

Reference 6

# Hepatitis B (chronic) : diagnosis and management

Clinical guideline

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This guideline partially replaces TA96.

This guideline is the basis of QS65.

## Introduction

This guideline updates and replaces recommendations in NICE technology appraisal 96 and incorporates recommendations from NICE technology appraisals 96, 153, 154 and 173. See [About this guideline](#) for details.

a

Chronic hepatitis B describes a spectrum of disease usually characterised by the presence of detectable hepatitis B surface antigen (HBsAg) in the blood or serum for longer than 6 months. In some people, chronic hepatitis B is inactive and does not present significant health problems, but others may progress to liver fibrosis, cirrhosis and hepatocellular carcinoma (HCC). The progression of liver disease is associated with hepatitis B virus (HBV) DNA levels in the blood. Without antiviral treatment, the 5-year cumulative incidence of cirrhosis ranges from 8 to 20%. People with cirrhosis face a significant risk of decompensated liver disease if they remain untreated. Five-year survival rates among people with untreated decompensated cirrhosis can be as low as 15%. Chronic hepatitis B can be divided into e antigen- (HBeAg) positive or HBeAg-negative disease based on the presence or absence of e antigen. The presence of HBeAg is typically associated with higher rates of viral replication and therefore increased infectivity.

b

The goal of treatment for chronic hepatitis B is to prevent cirrhosis, HCC and liver failure. In clinical practice surrogate markers are used to monitor progression of disease and treatment response, and include normalisation of serum alanine aminotransferase (ALT) levels, decrease in inflammation scores with no worsening or improvement in fibrosis on liver biopsies, suppression of serum HBV DNA to undetectable levels, loss of HBeAg and seroconversion to HBe antibody (anti-HBe), and loss of HBsAg and seroconversion to HBs antibody (anti-HBs).

c

Antiviral therapy suppresses HBV replication and decreases hepatic inflammation and fibrosis, thereby reducing the likelihood of serious clinical disease. Since the introduction of effective treatment in the form of interferon alfa, several nucleoside and nucleotide analogues are now approved for use in adults with chronic hepatitis B, together with a pegylated form of interferon alfa.

d

With multiple treatment options that are efficacious and safe, the key questions are which patients need immediate treatment and what sequence and combination of drug regimens should be used, and which patients can be monitored and delay treatment.

In this guideline we cover the following:

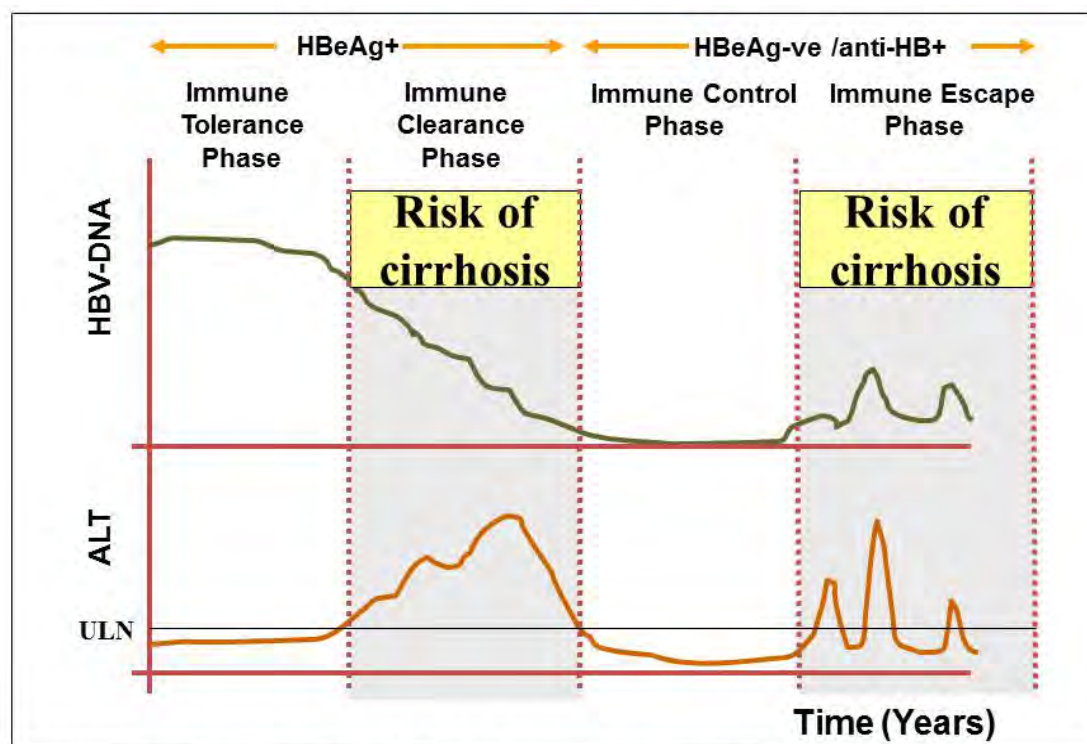
- information needs of people with chronic hepatitis B and their carers
- where children, young people and adults with chronic hepatitis B should be assessed
- assessment of liver disease, including the use of non-invasive tests and genotype testing
- criteria for offering antiviral treatment
- the efficacy, safety and cost effectiveness of currently available treatments
- selection of first-line therapy
- management of treatment failure or drug resistance
- whether there is a role for combination therapy
- when it is possible to stop treatment
- managing the care of pregnant and breastfeeding women and prevention of vertical transmission
- prophylactic treatment during immunosuppressive therapy
- monitoring for treatment response, severity of fibrosis and development of HCC.

The spontaneous mutation rate of HBV DNA is high. Exposure of HBV to nucleoside or nucleotide analogues selects for mutations in the polymerase gene that confer resistance or decreased susceptibility to the drugs. The relative risk of drug resistance must be taken into account when considering treatment with nucleoside or nucleotide analogues, including the level of cross resistance between different agents.

Figure 1 depicts the natural history of chronic HBV infection. The immune-tolerance phase is seen in HBeAg-positive disease and is characterised by high levels of HBV replication with normal ALT levels and limited liver necroinflammation. Because there is minimal immune response to the virus it is unusual for spontaneous HBeAg loss to occur. This phase is commonly seen in children. It is followed by an immune-clearance or immune-reactive phase in which the immune system recognises and starts to clear the virus. ALT levels are typically elevated or fluctuating, and there is a higher risk of liver fibrosis. This tends to be the initial phase in people infected with HBV as adults. It lasts from weeks to years and ends with HBeAg seroconversion.

With the loss of HBeAg the person may enter an immune-control phase with very low or undetectable HBV DNA levels, normal ALT and minimal fibrosis progression. However, some people may experience rising HBV DNA levels despite HBeAg negativity. This is caused by virions that do not express HBeAg because of genetic mutations. This immune-escape phase can lead to active necroinflammation and progression of fibrosis.

Figure 1. Natural history of chronic HBV infection



After Chu et al, Hepatology 1985;5:431-34

ULN: upper limit of normal of ALT

Substantial progress has been made in the treatment of chronic hepatitis B in the past decade but the appropriate time for starting treatment remains a topic of debate. Although currently available treatment is effective in suppressing HBV replication, it fails to eradicate the virus necessitating long treatment duration and perhaps lifelong treatment.

**The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.**

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The patient (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's [Good practice in](#)

prescribing medicines – guidance for doctors for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

## Patient-centred care

This guideline offers best practice advice on the care of children, young people and adults with chronic hepatitis B.

Patients and healthcare professionals have rights and responsibilities as set out in the [NHS Constitution for England](#) – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the [Department of Health's advice on consent](#). If someone does not have capacity to make decisions, healthcare professionals should follow the [code of practice that accompanies the Mental Capacity Act](#) and the supplementary [code of practice on deprivation of liberty safeguards](#). In Wales, healthcare professionals should follow [advice on consent from the Welsh Government](#).

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in [Patient experience in adult NHS services](#).

If a young person is moving between paediatric and adult services, care should be planned and managed according to the best practice guidance described in the Department of Health's [Transition: getting it right for young people](#).

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with chronic hepatitis B. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.



## Terms used in this guidance

### **Chronic hepatitis B**

Chronic hepatitis B is defined as persistence of hepatitis B surface antigen (HBsAg) for 6 months or more after acute infection with hepatitis B virus (HBV).

### **HBV DNA**

HBV DNA level, or 'viral load', is an indicator of viral replication. Higher HBV DNA levels are usually associated with an increased risk of liver disease and hepatocellular carcinoma. HBV DNA level typically falls in response to effective antiviral treatment.

### **Hepatitis B surface antigen (HBsAg)**

Hepatitis B surface antigen (HBsAg) is a viral protein detectable in the blood in acute and chronic hepatitis B infection.

### **HBsAg seroconversion**

The development of antibodies against HBsAg is known as HBsAg seroconversion. It signifies clearance of HBsAg and resolution of the chronic infection.

### **Hepatitis B e antigen (HBeAg)**

Hepatitis B e antigen (HBeAg) is an indicator of viral replication, although some variant forms of the virus do not express HBeAg (see 'HBeAg-negative chronic hepatitis B' below). Active infection can be described as HBeAg-positive or HBeAg-negative according to whether HBeAg is secreted.

### **HBeAg-negative chronic hepatitis B**

HBeAg-negative hepatitis B is a form of the virus that does not cause infected cells to secrete HBeAg. People can be infected with the HBeAg-negative form of the virus from the beginning, or the viral mutation can emerge later in the course of infection in people initially infected with the HBeAg-positive form of the virus.

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## **HBeAg seroconversion**

HBeAg seroconversion occurs when people infected with the HBeAg-positive form of the virus develop antibodies against the 'e' antigen. The seroconverted disease state is referred to as the 'inactive HBV carrier state' when HBeAg has been cleared, anti-HBe is present and HBV DNA is undetectable or less than 2000 IU/ml. Once seroconversion has taken place, most people remain in the inactive HBV carrier state (the immune-control phase; see [figure 1](#)). However, increasing HBV DNA and recurrent hepatitis after seroconversion indicate the emergence of the HBeAg-negative strain of the virus (the immune-escape phase; see [figure 1](#)).

## Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

### *Assessment and referral*

- Arrange the following tests in primary care for adults who are [hepatitis B surface antigen \(HBsAg\)](#) positive:
  - [hepatitis B e antigen \(HBeAg\)](#)/antibody (anti-HBe) status
  - HBV DNA level
  - IgM antibody to hepatitis B core antigen (anti-HBc IgM)
  - hepatitis C virus antibody (anti-HCV)
  - hepatitis delta virus antibody (anti-HDV)
  - HIV antibody (anti-HIV)
  - IgG antibody to hepatitis A virus (anti-HAV)
  - additional laboratory tests including alanine aminotransferase (ALT) or aspartate aminotransferase (AST), gamma-glutamyl transferase (GGT), serum albumin, total bilirubin, total globulins, full blood count and prothrombin time
  - tests for hepatocellular carcinoma (HCC), including hepatic ultrasound and alpha-fetoprotein testing.
- Include the results of the initial tests with the referral (see [recommendation 1.2.1](#)).

### *Treatment sequence in adults with HBeAg-positive chronic hepatitis B and compensated liver disease*

- Offer a 48-week course of peginterferon alfa-2a as first-line treatment in adults with HBeAg-positive chronic hepatitis B and compensated liver disease<sup>[1]</sup>.
- Offer tenofovir disoproxil as second-line treatment to people who do not undergo [HBeAg seroconversion](#) or who relapse (revert to being HBeAg positive following seroconversion) after first-line treatment with peginterferon alfa-2a.

- Offer entecavir as an alternative second-line treatment to people who cannot tolerate tenofovir disoproxil or if it is contraindicated.

### *Treatment sequence in adults with HBeAg-negative chronic hepatitis B and compensated liver disease*

- Offer a 48-week course of peginterferon alfa-2a as first-line treatment in adults with HBeAg-negative chronic hepatitis B and compensated liver disease<sup>[1]</sup>.
- Offer entecavir or tenofovir disoproxil as second-line treatment to people with detectable HBV DNA after first-line treatment with peginterferon alfa-2a.

### *Women who are pregnant or breastfeeding*

- Offer tenofovir disoproxil to women with HBV DNA greater than  $10^7$  IU/ml in the third trimester to reduce the risk of transmission of HBV to the baby<sup>[2]</sup>.

### *Prophylactic treatment during immunosuppressive therapy*

- In people who are HBsAg positive and have HBV DNA greater than 2000 IU/ml, offer prophylaxis with entecavir or tenofovir disoproxil<sup>[3]</sup>.
  - Start prophylaxis before beginning immunosuppressive therapy and continue for a minimum of 6 months after HBeAg seroconversion and HBV DNA is undetectable.
- In people who are HBsAg positive and have HBV DNA less than 2000 IU/ml, offer prophylaxis:
  - consider lamivudine<sup>[3]</sup> if immunosuppressive therapy is expected to last less than 6 months
    - ◊ monitor HBV DNA monthly in people treated with lamivudine and change to tenofovir disoproxil if HBV DNA remains detectable after 3 months
  - consider entecavir or tenofovir disoproxil<sup>[3]</sup> if immunosuppressive therapy is expected to last longer than 6 months
  - start prophylaxis before beginning immunosuppressive therapy and continue for a minimum of 6 months after stopping immunosuppressive therapy.

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<sup>[1]</sup> Avoid use of peginterferon alfa-2a in pregnancy unless the potential benefit outweighs risk. Women of childbearing potential must use effective contraception throughout therapy.

<sup>[2]</sup> At the time of publication (June 2013), tenofovir disoproxil did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing medicines – guidance for doctors](#) for further information.

<sup>[3]</sup> At the time of publication (June 2013), entecavir, lamivudine and tenofovir disoproxil did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing medicines – guidance for doctors](#) for further information.

## 1 Recommendations

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation). See [About this guideline](#) for details.

In this guideline, children and young people are defined as aged up to 18 years. Please follow the [recommendations for women who are pregnant](#) for young people with chronic hepatitis B who are pregnant.

### 1.1 Patient information

1.1.1 Provide information on the following topics to people with [chronic hepatitis B](#) and to family members or carers (if appropriate) before assessment for antiviral treatment:

- the natural history of chronic hepatitis B, including stages of disease and long-term prognosis
- lifestyle issues such as alcohol, diet and weight
- family planning
- monitoring
- routes of hepatitis B virus (HBV) transmission
- the benefits of antiviral treatment, including reduced risk of serious liver disease and death and reduced risk of transmission of HBV to others
- treatment options and contraindications based on the patient's circumstances, including peginterferon alfa-2a and nucleoside or nucleotide analogues
- short- and long-term treatment goals
- causes of treatment failure, including non-adherence to prescribed medicines, and options for re-treatment

- risks of treatment, including adverse effects and drug resistance.

- 1.1.2 Offer a copy of the personalised care plan to people with chronic hepatitis B and to family members or carers (if appropriate) outlining proposed treatment and long-term management, for example, a copy of the hospital consultation summary.
- 1.1.3 Provide information on self-injection techniques to people beginning peginterferon alfa-2a or to family members or carers.
- 1.1.4 NICE has produced public health guidance on ways to promote and offer testing to people at increased risk of infection with hepatitis B. All healthcare professionals should follow the recommendations in [Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection](#) (NICE public health guidance 43).
- 1.1.5 NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in [Patient experience in adult NHS services](#) (NICE clinical guidance 138).

## 1.2 *Assessment and referral in primary care*

### Adults who are HBsAg positive

- 1.2.1 Arrange the following tests in primary care for adults who are [hepatitis B surface antigen](#) (HBsAg) positive:
- [hepatitis B e antigen](#) (HBeAg)/antibody (anti-HBe) status
  - [HBV DNA](#) level
  - IgM antibody to hepatitis B core antigen (anti-HBc IgM)
  - hepatitis C virus antibody (anti-HCV)
  - hepatitis delta virus antibody (anti-HDV)
  - HIV antibody (anti-HIV)
  - IgG antibody to hepatitis A virus (anti-HAV)

- additional laboratory tests including alanine aminotransferase (ALT) or aspartate aminotransferase (AST), gamma-glutamyl transferase (GGT), serum albumin, total bilirubin, total globulins, full blood count and prothrombin time
- tests for hepatocellular carcinoma (HCC), including hepatic ultrasound and alpha-fetoprotein testing.

1.2.2 Refer all adults who are HBsAg positive to a hepatologist or to a gastroenterologist or infectious disease specialist with an interest in hepatology.

1.2.3 Include the results of the initial tests with the referral (see recommendation 1.2.1).

### **Pregnant women who test HBsAg positive at antenatal screening**

1.2.4 Refer pregnant women who are HBsAg positive to a hepatologist, or to a gastroenterologist or infectious disease specialist with an interest in hepatology, for assessment within 6 weeks of receiving the screening test result and to allow treatment in the third trimester (see [recommendation 1.5.39](#)).

### **Adults with decompensated liver disease**

1.2.5 Refer adults who develop decompensated liver disease immediately to a hepatologist or to a gastroenterologist with an interest in hepatology. Symptoms of decompensated liver disease include (but are not limited to) ascites, encephalopathy and gastrointestinal haemorrhage.

### **Children and young people who are HBsAg positive**

1.2.6 Arrange the following tests for children and young people who are HBsAg positive:

- HBeAg/anti-HBe status
- HBV DNA level
- anti-HBc IgM
- anti-HCV



- anti-HDV
- anti-HIV
- anti-HAV
- additional laboratory tests, including ALT or AST, GGT, serum albumin, total bilirubin, total globulins, full blood count and prothrombin time
- tests for HCC, including hepatic ultrasound and alpha-fetoprotein testing.

1.2.7 Refer all children and young people who are HBsAg positive to a paediatric hepatologist or to a gastroenterologist or infectious disease specialist with an interest in hepatology.

1.2.8 Include the results of the initial tests with the referral (see recommendation 1.2.6).

### 1.3 *Assessment of liver disease in secondary specialist care*

#### **Adults with chronic hepatitis B**

Please refer to [recommendations 1.5.3 to 1.5.7](#) for detailed guidance on offering antiviral treatment.

1.3.1 Ensure all healthcare professionals who refer adults for non-invasive tests for liver disease are trained to interpret the results and aware of co-factors that influence liver elasticity (for example, fatty liver caused by obesity or alcohol misuse).

1.3.2 Discuss the accuracy, limitations and risks of the different tests for liver disease with the patient.

1.3.3 Offer transient elastography as the initial test for liver disease in adults newly referred for assessment.

1.3.4 Offer antiviral treatment without a liver biopsy to adults with a transient elastography score greater than or equal to 11 kPa<sup>[4]</sup>, in line with [recommendation 1.5.6](#).

- 1.3.5 Consider liver biopsy to confirm the level of fibrosis in adults with a transient elastography score between 6 and 10 kPa<sup>[6]</sup>. Offer antiviral treatment in line with [recommendations 1.5.3 to 1.5.7](#).
- 1.3.6 Offer liver biopsy to adults with a transient elastography score less than 6 kPa if they are younger than 30 years and have HBV DNA greater than 2000 IU/ml and abnormal ALT (greater than or equal to 30 IU/L for males and greater than or equal to 19 IU/L for females) on 2 consecutive tests conducted 3 months apart<sup>[6]</sup>. Offer antiviral treatment in line with [recommendations 1.5.3 to 1.5.7](#).
- 1.3.7 Do not offer liver biopsy to adults with a transient elastography score less than 6 kPa who have normal ALT (less than 30 IU/L in males and less than 19 IU/L in females) and HBV DNA less than 2000 IU/ml as they are unlikely to have advanced liver disease or need antiviral treatment (see [recommendations 1.5.3 to 1.5.7](#))<sup>[6]</sup>.
- 1.3.8 Offer an annual reassessment of liver disease using transient elastography to adults who are not taking antiviral treatment.

## Children and young people with chronic hepatitis B

- 1.3.9 Discuss the accuracy, limitations and risks of liver biopsy in determining the need for antiviral treatment with the child or young person and with parents or carers (if appropriate).
- 1.3.10 Consider liver biopsy to assess liver disease and the need for antiviral treatment in children and young people with HBV DNA greater than 2000 IU/ml and abnormal ALT (greater than or equal to 30 IU/L for males and greater than or equal to 19 IU/L for females) on 2 consecutive tests conducted 3 months apart. Offer biopsy under a general anaesthetic to children who are too young to tolerate the procedure under a local anaesthetic.

## 1.4 Genotype testing

- 1.4.1 Do not offer genotype testing to determine initial treatment in people with chronic hepatitis B.

## 1.5 *Antiviral treatment*

### Adults with chronic hepatitis B

Recommendations 1.5.8 to 1.5.12 are reproduced from existing NICE technology appraisals on options for the treatment of chronic hepatitis B, and 1.5.13 to 1.5.15 update guidance in NICE technology appraisal 96<sup>[7]</sup>. The GDG has reviewed the evidence and has made recommendations on treatment sequences and combination drug regimens (see recommendations 1.5.16 to 1.5.28).

Recommendations 1.5.8 to 1.5.43 do not apply to people with chronic hepatitis B who also have hepatitis C, hepatitis D or HIV.

- 1.5.1 Discuss treatment options, adverse effects and long-term prognosis with the patient before starting treatment.
- 1.5.2 Re-assess the person's risk of exposure to HIV before starting treatment and offer repeat testing if needed.
- 1.5.3 Offer antiviral treatment to adults aged 30 years and older who have HBV DNA greater than 2000 IU/ml and abnormal ALT (greater than or equal to 30 IU/L in males and greater than or equal to 19 IU/L in females) on 2 consecutive tests conducted 3 months apart.
- 1.5.4 Offer antiviral treatment to adults younger than 30 years who have HBV DNA greater than 2000 IU/ml and abnormal ALT (greater than or equal to 30 IU/L in males and greater than or equal to 19 IU/L in females) on 2 consecutive tests conducted 3 months apart if there is evidence of necroinflammation or fibrosis on liver biopsy or a transient elastography score greater than 6 kPa.
- 1.5.5 Offer antiviral treatment to adults who have HBV DNA greater than 20,000 IU/ml and abnormal ALT (greater than or equal to 30 IU/L in males and greater than or equal to 19 IU/L in females) on 2 consecutive tests conducted 3 months apart regardless of age or the extent of liver disease.
- 1.5.6 Offer antiviral treatment to adults with cirrhosis and detectable HBV DNA, regardless of HBeAg status, HBV DNA and ALT levels.

- 1.5.7 Consider antiviral treatment in adults with HBV DNA greater than 2000 IU/ml and evidence of necroinflammation or fibrosis on liver biopsy.
- 1.5.8 Peginterferon alfa-2a is recommended as an option for the initial treatment of adults with chronic hepatitis B (HBeAg-positive or HBeAg-negative), within its licensed indications. [This recommendation is from [Adefovir dipivoxil and peginterferon alfa-2a for the treatment of chronic hepatitis B \(NICE technology appraisal guidance 96\)](#).]
- 1.5.9 Entecavir, within its marketing authorisation, is recommended as an option for the treatment of people with chronic HBeAg-positive or HBeAg-negative hepatitis B in whom antiviral treatment is indicated. [This recommendation is from [Entecavir for the treatment of chronic hepatitis B \(NICE technology appraisal guidance 153\)](#).]
- 1.5.10 Tenofovir disoproxil, within its marketing authorisation, is recommended as an option for the treatment of people with chronic HBeAg-positive or HBeAg-negative hepatitis B in whom antiviral treatment is indicated. [This recommendation is from [Tenofovir disoproxil fumarate for the treatment of hepatitis B \(NICE technology appraisal guidance 173\)](#).]
- 1.5.11 Telbivudine is not recommended for the treatment of chronic hepatitis B. [This recommendation is from [Telbivudine for the treatment of chronic hepatitis B \(NICE technology appraisal guidance 154\)](#).]
- 1.5.12 People currently receiving telbivudine should have the option to continue therapy until they and their clinicians consider it appropriate to stop. [This recommendation is from [Telbivudine for the treatment of chronic hepatitis B \(NICE technology appraisal guidance 154\)](#).]
- 1.5.13 Do not offer adefovir dipivoxil for treatment of chronic hepatitis B.
- 1.5.14 People currently receiving adefovir dipivoxil should be offered the option to switch to a different treatment. Offer tenofovir disoproxil or entecavir, depending on previous antiviral exposure:
- offer tenofovir disoproxil to people with a history of lamivudine resistance.

- 1.5.15 Antiviral treatment should be initiated only by an appropriately qualified healthcare professional with expertise in the management of viral hepatitis. Continuation of therapy under shared-care arrangements with a GP is appropriate.

### Treatment sequence in adults with HBeAg-positive chronic hepatitis B and compensated liver disease

- 1.5.16 Offer a 48-week course of peginterferon alfa-2a as first-line treatment in adults with HBeAg-positive chronic hepatitis B and compensated liver disease<sup>[8]</sup>.
- 1.5.17 Consider stopping peginterferon alfa-2a 24 weeks after starting treatment if HBV DNA level has decreased by less than 2 log<sub>10</sub> IU/ml and/or if HBsAg is greater than 20,000 IU/ml, and offer second-line treatment in line with recommendations 1.5.18 and 1.5.19.
- 1.5.18 Offer tenofovir disoproxil as second-line treatment to people who do not undergo HBeAg seroconversion or who relapse (revert to being HBeAg positive following seroconversion) after first-line treatment with peginterferon alfa-2a.
- 1.5.19 Offer entecavir as an alternative second-line treatment to people who cannot tolerate tenofovir disoproxil or if it is contraindicated.
- 1.5.20 Review adherence in people taking tenofovir disoproxil who have detectable HBV DNA at 48 weeks of treatment and, if appropriate, provide support in line with Medicines adherence (NICE clinical guidance 76).
- If HBV DNA remains detectable at 96 weeks, and there is no history of lamivudine resistance, consider adding lamivudine to tenofovir disoproxil.
  - In people with a history of lamivudine resistance, consider adding entecavir to tenofovir disoproxil.
- 1.5.21 Consider stopping nucleoside or nucleotide analogue treatment 12 months after HBeAg seroconversion in people without cirrhosis.
- 1.5.22 Do not stop nucleoside or nucleotide analogue treatment 12 months after HBeAg seroconversion in people with cirrhosis.

## Treatment sequence in adults with HBeAg-negative chronic hepatitis B and compensated liver disease

- 1.5.23 Offer a 48-week course of peginterferon alfa-2a as first-line treatment in adults with HBeAg-negative chronic hepatitis B and compensated liver disease<sup>[8]</sup>.
- 1.5.24 Consider stopping peginterferon alfa-2a 24 weeks after starting treatment if HBV DNA level has decreased by less than 2 log<sub>10</sub> IU/ml and HBsAg has not decreased, and consider second-line treatment in line with recommendation 1.5.25.
- 1.5.25 Offer entecavir or tenofovir disoproxil as second-line treatment to people with detectable HBV DNA after first-line treatment with peginterferon alfa-2a.
- 1.5.26 Consider switching from tenofovir disoproxil to entecavir, or from entecavir to tenofovir disoproxil, as third-line treatment in people who have detectable HBV DNA at 48 weeks of treatment.
- 1.5.27 Consider stopping nucleoside or nucleotide analogue treatment 12 months after achieving undetectable HBV DNA and HBsAg seroconversion in people without cirrhosis.
- 1.5.28 Do not stop nucleoside or nucleotide analogue treatment after achieving undetectable HBV DNA and HBsAg seroconversion in patients with cirrhosis.

## Children and young people with chronic hepatitis B and compensated liver disease

- 1.5.29 Discuss treatment options, adverse effects and long-term prognosis with the child or young person and with parents or carers (if appropriate) before starting treatment.
- 1.5.30 Re-assess the child or young person's risk of exposure to HIV before starting treatment and offer repeat testing if necessary.
- 1.5.31 Offer antiviral treatment if there is evidence of significant fibrosis (METAVIR stage greater than or equal to F2 or Ishak stage greater than or equal to 3) or abnormal ALT (greater than or equal to 30 IU/L for males and greater than or equal to 19 IU/L for females) on 2 consecutive tests conducted 3 months apart.

- 1.5.32 Consider a 48-week course of peginterferon alfa-2a as first-line treatment in children and young people with chronic hepatitis B and compensated liver disease<sup>[8],[9]</sup>.
- 1.5.33 Consider stopping peginterferon alfa-2a 24 weeks after starting treatment if HBV DNA level has decreased by less than 2 log<sub>10</sub> IU/ml and/or if HBsAg is greater than 20,000 IU/ml.
- 1.5.34 Consider a nucleoside or nucleotide analogue as second-line treatment in children and young people with detectable HBV DNA after first-line treatment with peginterferon alfa-2a<sup>[10]</sup>.

### Adults with decompensated liver disease

- 1.5.35 Manage decompensated liver disease in adults in conjunction with a liver transplant centre.
- 1.5.36 Do not offer peginterferon alfa-2a to people with chronic hepatitis B and decompensated liver disease.
- 1.5.37 Offer entecavir as first-line treatment in people with decompensated liver disease if there is no history of lamivudine resistance.
- Offer tenofovir disoproxil to people with a history of lamivudine resistance.
  - Reduce the dose of tenofovir disoproxil in people with renal impairment, in line with guidance in the summary of product characteristics.

### Women who are pregnant or breastfeeding

- 1.5.38 Discuss with pregnant women the benefits and risks of antiviral treatment for them and their baby.
- 1.5.39 Offer tenofovir disoproxil to women with HBV DNA greater than 10<sup>7</sup> IU/ml in the third trimester to reduce the risk of transmission of HBV to the baby<sup>[11]</sup>.
- 1.5.40 Monitor quantitative HBV DNA 2 months after starting tenofovir disoproxil and ALT monthly after the birth to detect postnatal HBV flares in the woman.

- 1.5.41 Stop tenofovir disoproxil 4 to 12 weeks after the birth unless the mother meets criteria for long-term treatment (see recommendations 1.5.4 to 1.5.8).
- 1.5.42 Offer active and passive hepatitis B immunisation in infants and follow up in line with the guidance below:
- [Hepatitis B antenatal screening and newborn immunisation programme: best practice guidance](#)
  - [Immunisation against infectious disease \(the Green book\)](#)
  - [Hepatitis B and C: ways to promote and offer testing](#). NICE public health guidance 43 (2012)
  - [Reducing differences in the uptake of immunisations](#). NICE public health guidance 21 (2009).
- 1.5.43 Advise women that there is no risk of transmitting HBV to their babies through breastfeeding if guidance on hepatitis B immunisation has been followed, and that they may continue antiviral treatment while they are breastfeeding.

### Adults who are co-infected with hepatitis C

- 1.5.44 Offer peginterferon alfa and ribavirin in adults co-infected with chronic hepatitis B and C<sup>[8]</sup>.

### Adults who are co-infected with hepatitis D

- 1.5.45 Offer a 48-week course of peginterferon alfa-2a in people co-infected with chronic hepatitis B and hepatitis delta infection who have evidence of significant fibrosis (METAVIR stage greater than or equal to F2 or Ishak stage greater than or equal to 3)<sup>[8]</sup>.
- 1.5.46 Consider stopping peginterferon alfa-2a if there is no decrease in HDV RNA after 6 months to 1 year of treatment. Otherwise, continue treatment and re-evaluate treatment response annually.
- 1.5.47 Stop treatment after HBsAg seroconversion.



## Prophylactic treatment during immunosuppressive therapy

- 1.5.48 Perform the following tests in people who are HBsAg and/or anti-HBc positive before starting immunosuppressive therapy for autoimmune or atopic diseases, chemotherapy, bone marrow or solid organ transplantation:
- antibody to hepatitis B surface antigen (anti-HBs)
  - plasma or serum HBV DNA level
  - ALT.
- 1.5.49 In people who are HBsAg positive and have HBV DNA greater than 2000 IU/ml, offer prophylaxis with entecavir or tenofovir disoproxil<sup>[12]</sup>.
- Start prophylaxis before beginning immunosuppressive therapy and continue for a minimum of 6 months after HBeAg seroconversion and HBV DNA is undetectable.
- 1.5.50 In people who are HBsAg positive and have HBV DNA less than 2000 IU/ml, offer prophylaxis.
- Consider lamivudine<sup>[12]</sup> if immunosuppressive therapy is expected to last less than 6 months.
    - Monitor HBV DNA monthly in people treated with lamivudine and change to tenofovir disoproxil if HBV DNA remains detectable after 3 months.
  - Consider entecavir or tenofovir disoproxil<sup>[12]</sup> if immunosuppressive therapy is expected to last longer than 6 months.
  - Start prophylaxis before beginning immunosuppressive therapy and continue for a minimum of 6 months after stopping immunosuppressive therapy.
- 1.5.51 In people who are HBsAg negative and anti-HBc positive (regardless of anti-HBs status) and are starting rituximab or other B cell-depleting therapies:
- offer prophylaxis with lamivudine<sup>[12]</sup>
  - start prophylaxis before beginning immunosuppressive therapy and continue for a minimum of 6 months after stopping immunosuppressive therapy.

1.5.52 In people who are HBsAg negative, anti-HBc positive and anti-HBs negative and are not taking rituximab or other B cell-depleting therapies:

- monitor HBV DNA monthly and offer prophylaxis to people whose HBV DNA becomes detectable
  - consider lamivudine<sup>[12]</sup> in people with HBV DNA less than 2000 IU/ml and for whom immunosuppressive therapy is expected to last less than 6 months; change to tenofovir disoproxil if HBV DNA remains detectable after 6 months
  - consider entecavir or tenofovir disoproxil<sup>[12]</sup> in people with HBV DNA greater than 2000 IU/ml and for whom immunosuppressive therapy is expected to last longer than 6 months
  - continue antiviral therapy for a minimum of 6 months after stopping immunosuppressive therapy.

1.5.53 Do not offer prophylaxis to people who are HBsAg negative and anti-HBc and anti-HBs positive who are not taking rituximab or other B cell-depleting therapies.

## 1.6 Monitoring

### Monitoring in people who do not meet criteria for antiviral treatment

Further information on the progression of chronic hepatitis B can be found in the Introduction (see [Figure 1](#)).

#### *Adults with HBeAg-positive disease in the immune-tolerant and immune clearance phases*

- 1.6.1 Monitor ALT levels every 24 weeks in adults with HBeAg-positive disease who are in the immune-tolerant phase (defined by active viral replication and normal ALT levels [less than 30 IU/L in males and less than 19 IU/L in females]).
- 1.6.2 Monitor ALT every 12 weeks on at least 3 consecutive occasions if there is an increase in ALT levels.

### ***Adults with inactive chronic hepatitis B (immune-control phase)***

- 1.6.3 Monitor ALT and HBV DNA levels every 48 weeks in adults with inactive chronic hepatitis B infection (defined as HBeAg negative on 2 consecutive tests with normal ALT [less than 30 IU/L in males and less than 19 IU/L in females] and HBV DNA less than 2000 IU/ml).
- Consider monitoring more frequently (for example, every 12–24 weeks) in people with cirrhosis who have undetectable HBV DNA.

### ***Children and young people***

- 1.6.4 Monitor ALT levels every 24 weeks in children and young people with HBeAg-positive disease who have normal ALT levels (less than 30 IU/L for males and less than 19 IU/L for females) and no evidence of significant fibrosis (METAVIR stage less than F2 or Ishak stage less than 3).
- 1.6.5 Review annually children and young people with HBeAg-negative disease who have normal ALT (less than 30 IU/L for males and less than 19 IU/L for females), no evidence of significant fibrosis (METAVIR stage less than F2 or Ishak stage less than 3) and HBV DNA less than 2000 IU/ml.
- 1.6.6 Review every 12 weeks children and young people with HBeAg-negative disease who have abnormal ALT (greater than or equal to 30 IU/L for males and greater than or equal to 19 IU/L for females) and HBV DNA greater than 2000 IU/ml.

### ***Children, young people and adults with HBeAg or HBsAg seroconversion after antiviral treatment***

- 1.6.7 In people with HBeAg seroconversion after antiviral treatment, monitor HBeAg, anti-HBe, HBV DNA level and liver function at 4, 12 and 24 weeks after HBeAg seroconversion and then every 6 months.
- 1.6.8 Monitor HBsAg and anti-HBs annually in people with HBsAg seroconversion after antiviral treatment and discharge people who are anti-HBs positive on 2 consecutive tests.

## Monitoring in people taking antiviral treatment

### *Children, young people and adults taking peginterferon alfa-2a*

- 1.6.9 Review injection technique and adverse effects weekly during the first month of treatment in people taking peginterferon alfa-2a<sup>[10]</sup>.
- 1.6.10 Monitor full blood count, liver function (including bilirubin, albumin and ALT), renal function (including urea and electrolyte levels) and thyroid function (and in children, weight and height) before starting peginterferon alfa-2a and 2, 4, 12, 24, 36 and 48 weeks after starting treatment to detect adverse effects<sup>[10]</sup>.
- 1.6.11 Monitor HBV DNA and quantitative HBsAg levels and HBeAg status before starting peginterferon alfa-2a at 12, 24 and 48 weeks after starting treatment to determine treatment response<sup>[10]</sup>.

### *Children, young people and adults with compensated liver disease taking entecavir or lamivudine*

- 1.6.12 Monitor full blood count, liver function (including bilirubin, albumin and ALT) and renal function (including urea and electrolyte levels) in people with compensated liver disease before starting entecavir or lamivudine, 4 weeks after starting treatment and then every 3 months to detect adverse effects<sup>[10]</sup>.
- 1.6.13 Monitor HBV DNA and quantitative HBsAg levels and HBeAg status before starting entecavir or lamivudine, 12, 24 and 48 weeks after starting treatment and then every 6 months to determine treatment response and medicines adherence<sup>[10]</sup>.
- 1.6.14 Monitor HBV DNA levels every 12 weeks in people with HBeAg-negative disease who have been taking lamivudine for 5 years or longer<sup>[10]</sup>.

### *Children, young people and adults with compensated liver disease taking tenofovir disoproxil*

- 1.6.15 Monitor full blood count, liver function (including bilirubin, albumin and ALT), renal function (including urea and electrolyte levels and urine protein/creatinine ratio), and phosphate levels in people with compensated liver disease

before starting tenofovir disoproxil, 4 weeks after starting treatment and then every 3 months to detect adverse effects<sup>[10]</sup>.

- 1.6.16 Monitor HBV DNA and quantitative HBsAg levels and HBeAg status before starting tenofovir disoproxil, 12, 24 and 48 weeks after starting treatment and then every 6 months to determine treatment response and medicines adherence<sup>[10]</sup>.

### ***Children, young people and adults with decompensated liver disease who are taking entecavir or lamivudine***

- 1.6.17 Monitor full blood count, liver function (including bilirubin, albumin and ALT), renal function (including urea and electrolyte levels and urine protein/creatinine ratio), blood clotting, HBV DNA level and HBeAg status in people with decompensated liver disease before starting entecavir or lamivudine and weekly after starting treatment to assess treatment response and adverse effects. When the person is no longer decompensated, follow the recommendations in 'Children, young people and adults with compensated liver disease taking entecavir or lamivudine'<sup>[10]</sup>.

### ***Children, young people and adults with decompensated liver disease who are taking tenofovir disoproxil***

- 1.6.18 Monitor full blood count, liver function (including bilirubin, albumin and ALT), renal function (including urea and electrolyte levels and urine protein/creatinine ratio) and phosphate, blood clotting, HBV DNA level and HBeAg status in people with decompensated liver disease before starting tenofovir disoproxil and weekly after starting treatment to assess treatment response and adverse effects. When the person is no longer decompensated, follow the recommendations in 'Children, young people and adults with compensated liver disease taking tenofovir disoproxil'<sup>[10]</sup>.

## ***1.7 Surveillance testing for hepatocellular carcinoma in adults with chronic hepatitis B***

- 1.7.1 Perform 6-monthly surveillance for HCC by hepatic ultrasound and alpha-fetoprotein testing in people with significant fibrosis (METAVIR stage greater than or equal to F2 or Ishak stage greater than or equal to 3) or cirrhosis.

- 1.7.2 In people without significant fibrosis or cirrhosis (METAVIR stage less than F2 or Ishak stage less than 3), consider 6-monthly surveillance for HCC if the person is older than 40 years and has a family history of HCC and HBV DNA greater than or equal to 20,000 IU/ml.
- 1.7.3 Do not offer surveillance for HCC in people without significant fibrosis or cirrhosis (METAVIR stage less than F2 or Ishak stage less than 3) who have HBV DNA less than 20,000 IU/ml and are younger than 40 years.

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<sup>[4]</sup> Adults with a transient elastography score greater than or equal to 11 kPa are very likely to have cirrhosis and confirmation by liver biopsy is not needed.

<sup>[5]</sup> The degree of fibrosis cannot be accurately predicted in adults with a transient elastography score between 6 to 10 kPa. Some people may choose to have a liver biopsy in these circumstances to confirm the extent of liver disease.

<sup>[6]</sup> Adults with a transient elastography score less than 6 kPa are unlikely to have significant fibrosis.

<sup>[7]</sup> [Adefovir dipivoxil and peginterferon alfa-2a for the treatment of chronic hepatitis B](#) (NICE technology appraisal guidance 96), [Entecavir for the treatment of chronic hepatitis B](#) (NICE technology appraisal guidance 153), [Telbivudine for the treatment of chronic hepatitis B](#) (NICE technology appraisal guidance 154) and [Tenofovir disoproxil fumarate for the treatment of hepatitis B](#) (NICE technology appraisal guidance 173).

<sup>[8]</sup> Avoid use of peginterferon alfa-2a in pregnancy unless the potential benefit outweighs risk. Women of childbearing potential must use effective contraception throughout therapy.

<sup>[9]</sup> At the time of publication (June 2013), peginterferon alfa-2a did not have a UK marketing authorisation for use in children for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing medicines – guidance for doctors](#) for further information.

<sup>[10]</sup> At the time of publication (June 2013), peginterferon alfa-2a and entecavir did not have a UK marketing authorisation for use in children for this indication, and tenofovir disoproxil did not have a UK marketing authorisation for use in children younger than 12 years for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision.

Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing medicines – guidance for doctors](#) for further information.

<sup>[11]</sup> At the time of publication (June 2013), tenofovir disoproxil did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing medicines – guidance for doctors](#) for further information.

<sup>[12]</sup> At the time of publication (June 2013), entecavir, lamivudine and tenofovir disoproxil did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing medicines – guidance for doctors](#) for further information.

## 2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

### 2.1 *Stopping antiviral treatment in HBeAg-negative disease*

Further research should be undertaken to evaluate the clinical and cost effectiveness of [hepatitis B surface antigen](#) (HBsAg) quantitative assays in determining treatment duration in [hepatitis B e antigen-](#) (HBeAg) negative disease.

#### Why this is important

In HBeAg-positive disease, [HBeAg seroconversion](#) is a predictor of durable response to antiviral treatment and can be used as a milestone after which treatment can be stopped. At present, similar parameters have not been defined in HBeAg-negative disease. Quantitative HBsAg may have a role in determining treatment duration in this setting. Establishing threshold levels for HBsAg titre associated with durable off-treatment control in HBeAg-negative disease would transform current treatment strategies. People on long-term nucleoside or nucleotide analogues could safely stop treatment once they achieved a threshold level of HBsAg. Further research is needed to define these levels of HBsAg and to determine when treatment in HBeAg-negative disease can be safely stopped.

### 2.2 *ALT values for children and young people*

Further research should be undertaken to examine whether the upper limit of normal ALT values for adults (below 30 IU/L for males and below 19 IU/L for females) are appropriate for use in children and young people with [chronic hepatitis B](#) when making decisions on when to initiate treatment.

#### Why this is important

Recent studies have highlighted the imprecision of using biochemical activity as a measure of immune activity in children and young people with chronic hepatitis B. Researchers have found T-cell exhaustion and even HBV-specific immune responses in children and young people considered to have immune-tolerant disease. These findings need to be validated in larger studies to see if upper limit of normal ALT values derived from adults accurately reflect disease activity in children and young people. Further research is needed to investigate whether there is a genuine state of



immune tolerance in children and young people reflected in lower levels of biochemical activity and a lower upper limit of normal ALT value.

### 2.3 *Long-term safety of tenofovir disoproxil in chronic hepatitis B*

Further research should be undertaken to determine the long-term safety of tenofovir disoproxil, including the risk of clinically significant hypophosphataemia and related bone toxicity, in people with chronic hepatitis B. The cost effectiveness of routine monitoring for phosphate loss and bone disease in people with chronic hepatitis B who are receiving tenofovir disoproxil treatment needs further evaluation.

#### **Why this is important**

Tenofovir disoproxil is recommended as an option for treatment of people with chronic hepatitis B, and is typically prescribed for long-term use. Kidney dysfunction has been reported in people treated with tenofovir disoproxil, including rare cases of proximal renal tubular dysfunction that appear related to long-term exposure but are not well understood. Adverse renal effects such as hypophosphataemia may have an impact on bone architecture which could result in clinical problems such as fragility fractures. Monitoring for phosphate loss and bone disease could have a role in preventing clinically significant bone problems in people with chronic hepatitis B receiving long-term tenofovir disoproxil. However, the cost effectiveness and clinical utility of routine monitoring needs to be established before recommendations can be made about its use.

### 2.4 *Prophylactic treatment in people receiving immunosuppressive therapy*

Further research should be undertaken to determine whether long-term use of mild immunosuppressive agents for autoimmune and allergic problems presents a risk for reactivation of HBV infection in people with previous or current chronic hepatitis B, including occult HBV infection. The cost effectiveness of routine tests for HBV in this population, including [HBV DNA](#) for occult HBV infection, and the need for prophylactic treatment with nucleoside or nucleotide analogues needs further evaluation.

#### **Why this is important**

Reactivation of HBV may occur spontaneously or arise during immunosuppression. Solid organ transplantation, chemotherapy and immunosuppressive drugs used to treat autoimmune diseases are key causes of HBV reactivation. Antiviral agents can be used as prophylaxis to prevent reactivation of HBV infection in people receiving immunosuppressive therapy but the optimal treatment and duration of therapy are unknown. Decision-making and cost-effectiveness studies

are needed to determine optimal screening strategies to identify people at risk of HBV reactivation. People with occult HBV (including people coming from high endemicity regions) might carry a low, but not negligible, risk of viral reactivation. Prospective studies are needed to assess the risk of HBV reactivation in people receiving mild immunosuppressants or biological treatment for autoimmune diseases, to identify risk factors that predict HBV reactivation in this population, and evaluate treatment or pre-emptive strategies using existing nucleoside and nucleotide analogues.

## 3 Other information

### 3.1 *Scope and how this guideline was developed*

NICE guidelines are developed in accordance with a [scope](#) that defines what the guideline will and will not cover.

#### How this guideline was developed

NICE commissioned the National Clinical Guideline Centre to develop this guideline. The Centre established a Guideline Development Group (see [section 4](#)), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

### 3.2 *Related NICE guidance*

Details are correct at the time of consultation on the guideline (January 2013). Further information is available on the [NICE website](#).

#### Published

##### *General*

- [Patient experience in adult NHS services](#). NICE clinical guidance 138 (2012).
- [Medicines adherence](#). NICE clinical guidance 76 (2011).
- [Looked-after children and young people](#). NICE public health guidance 28 (2010)

##### *Condition-specific*

- [Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection](#). NICE public health guidance 43 (2012).
- [Increasing the uptake of HIV testing among men who have sex with men](#). NICE public health guidance 34 (2011).
- [Increasing the uptake of HIV testing among black Africans in England](#). NICE public health guidance 33 (2011).

- [Alcohol-use disorders](#). NICE clinical guideline 115 (2011).
- [Reducing differences in the uptake of immunisations](#). NICE public health guidance 21 (2009).
- [Tenofovir disoproxil fumarate for the treatment of hepatitis B](#). NICE technology appraisal guidance 173 (2009).
- [Antenatal care](#). NICE clinical guideline 62 (2008).
- [Entecavir for the treatment of chronic hepatitis B](#). NICE technology appraisal guidance 153 (2008).
- [Telbivudine for the treatment of chronic hepatitis B](#). NICE technology appraisal guidance 154 (2008).
- [Adefovir dipivoxil and peginterferon alfa-2a for the treatment of chronic hepatitis B](#). NICE technology appraisal guidance 96 (2006).
- [Obesity](#). NICE clinical guideline 43 (2006).

## Under development

NICE is developing the following guidance (details available from [the NICE website](#)):

- Hepatitis C. NICE clinical guideline. Publication date to be confirmed.

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## Changes after publication

**January 2014:** A correction has been made to the units used for abnormal alanine aminotransferase (ALT) in men and women. The abnormal ALT levels should read greater than or equal to 30 IU/L for males and greater than or equal to 19 IU/L for females, not IU/ml. This has been changed in recommendations 1.3.6, 1.3.7, 1.3.10, 1.5.3–5, 1.5.31, 1.6.1, 1.6.3–6, and 2.2.

## About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

NICE guidelines are developed in accordance with a [scope](#) that defines what the guideline will and will not cover.

This guideline was developed by the National Clinical Guideline Centre, which is based at the Royal College of Physicians. The Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

## Update information

In this guideline, recommendations 1.5.13 to 1.5.15 update and replace recommendations 1.2 to 1.4 on the use of adefovir dipivoxil for treating chronic hepatitis B in [Adefovir dipivoxil and peginterferon alfa-2a for the treatment of chronic hepatitis B](#) (NICE technology appraisal guidance 96). NICE technology appraisal guidance 153, 154, 173 and recommendation 1.1 of NICE technology appraisal guidance 96 have been incorporated into this guideline and remain extant.

## Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also [Patient-centred care](#)).

### **Interventions that must (or must not) be used**

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

### **Interventions that should (or should not) be used – a 'strong' recommendation**

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer...') when we are confident that an intervention will not be of benefit for most patients.

### **Interventions that could be used**

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

### ***Other versions of this guideline***

The full guideline, '[Hepatitis B \(chronic\): Diagnosis and management of chronic hepatitis B in children, young people and adults](#)' contains details of the methods and evidence used to develop the guideline. It is published by the National Clinical Guideline Centre.

The recommendations from this guideline have been incorporated into a [NICE Pathway](#).

We have produced [information for the public](#) about this guideline.

### ***Implementation***

[Implementation tools and resources](#) to help you put the guideline into practice are also available.

## *Your responsibility*

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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