBsAg seroconversion fell below the 0.2% HCC incidence established for HCC surveillance on cost effectiveness. It was 1.5% over 12 years, I think. Therefore, non-cirrhotic would not be recommended for HCC surveillance on these criteria?

A. Answered live

Q. In high-risk populations, what are your thoughts on people who don't seroconvert to the Hep B immunisation?

A. I think you're asking about non-responders to HBV immunisation? First you should check they are HBV core Ab negative. If they are core positive then they've already had exposure to HBV, so will immunisation will not work on them. If they are core negative, they you should follow the Australian Immunisation Handbook which says to give a 4th booster shot, and if that doesn't work, to repeat the course of the primary immunisation schedule (another 2 shots after the booster). Immunisation handbook.

Q. What about renal dialysis and need for prophylactic anti-viral when HepbSAg neg, hepbBc positive? At risk of reactivating?

A. No need for prophylaxis in renal dialysis**.**

Q. If the patient recovered from acute hepatitis, do they have the same risk with the pt who are treated with antiviral and seroconverted? For develop HCC

A. To my knowledge, this has not been specifically studied, however we should expect recovered acute HBV patients would have less HCC risk as they have spent less/no cumulative time with chronic active hepatitis.

Q. Ken, I know it is hard to give a guideline on HCC surveillance after HBsAg seroconversion. However, should we continue HCC surveillance if age >50 at time of clearance, male and cirrhosis?

A. Short answer is yes.
Long answer: Patients with cirrhosis should continue HCC surveillance regardless of HBsAg status (like any other patients with cirrhosis).
What to do with patients with HBsAg seroconversion who are non-cirrhotic is a bit more tricky. Their risk of HCC is still there and the latest Yip et al. paper I mentioned in my talk showed no change in the cumulative incidence of HCC after sAg seroconversion. This suggests that I would be reasonable to continue surveillance in those who you were already surveying before seroconversion because they were deemed high risk (i.e. Asian males >40, Asian females >50, etc.). This is what is recommended in the Australian HBV guidelines: "Recommendation 17 HCC surveillance should continue in the event of observed HBsAg loss in individuals assessed as having a high baseline risk for HCC (Table 17)." However, as Ben Cowie pointed out, these patients may fall below the cost effectiveness threshold of 1.5%/year incidence of HCC for starting surveillance. My colleagues in Hong Kong offer it to males who are age ≥50. Note this all pertains to patients who you caught during sAgn seroconversion.
For those who present with HbSAg negative initially and it is not known when in their life they seroconverted it is even harder to know what to do with HCC surveillance then.

Session: Navigating Medicare
Q. What software are you talking about, for Medicare compliance?

A. Answered live

Q. Can you give us a link to buy TAF overseas?

A. Hi Kam - we can check with Sam but Green Cross pharmacy is one that’s commonly used - I’m not sure if TAF alone is available (it may be) but TAF plus FTC is for $73 USD for 90 pills - https://www.generics.greencrosspharmacy.online/product-page/tafero-em-x-3-bottte-90-pills-generic-descovy

Q. How much does Inca cost to subscribe?

A. Answered live

Q. We prescribe tenofovir disoproxil. Some patients from China use tenofovir alafenamide. Is this drug interchangeable?

A. Hi Irene. They are both effective at controlling hepatitis B. Main difference is potential side effect profile. So - someone who'd had (for example) Fanconi's syndrome or significant renal issues with TDF, would not use that in place of TAF. Otherwise, with TDF on PBS and TAF not in Australia, you can use TDF for PBS-based treatment of someone who's been initiated on TAF and it's safe to do this.

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A. Unanswered

Session: Case study on providing culturally appropriate care to patients who identify as Aboriginal and/or Torres Strait Islander

Q. What is your experience in pt's compliance, follow up, close contact investigation? How is the medication dispensed for patient who are moving often? What can we do to increase the compliance rate in Indigenous patients?

A. Answered live

Q. Is there any research to find out what is the most HepB transmission mode in Indigenous population?

A. Answered live

Q. Thanks Joe and Corey for such a fantastic presentation - incredibly interesting and valuable. What are some ways health practitioners can build trust with Aboriginal and/or Torres Strait Islander patients when working in a system that has traditionally not always been a safe environment?

A. Answered live

Q. As the patients could be transient. When the pt comes to the clinic with recalls for "routine" HepB follow up. How could you know that the patient has already had a test done elsewhere? Is there any risk of double test and break the rule of Medicare in HepB testing? Who would have to cope with the cost in that case?

A. Answered live

Session: Hepatitis B s100 Prescriber submissions: Models of care

Q. Have you considered buying a Shearwave elastography probe for your ultrasound?

A. Answered Live

Q. Thanks David, I see the logic of HCC surveillance expanded beyond the GESA guidelines, but what process did you go through to address potential harms done by screening outside guidelines? (i.e. subsequent over investigation... I assume your team have discussed it, and the investigations are low harm interventions?)

A. Answered live

Session: Case study on hepatitis B and pregnancy

Q. If you have a pregnant mother who has undetectable HBV DNA, would you still need to give HBIg?

A. Yes, because if they have chronic hepatitis B (HBsAg positive) then there is still a risk to the infant regardless. The undetectable viral load is only a small snapshot of that particular time of when the test was performed. They may have detectable viral load during other times of the pregnancy, even if low levels.