San Francisco Hep B Free - Bay Area ECHO Notes

Session 16

March 15, 2022

I. Didactic Presentation: Hepatitis B and HIV Coinfection (Dr. Jeff Burack, Medical Director and Attending Physician, East Bay Advanced Care (formerly East Bay AIDS Center,) Alta Bates Summit Medical Center, Berkeley & Oakland, CA) - presentation can be found at https://www.sfhepbfree.org/echo-program Password: Echo2020

II. Case Presentation: Dr. Will Holt - Hepatology (Sutter Health)

Case summary (Case was hypothetical this session):

- A 31 year-old man with chronic hepatitis B schedules a clinic visit to request coming off of Truvada for PREP. This is your second visit with him – he established care after moving here from out of state just 2 months ago. He has known horizontally acquired chronic hepatitis B, apparently diagnosed before starting PREP 2 years ago and very likely acquired at age 28. He has a paper copy of his labs from his prior clinic with him but has not yet done the labs that you ordered at the first visit. (See "Labs" section.) During the visit he tells you that he actually stopped Truvada 4 weeks ago. He has no physical complaints but wants to know if he should be on any medication for HBV.

- The same patient is lost to follow up for 8 years, then returns to your clinic – now 39 years old. He had been living out of state and has decided to move back to the Bay Area. He was diagnosed with HIV 6 years ago and has been doing very well on dolutegravir plus TAF-emtricitabine (Descovy). He still has no physical complaints and wants to know whether he should have liver cancer screening.

Clinical Questions:

1) What HBV-related factors should be considered when starting and stopping PREP?
2) Which patients with HIV-HBV coinfection need HCC surveillance?

<u>Recommendations from Project ECHO panel:</u>

Dr. Will Holt - Hepatology (Sutter Health)

Dr. Frank Trinh – Infectious Disease (San Mateo Medical Center)

Dr. Anita Chang – Primary Care (Asian Health Services)

What HBV-related factors should be considered when starting and stopping PREP?

- When stopping PREP in a patient with chronic HBV, there is a risk of HBV flare when coming off Truvada or Descovy (which contain TDF and TAF, respectively).

Most patients should be transitioned to tenofovir or entecavir, unless it is clearly documented that the risks of treatment withdrawal are acceptable (no significant fibrosis, no history of major flare) and the patient will be followed very closely (labs every 2-4 weeks in the months that follow treatment cessation). It is this risk of flare that lead to the black box warning on Truvada and Descovy. Note that this pertains to patients on PREP who are not infected with HIV – it is not recommended that patients with chronic HBV who are infected with HIV be taken off of HBV therapy.

- In HIV/HBV coinfected patients, providers should work with the patient's HIV provider to create and HIV regimen that treats both diseases – these are well-established and many options exist because tenofovir is part of so many HIV regimens already (ie, low concern for drug interactions). More common than drug-drug interactions is the risk of elevated liver tests from the HIV regimen, from HIV itself or from comorbid disease (esp fatty liver but also noncirrhotic portal hypertension, for example). Patients with HIV/HBV coinfection should be monitored the same as those with HBV infection alone – labs every 3-6 months depending on disease and treatment stability and HCC surveillance when indicated (see below).

Which patients with HIV-HBV coinfection need HCC surveillance?

- Patients with HBV and HIV coinfection use the same criteria for HCC surveillance as those without HIV coinfection: chronic HBV (positive HBsAg on 2 occasions at least 6 months apart) and age >50 in women and age >40 in men, any patient with cirrhosis and any patient with a 1st degree family member with HCC. While the HCC surveillance guidance is the same, it's important to remember that the natural history of HBV in patients infected with HIV is more aggressive and the risk of disease progression to cirrhosis and its complications is higher. As such, patients with chronic HBV who are infected with HIV should be on HBV therapy.