Bookmark

My Bookmarks

Menu:

- Epidemiology
- Virology
- Diagnostic testing and interpreting
- Prevention
- Clinical assessment
- Treatment and management
- Liver disease and HCC
- Pregnancy, children, co-infection and immunosuppression
- Occupational health; privacy and confidentiality

GESA Australian Consensus Recommendations

To download or print a full copy of the Australian consensus recommendations for the management of hepatitis B infection click below.

Print PDF

Quality of Evidence

Table 1. Quality of evidence and strength of recommendations

Evidence quality	Definition	Grade
High	We are very confident that the true effect lies close to that of the estimate of the effect.	A
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.	B
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.	C
Very low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.	D
Recommendation	**Notes**	**Grade**
Strong	Recommendation is made with strong certainty. Factors influencing the strength of the recommendation included the quality of the evidence, presumed patient-important outcomes and cost.	1
Weak	There is variability in preferences and values, or more uncertainty. Recommendation is made with less certainty, higher cost or higher resource consumption.	2

The full list of recommendations are listed in Table 2. However, readers should refer to the full statement for additional information and should not interpret the recommendations in isolation.

Table of Recommendations

The full list of recommendations are listed in Table 2. However, readers should refer to the full statement for additional information and should not interpret the recommendations in isolation.

Table 2. Recommendations of the hepatitis B consensus statement (taken from the GESA Australian consensus recommendations for the management of hepatitis B infection 2022)

No.	Consensus recommendation	GRADE classification*	Level of agreement, *n*[†] (%)[‡]
1	At a minimum, all population groups with elevated (≥2%) CHB prevalence, a high risk of transmission and/or an increased risk of adverse outcomes from HBV infection (Table 4) should be offered testing to determine their HBV status.	C1	66 (98.5%)
2	All individuals with CHB should have a culturally and language-appropriate discussion regarding the management of CHB (using an accredited interpreter when necessary).	C1	66 (98.5%)
3	The ULN for serum ALT should be considered 19 IU/L in females and 30 IU/L in males.	C1	63 (95.2%)
4	Evaluation of people with CHB infection should include repeated assessments (e.g. HBV serology, ALT, HBV DNA level) to determine phase of disease and requirement for antiviral treatment.	A1	65 (100%)
5	Non-invasive assessment of liver fibrosis should be performed in all people with CHB as part of initial assessment.	A1	63 (98.4%)
6	Liver biopsy should only be considered when it influences management (e.g. uncertainty regarding the staging of fibrosis or coexistent pathologies).	A1	60 (96.7%)
7	The treatment of people with HBeAg-positive chronic infection characterised by persistently normal ALT is not routinely recommended. Antiviral therapy may be considered in certain circumstances (Table 13).	B1	65 (94.9%)
8	In people with HBeAg-positive chronic hepatitis, antiviral therapy is indicated when HBV DNA is >20,000 IU/mL and ALT is persistently elevated or there is evidence of fibrosis.	A1	62 (98.4%)
9	In people with HBeAg-negative chronic hepatitis, antiviral therapy is indicated when HBV DNA is >2000 IU/mL and ALT is persistently elevated or there is evidence of fibrosis.	A1	63 (98.4%)
10	All people with cirrhosis and any detectable HBV DNA, regardless of ALT levels, should be treated with antiviral therapy.	A1	62 (100%)
11	Where oral antiviral therapy is indicated, a potent NA with a high barrier to resistance (entecavir, tenofovir) should be used.	A1	62 (100%)
12	Interferon-based treatment regimens are contraindicated in decompensated cirrhosis.	B1	59 (98.3%)
13	All people being treated with antiviral therapy should undergo periodic review, including ALT, serum HBV DNA and, for tenofovir, renal function (eGFR) and serum phosphate.	A1	64 (100%)
14	Cessation of oral antiviral therapy may be considered in people without cirrhosis following HBeAg seroconversion or sustained HBsAg loss after a period of treatment consolidation		

	However, regular monitoring must be undertaken after treatment cessation, preferably in consultation with a clinician experienced in treating hepatitis B.	B2	60 (90.0%)
15	HCC surveillance should be offered to all people with cirrhosis, as well as non-cirrhotic individuals at increased risk of HCC (Table 17).	C1	64 (98.4%)
16	Liver ultrasound should be performed every 6 months in people with CHB infection who require HCC surveillance.	B1	62 (98.4%)
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).	C1	63 (88.9%)
18	People with acute or acute-on-chronic liver failure from hepatitis B should be managed in consultation with a liver transplant unit.	C1	60 (96.7%)
19	People with extrahepatic manifestations of CHB infection should receive antiviral treatment.	C1	58 (96.6%)
20	Metabolic comorbidities, including obesity, diabetes mellitus, hypertension and dyslipidaemia, should be screened for and optimally managed in people with CHB.	C1	62 (95.2%)
21	All pregnant women should be tested for HBsAg during antenatal screening. HBsAg-positive women should undergo evaluation of phase of HBV infection (ALT, HBeAg, HBV DNA) and for presence of clinical liver disease.	A1	65 (100%)
22	Pregnant women with high viral load (>200,000 or 5.3 log10 IU/mL) should be offered tenofovir from the 28th week of pregnancy to reduce the risk of perinatal transmission of hepatitis B.	A1	61 (100%)
23	Infants born to HBsAg-positive mothers should receive HBIG and hepatitis B vaccination as soon as possible after birth (optimally within 4 hours). Infants should receive routine HBV vaccination at 2, 4 and 6 months of age.	A1	63 (98.4%)
24	Children born to HBsAg-positive women should be tested for HBsAg and anti-HBs 3 months after the last vaccine dose to determine vaccine response and to exclude MTCT.	A1	62 (91.9%)
25	HBsAg-positive people receiving cancer chemotherapy or moderate- or high-risk immunosuppression for non-malignant conditions (Table 20) should be treated with entecavir or tenofovir.	B1	63 (96.8%)
26	HBsAg-negative/anti-HBc-positive people who are being treated with agents associated with high risk of HBV reactivation (Table 19) should be treated with entecavir or tenofovir.	B1	61 (98.4%)
27	HBsAg-positive people receiving low-risk immunosuppression for non-malignant conditions (Table 20) should be monitored for hepatitis B reactivation with 3-monthly ALT and 6-monthly HBV DNA testing.	B1	62 (87.1%)
28	Testing for HCV, HIV and HDV should be performed in all HBsAg-positive people at initial assessment and periodically if there is ongoing risk of infection.	B1	63 (88.9%)
29	HBsAg-positive people receiving DAA therapy for hepatitis C are at high risk of hepatitis B reactivation. People with cirrhosis or who otherwise meet the criteria for treatment for hepatitis B should be treated with entecavir or tenofovir.	C1	60 (93.3%)
30	HBsAg-negative, anti-HBc-positive people receiving DAA therapy are at very low risk of HBV reactivation and do not need monitoring for hepatitis B reactivation in this setting.	B1	60 (93.3%)
31	Treatment of HBV–HIV coinfection should be with HBV-active antiretroviral therapy, including tenofovir, regardless of HBV disease phase.	B1	47 (100%)
32	Entecavir (with dose adjustment) or TAF is the preferred antiviral therapy in HBsAg-positive people with established renal impairment.	B1	60 (98.3%)

ALT = alanine aminotransferase; anti-HBc = hepatitis B core antibody; anti-HBs = hepatitis B surface antibody; CHB = chronic hepatitis B; DAA = direct-acting antiviral; eGFR = estimated glomerular filtration rate; GRADE = Grading of Recommendations Assessment, Development and Evaluation; HBeAg = hepatitis B e-antigen; HBIG = hepatitis B immunoglobulin; HBsAg = hepatitis B surface antigen; HBV = hepatitis B virus; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; HDV = hepatitis delta virus; MTCT = mother-to-child transmission; NA = nucleos(t)ide analogue; TAF = tenofovir alafenamide; ULN = upper limit of normal.

* GRADE quality of evidence classification: A = high; B = moderate; C = low; D = very low. Strength of recommendation: 1 = strong; 2 = weak.

† Number of experts who participated in the final modified Delphi process vote for this recommendation.

‡ Percentage of expert advisors who either agreed or strongly agreed (based on five-point Likert scale, comprising strongly disagree, disagree, neutral, agree and strongly agree) in the final modified Delphi round for each recommendation.