NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINES

Hepatitis B Positive, Management of women identified through antenatal screening, Obstetrics

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	3
Does this version include changes to clinical advice:	No
Date Approved:	30th October 2021
Date of Next Review:	30th November 2024
Lead Author:	Gillian Penrice
Approval Group:	Obstetrics Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Greater Glasgow & Clyde Obstetric Guidelines

Hepatitis B positive- Management of women identified through antenatal screening

Antenatal screening for three communicable diseases – hepatitis B, HIV, and syphilis - is offered to all pregnant women. The uptake is over 99.9% across Greater Glasgow and Clyde for all three diseases. The primary aim of screening for hepatitis B is to ensure a plan for treatment and management for affected individuals and their babies. This allows treatment to be given, which can reduce the risk of mother to child transmission, improves the long-term outcome and development of affected children, and ensures that women, their partners and families are offered appropriate referral, testing and treatment.

Approximately 50 mothers are identified by West of Scotland Specialist Virology Centre (WoSSVC) every year in NHS GGC as being hepatitis B surface antigen positive during antenatal screening.

1. Following identification of an HBsAg positive test from the booking blood sample, the WoSSVC writes to the clinician in charge of the patient and the nominated obstetrician at the referring unit in GGC as below:

Princess Royal Maternity	Dr Victoria Brace
QEUH	Dr Marianne Ledingham
Royal Alexandra Hospital	Dr Ruth Jewell

   The result is copied to Sandyford Shared Care Support Service – Tel: 0141 211 8639 and the GP (if patient registered).

   The Public Health Protection Unit (PHPU) is notified electronically on a weekly basis.

2. This letter will inform the obstetrician of the diagnosis of hepatitis B in the mother and will indicate, depending on available viral markers, if the baby requires immunoglobulin AND vaccine OR vaccine alone at birth. This letter will also contain a section to be completed by the obstetrician once the 26 week gestation hepatitis B DNA levels are known, along with instructions on how this will affect the recommendations for neonatal treatment.

3. The nominated obstetrician will:
   a. **Immediately refer the patient to the local hepatitis service for clinical review and advice**
   b. Send a letter to the patient informing them of the hepatitis B result
   c. Offer to refer the patient to the Counselling and Support Team (CAST) at the Brownlee Centre where screening of family members and contract tracing will be carried out
   d. Give the patient an appointment to attend for review at 26 weeks
   e. Ensure the hepatitis B status and management plan is recorded in Badgernet.

4. At the 26 week review the nominated obstetrician will have a sample taken for the HBV DNA viral load, liver function tests, prothrombin time and hepatitis C IgG.

5. If the HBV DNA viral load at booking is >200,000 IU/mL (≥log 5.3 or $10^{5.3}$ IU/ml[1]) then **urgent referral** to the hepatitis service should be made and antiviral therapy during the third trimester (from week 28 to 3 months after delivery) will be considered, to reduce viral load and risk of transmission to the infant.[1]

6. If the HBV DNA viral load is >200,000 IU/mL (≥ log 5.3 or $10^{5.3}$ IU/ml[1]) **at any point during pregnancy then urgent referral** to the hepatitis service should be made **AND** hepatitis B immunoglobulin (HBIg) and hepatitis B vaccine should be given to the infant at birth.[1]

7. The HBV DNA viral load should be documented clearly by the responsible obstetrician in the relevant section of the letter from the WoSSVC. Badgernet should also be amended with this level and the implications for neonatal management.

8. If HBV DNA viral load is ≤200,000 IU/mL (< log 5.3 or $10^{5.3}$ IU/ml[1]), then the woman would be monitored as normal during pregnancy. Again the HBV DNA viral load should be documented clearly by the responsible obstetrician in the relevant section of the letter from the WoSSVC. Badgernet should also be amended with this level and the implications for neonatal management.

9. When the woman is in labour, the obstetrician/midwife informs the paediatric team that the baby will require vaccination +/- immunoglobulin at birth as per letter from WoSSVC.

10. Neonatal paediatrician gives first dose of vaccine (and immunoglobulin if required) and informs the NHS GGC Screening Dept by email (HepB.Screening@ggc.scot.nhs.uk)

11. HBV vaccine and HBIg must be administered within 24 hours of birth, ideally as soon as possible (i.e. within 4 hours). HBV vaccine – Engerix B 10 mcg (0.5ml) or HBvaxPRO 5 mcg (0.5ml) given IM into anterolateral thigh (not into buttock). HBIg - 200IU (2 ml) given IM into upper outer quadrant of the buttock or anterolateral thigh of the opposite leg from site of HBV vaccination. Routine postnatal care, including breast feeding, is appropriate.

12. Before discharge from the maternity unit a check should be made that mothers have already attended the hepatitis service and if not a further appointment at 2 months is made.

13. The NHS GGC Screening Dept arrange call/recall for subsequent vaccination of the infant to complete the course. (Single dose at 1 month, 3 doses as part of the primary imms, single final dose at 12 months).

14. Following the 12 month dose of hepatitis B vaccine, the infant must be checked for response by assay for HBsAg and anti-HBs. The Screening Dept make this referral to Royal Hospital for Children for a blood test.

15. The PHPU monitors uptake of all babies receiving hepatitis B vaccination from data supplied by Screening Dept. PHPU liaises with the health visitor to promote uptake of vaccine in babies who have not completed the course. PHPU produces regular uptake figures to feedback to all involved. PHPU carries out a yearly audit of all HBV notifications in pregnancy.

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Title
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Implementation / Review Dates
Implemented 4/1/2012, Revision March 2015, On site 5.5.15, Next Reviewed October 2017 Next review October 2021

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References
1. EASL 2017 Clinical Practice Guidelines on the management of hepatitis B virus infection. Journal of Hepatology 2017 vol. 67 370–398