Hepatology Society of the Philippines

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One out of eight Filipinos is infected with the Hepatitis B virus (HBV). Therefore, chronic hepatitis B is a major public health concern in the Philippines. However, the current practice of screening for hepatitis B surface antigen (HBsAg) as a basis for employment has no evidence except in certain circumstances.

Hepatitis B surface antigen positivity alone has become a basis for discrimination, work restriction and subsequent disqualification from employment in the Philippines. Each year many potential workers are denied employment solely because of misconceptions about the risk of hepatitis B (HBV) transmission, lack of knowledge about the natural history of this disease and the risk of developing complications while at work.

This has prompted the Hepatology Society of the Philippines (HSP) to formulate guidelines to aid physicians involved in the evaluation of Hepatitis B surface antigen positive workers for employment. The main objectives of these guidelines is to help physicians recognize the implications of the different phases of chronic HBV infection on the risk of transmission in the workplace, eligibility for treatment and the risk of developing complications and to serve as a guide in categorizing the risk of transmission in the workplace based on the type of occupation and the individual’s infectivity.

These guidelines are made with the intention to balance the risk of HBV transmission in the workplace and the probability of losing highly skilled workers due to unduly stringent restrictions. These recommendations are meant to be flexible and are not intended to be the only acceptable approach in the evaluation for employment of HBsAg positive workers. Pertinent facts and circumstances surrounding each individual with chronic HBV infection should always be considered. These guidelines are based on current knowledge and will be updated as new data emerge.
INTRODUCTION

Chronic hepatitis B (CH B) affects 350 million people worldwide1 and is more prevalent in Asia, sub-Saharan Africa and the Pacific rim compared to other regions. 2 With a prevalence rate of approximately 6 to 12% 3,4,5,6 the Philippines is considered hyperendemic for hepatitis B (HBV). Although the reported prevalence of HBV infection among overseas Filipino workers is slightly lower (4.2%), 6 this still translates to as many as 12,000 potential workers yearly 7 who may be denied employment solely because of misconceptions about the risk of HBV transmission, the lack of knowledge about the natural history of this disease and the risk of developing complications while at work.

Although safe work practices and standard precautions 6 need to be adhered to by individuals with chronic HBV infection (Table 1), they should not be discriminated upon or treated differently from all other workers. The natural history of chronic HBV infection is variable, and persons with chronic HBV infection need lifelong monitoring to determine if and when intervention is needed.

These guidelines are recommendations on the evaluation of HBsAg positive workers for employment. Recent advances and new data on the epidemiology, diagnosis and natural history of HBV infection have prompted the Hepatology Society of the Philippines (HSP) to convene a working group to update the previous recommendations drafted in 2005 by the Council on Liver Diseases of the Philippine Society of Gastroenterology. The working group identified key issues and questions which needed to be addressed, with particular reference to HBsAg positive workers. Individuals from various sectors, including liver disease and infectious disease specialists, clinical epidemiologists and representatives from the Department of Health were invited to a series of meetings wherein issues on epidemiology, natural history and risk of transmission of HBV were presented and discussed. A review of existing guidelines and policies 8,9,10,11,12,13,14,15 was likewise performed. Based on data and evidence presented, the members of the working group were asked to revise and update the previous guidelines or propose new recommendations whenever appropriate.

These recommendations are meant to be flexible and are not intended to be the only acceptable approach in the evaluation for employment of HBsAg positive workers. Pertinent facts and circumstances surrounding each individual with chronic HBV infection should always be considered.

The main objective of these guidelines is to aid physicians involved in the evaluation of HBsAg positive workers for employment. It aims to 1) help physicians recognize the implications of the different phases of chronic HBV infection on the risk of transmission in the workplace, eligibility for treatment and the risk of developing complications and 2) serve as a guide in categorizing the risk of HBV transmission in the workplace according to the type of occupation and the individual’s infectivity.

These guidelines are based on current knowledge and will be updated as new data emerge.

HEPATITIS B Virology AND Serology

The hepatitis B virus belongs to the family hepadnavirus. The HBV genome is a relaxed, circular partially double stranded DNA of approximately 3200 base pairs. There are four (4) partially overlapping open reading frames encoding the envelope (preS/S), core (precore/core), polymerase, and X proteins. The polymerase protein functions as a reverse transcriptase as well as a DNA polymerase. The X protein is a potent transactivator of oncogenes and may play a role in the development of liver cancer.

The most common serologic tests for hepatitis B are the hepatitis B surface antigen (HBsAg) which denotes the presence or absence of infection, antibody to HBsAg (anti-HBs) which when positive signifies protection or immunity from HBV infection, and hepatitis B e antigen (HBeAg), antibody to HBeAg (anti-HBe), antibody to hepatitis B core antigen (anti-HBc), HBV DNA, and alanine aminotransferase (ALT) which collectively determines the phase of the infection.

9 Lok AS, McMahon BJ. Chronic hepatitis B. Hepatology 2007; 45:50739.
11 Liaw YF, Leung N, Guan R, Lau GK, Merican I, McCaugha...
Table 1. Recommendations for Application of Standard Precautions

Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non intact skin and mucous membranes may contain transmissible infectious agents such as hepatitis B. Standard precautions include infection prevention practices that must be observed in all patients, regardless of age, sex, economic background and so on and regardless of suspected or confirmed infection, in any setting in which the health care is delivered.

The 2007 US Centers for Disease Control recommendations for standard precautions include: hand hygiene; use of gloves, gown, mask, eye protection or eye shield, depending on the anticipated exposure; and safe injection practices. It also covers the proper handling and disinfection of environment and equipment which may be contaminated with body fluids.

Standard precautions are important not only to prevent infections from patients to health care workers, but to protect as well patients from getting infections from infected healthcare workers such as those who may have hepatitis B or from equipment used in other patients who may have the infection.

The important addition in the latest 2007 guidelines compared to its previous versions is the inclusion of safe injection practices to the components of Standard Precautions. This is an important new addition particularly in areas like the Philippines where the practice of reusing needles and multiple use of the same needle to give intravenous medications from multidose vials must be reviewed and improved.

The application of Standard Precautions is summarized in Table below:

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene</td>
<td>Practice hand hygiene with soap and water, alcohol or alcohol based handrub after touching blood, body fluids, secretions, excretions, contaminated items; after removing gloves, and at all times between patient contact</td>
</tr>
<tr>
<td>Personal protective equipment (PPE)</td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td>Use gloves whenever there is possibility of touching blood, body fluids, secretions, excretions, contaminated items; when anticipating touching mucous membranes and nonintact skin</td>
</tr>
<tr>
<td>Gown</td>
<td>Use gown during procedures and patientcare activities when contact of clothing or areas of exposed skin with blood, bodyfluids, secretions and excretions is anticipated.</td>
</tr>
<tr>
<td>Mask, eye protection or face shield</td>
<td>Use masks, and eye protection during procedures likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning and endotracheal intubation (goggles) or face shield</td>
</tr>
<tr>
<td>Soiled patient care equipment</td>
<td>Handle in a manner to prevent transfer of organisms to others</td>
</tr>
<tr>
<td>Environmental Control</td>
<td>Develop procedures for routine care, cleaning and disinfection of environmental surfaces especially frequently touched surfaces in the patient-care areas</td>
</tr>
<tr>
<td>Textile and laundry</td>
<td>Handle in a manner to prevent transfer of organisms to others</td>
</tr>
<tr>
<td>Injection practices</td>
<td>Use only aseptic technique when preparing and administering parenteral medications. Use sterile, singleuse, disposable needle and syringe for each injection. When possible, singledose vials is preferred over multipledose vials.</td>
</tr>
<tr>
<td>Needles and other sharps</td>
<td>Do not recap, bend, break or handle used needles. If recapping has to be done, use the one-handed scoop technique, Place used sharps only in puncture-resistant containers.</td>
</tr>
<tr>
<td>Patient resuscitation</td>
<td>Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions</td>
</tr>
<tr>
<td>Cough etiquette</td>
<td>Instruct coughing patients to cover mouth and nose whenever sneezing, coughing; wear surgical mask if tolerated</td>
</tr>
</tbody>
</table>

MODES OF TRANSMISSION

HBV is transmitted by perinatal (mother to infant), percutaneous, mucous membrane and sexual exposure to infectious blood and open cuts that contain blood.\(^\text{16}\) HBV DNA has been detected in a wide variety of body fluids such as blood, tears, urine, saliva, breast milk, seven and vaginal fluid. HBV can survive outside the body for up to seven (7) days and HBsAg positive individuals can shed large quantities of viral particles on environmental surfaces, although there have been no reports of transmission from fomites. The presence of HBsAg in serum directly correlates with higher titers of HBV DNA. However, HBV strains that have mutations in the precore or basal core promoter regions of the viral genome, which eliminates and decreases the expression of the HBeAg, respectively, have also been associated with high viral loads and perinatal and percutaneous viral transmission.

Percutaneous exposures that have resulted in HBV transmission include the use of contaminated equipment for therapeutic injections and dental procedures, illicit or injection drug use, transfusion of blood or blood products, and needlestick or other injuries from sharp instruments held by medical and dental personnel. Outbreaks of hepatitis B have also been associated with tattooing and acupuncture. Perinal and sexual transmission of HBV usually results from exposure of mucous membranes to infectious blood or serum derived body fluids. Although HBV DNA has been quantified in saliva\(^\text{16}\) and transmission reported in people bitten\(^*\) or spit at in the eye by HBsAg positive carriers, transmission has not been demonstrated in susceptible persons orally exposed (e.g. kissing) to HBV DNA-positive saliva.

NATURAL HISTORY OF HEPATITIS B INFECTION

Acute infection with HBV produces clinically apparent disease only in a minority of cases. The rate of evolution into chronic infection depends on the age of the individual when infected. Perinatal infection from an infected mother is almost always asymptomatic or without symptoms, and evolves to chronic infection in 90% of cases. The risk of perinatal infection is approximately 90% in babies born to HBsAg positive mothers and 10% in babies born to HBeAg negative mothers and is related to the maternal serum HBV DNA level, where a level below 2 million IU/mL is not likely to transmit infection.\(^\text{17}\) In about 5% of babies born to HBeAgnegative mothers, acute symptomatic or fulminant hepatitis develops within the first 3-4 months of life.\(^\text{21}\)

Infection acquired in early childhood (1-5 years), presumably from open cuts, scratches and wounds, is in general asymptomatic and evolves to chronic infections in 2530% of cases. In contrast, approximately 30% of infection in adults present as icteric hepatitis and 0.10.5% develop fulminant hepatitis. Infection resolves with the development of antiHBs in >95% of adults and is more common in adults who develop acute icteric hepatitis B.\(^\text{22}\)

Acute HBV infection leads to one of these three outcomes:

* Fulminant hepatitis
* Recovery from acute infection with disappearance of HBsAg
* Chronic Hepatitis B infection

Chronic HBV infection is characterized by the persistence of serum HBsAg for at least six (6) months. In adult-acquired infection, it is important to recognize that it may occasionally take a few months for some individuals to clear HBsAg, but HBsAg should generally be undetectable 1 year after acute HBV infection.\(^\text{15}\) In perinatally-acquired infection, the rate of HBsAg clearance ranges from 0.12% per year although a recent study from Taiwan suggests that as much as 25% will have HBsAg clearance if followed for 20 years.\(^\text{24}\)

Since HBV is not directly cytopathic, the level of liver necroinflammation is dependent on the activity of the immune system. During the initial phase of chronic HBV infection, serum HBV DNA levels are high, HBsAg is present, and the immune system is not activated against HBV, as evidenced by normal ALT levels and minimal or absent necroinflammation on liver biopsy. The majority of carriers (70-80%) eventually loses HBsAg and develops antiHBs. In most individuals who have undergone seroconversion from HBsAg to antiHBs, levels of HBV DNA decrease below 2,000 IU/mL, ALT normalize and necroinflammation decreases. However, in some cases, liver disease persists or relapses after a period of inactivity. Most of these patients have mutations in the core promoter and precore regions of the viral genome. The different serological patterns and phases of chronic HBV infection are highly dependent on how the balance swings between immune system control and viral activity. Table 2 defines the diagnostic criteria and terms used in chronic hepatitis B infection.


\(^{24}\) Chu CM, Liaw YF. HBsAg seroclearance in asymptomatic carriers of high endemic areas: appreciably high rates during a longterm followup. Hepatology 2007;45:118792.
Evaluation of HBsAg(+) Workers (HSP)

<table>
<thead>
<tr>
<th>Table 2: Glossary of terms and diagnostic criteria used in chronic HBV infection</th>
</tr>
</thead>
</table>

### Chronic Hepatitis B
A chronic necroinflammatory disease of the liver caused by persistent infection with HBV and can be subdivided into:

1. **HBeAg-positive chronic hepatitis B**
   **Diagnostic Criteria:**
   - a. HBsAg positive >6 months
   - b. HBeAg positive, antiHBe negative
   - c. Serum HBV DNA >20,000 IU/ml or >112,000 copies/ml
   - d. Persistent or intermittent elevation in ALT levels
   - e. Liver biopsy showing HAI >4

2. **HBeAg-negative chronic hepatitis B**
   **Diagnostic Criteria:**
   - a. HBsAg positive >6 months
   - b. HBeAg negative, antiHBe positive
   - c. Serum HBV DNA >2,000 IU/ml or >11,200 copies/ml
   - d. Persistent or intermittent elevation in ALT levels
   - e. Liver biopsy showing HAI >4

### Inactive HBsAg Carrier State

Persistent HBV infection of the liver without significant ongoing necroinflammatory disease.

**Diagnostic Criteria:**
- a. HBsAg positive >6 months
- b. HBeAg negative, anti HBe positive
- c. Serum HBV DNA <2,000 IU/ml or <11,200 copies/ml
- d. Persistently normal ALT levels
- e. Liver biopsy confirms absence of necroinflammatory disease

### Acute Exacerbation or Flare of Hepatitis B

Intermittent elevations of ALT to more than 10 times Upper Limit of Normal (ULN) or more than 2 times the baseline value.

### Resolved Hepatitis B

Previous HBV infection without further virologic, biochemical or histologic evidence of active infection or disease.

**Diagnostic Criteria:**
- a. Previous known history of acute or chronic hepatitis B
- b. HBsAg negative with or without antiHBs
- c. Undetectable serum HBV DNA
- d. Normal ALT levels

* To convert IU/ml to copies/ml, multiply equivalent IU by 5.6
** Very low levels may be detected by PCR-based assays

### Phases of chronic hepatitis B infections

**A. Immune Tolerant Phase**

This is the initial phase of chronic HBV infection and is commonly found in areas where perinatal transmission is the predominant mode of transmission. These patients have no symptoms, with normal or slightly increased serum ALT levels and minimal necroinflammation on histology signifying a lack of, or a very weak immune response against the infected hepatocytes. The rate of progression into chronic hepatitis, where the ALT increases and necroinflammation starts to appear on histology, is 2.2% per year while the rate of progression to cirrhosis is very low at 0.5% per year.

**B. Immune Clearance Phase**

During the course of chronic HBV infection, the immune system becomes activated against the hepatitis B virus and attempts to clear the virus by cytotoxic or cytokine-mediated means. The effects of this immune system activation are an increase in ALT levels and histologic activity, reflecting immune mediated lysis of infected hepatocytes, and a decrease in HBV DNA levels. In some individuals, this is followed by HBeAg seroconversion. However, in some, this phase is prolonged and results in the persistence of inflammatory activity and eventual increase in HBV DNA levels (HBeAg-positive chronic hepatitis B). Patients in this phase have a high likelihood of having and acute exacerbation or flare of their hepatitis (28.6% per year) and an increased rate of developing cirrhosis (26% per year) if not followed up and treated at an opportune time.

**C. Low or Nonreplicative Phase**

This phase usually follows spontaneous or treatment induced seroconversion from HBeAg to antiHBe, and usually occurs in the 3rd to 4th decade in individuals infected perinatally. This is marked by a reduction of serum HBV DNA below 2,000 IU/mL, followed by normalization of ALT levels and resolution of liver necroinflammation. This is also termed the inactive HBsAg carrier state, which makes up 70-80% of individuals with chronic HBV infection. These individuals have a good prognosis with a risk of developing cirrhosis of only 0.9% per year. However, not all individuals remain in the inactive carrier state. Around 10-30% (2.2% per year) may undergo subsequent spontaneous or immunosuppression-induced reactivation of HBV replication with reappearance of high levels of HBV DNA with or without reversion to serum HBeAg positive status and a rise in ALT levels when followed serially over time.

**D. Reactivation Phase**

 Reactivation of HBV replication and liver inflammation may be observed after HBeAg seroconversion. This phase is marked by elevated ALT levels, negative serum HBeAg, and increased HBV DNA levels (usually > 2,000 IU/ml) and is appropriately termed the HBeAg negative chronic hepatitis B phase. It is important to note that around 20-45% of individuals in this phase will have fluctuating HBV DNA and ALT levels such that serial monitoring may be needed in order to properly differentiate this phase from the inactive carrier state. The risk of having an acute flare or exacerbation of hepatitis is...
10.3% per year 26 while the probability of progression into cirrhosis is 8-10% per year. 31, 32

E. Recovery Phase

The disappearance of HBsAg and development of anti-HBs signifies the recovery phase. These individuals good prognosis. However, the age at which this phase occurs, the frequency and severity of hepatitis exacerbations and development of cirrhosis before this phase is reached may also be important determinants of prognosis. 33,34

RISK OF HBV TRANSMISSION IN THE WORKPLACE

The risk of transmission of HBV from an infected worker to a person in the workplace is dependent on two main factors: 1) the risk of exposure to infectious HBV particles in the workplace, which is primarily dependent on the type of occupation, and; 2) the infectivity of the infected worker, which is dependent on viral factors.

Consistent with the known modes of transmission of HBV, there has been no report of HBV transmission through casual contact in the workplace, although there have been reports of transmission where close body contact is involved such as in athletes engaged in contact sports.16,35

The type of occupation that carries the highest risk of exposure to HBV from an infected worker is one that entails exposure to sharp instruments/needles that have the potential to cause a break in the skin and thus expose another person to infectious blood or body fluids. These occupations include those that require workers to perform form so-called exposure-prone procedures (EPPs) and are largely limited to the health care setting. Exposure-prone procedures are those that involve digital palpation of a needle tip in a body cavity, the simultaneous presence of the health care worker's (HCW) fingers and a needle or other sharp instrument in a poorly visualized or highly confined space, or having interrupted vision during a surgical procedure.36 Table 4 presents a list of procedures from different health care-related occupations that are considered to be EPPs. This list, however, is only meant to be a guide. A definitive and exhaustive list of EPPs is not possible because individual working practices and risk of exposure may vary. Evidence from which these classifications were based are weak and relied mostly on case series and expert opinion.

Table 4: ExposureProne Procedures (EPPs)

<table>
<thead>
<tr>
<th>A. Surgery</th>
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<tbody>
<tr>
<td>1. Abdominal Surgery</td>
</tr>
<tr>
<td>* All open surgical procedures, including major organ retrieval</td>
</tr>
<tr>
<td>* All laparoscopic procedures that are converted to open procedures</td>
</tr>
<tr>
<td>2. Thoracic surgery</td>
</tr>
<tr>
<td>* Any open surgical procedure</td>
</tr>
<tr>
<td>3. Neurosurgery</td>
</tr>
<tr>
<td>* Craniotherapy and intracranial procedures</td>
</tr>
<tr>
<td>* Openprocedure surgery</td>
</tr>
<tr>
<td>4. Obstetrics and gynecology</td>
</tr>
<tr>
<td>* All open surgeries</td>
</tr>
<tr>
<td>* Repairs following episio tomes or perineal tears</td>
</tr>
<tr>
<td>* All laparoscopic procedures that are converted into open procedures</td>
</tr>
<tr>
<td>* Cone biopsies with a scalpel</td>
</tr>
<tr>
<td>5. Orthopedic surgery</td>
</tr>
<tr>
<td>* Open surgical procedure</td>
</tr>
<tr>
<td>* Procedures involving the cutting or fixation of bones</td>
</tr>
<tr>
<td>* Procedures that involve the distant transfer of tissues from a second site</td>
</tr>
<tr>
<td>* Acute hand trauma</td>
</tr>
<tr>
<td>* Nail avulsion of toes for in-frowning toenails and Zadek's procedure</td>
</tr>
<tr>
<td>* Arthroscopic procedures that are converted into open procedures</td>
</tr>
<tr>
<td>6. Ophthalmology</td>
</tr>
<tr>
<td>7. Orbital surgery</td>
</tr>
<tr>
<td>8. Otorhinolaryngological surgery</td>
</tr>
<tr>
<td>* All procedures except simple ear and nasal procedures provided fingertips are always visible, endoscopy provided fingertips are always (cont.)</td>
</tr>
</tbody>
</table>

It is interesting to note that while the risk of transmission from an infected worker to a patient is relatively low, the risk of transmission from an infected patient to a HCW can be as high as 30%, which stresses the need for HBV vaccination in all susceptible health care workers. Table 5 gives a summary of the types of occupations according to the risk of HBV exposure, where Category 1 poses the highest and Category 3 poses the lowest risk of exposure to HBV from infected workers.

Table 5: Categories of occupations according to risk of HBV exposure from infected workers

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Health care workers (HCWs) who are performing or who have reasonable expectation of performing exposure-prone procedures (EPPs)</td>
</tr>
<tr>
<td>Category 2</td>
<td>HCWs who are not performing or who do not have a reasonable expectation of performing EPPs</td>
</tr>
<tr>
<td>Category 3</td>
<td>Non-HCWs</td>
</tr>
</tbody>
</table>

The infectivity of an HBsAg-positive worker is highly dependent on the serum HBV DNA level and the phase of HBV infection. However, determining a serum HBV DNA cutoff considered safe in the workplace and with a zero probability of HBV transmission is not possible because there are no randomized controlled studies looking at this particular question. In addition, the determination of an HBV DNA cut-off needs to take into account natural fluctuations of HBV DNA levels over time and assay variability between laboratories.

Policy statements from other countries have based their recommendations on data extrapolated from studies on vertical and perinatal transmission. In the United Kingdom and Ireland, HCWs who are HBeAg-positive or have HBV DNA greater than 2,000 IU/mL are not allowed to perform EPPs, while in the United States, HBeAg positivity alone is the basis for exclusion from performing EPPs.

We have categorized the infectivity of an HBsAg-positive worker as either high or low according to HBeAg status and HBV DNA level. Table 6 shows the risk of HBV transmission in the workplace, which is a composite of the infectivity of the worker and the risk of exposure according to the type of occupation. Recommendations regarding HBV transmission in the workplace are further discussed in the section on policy statements. A proposed algorithm on the evaluation of HBsAg-positive workers for employment is presented in Figure 1.
Table 6: Risk of transmission of HBV in relation to exposure risk and infectivity

<table>
<thead>
<tr>
<th>Infectivity</th>
<th>OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Category 1 *</td>
</tr>
<tr>
<td>High (HBV DNA &gt; 2,000 IU/ml)</td>
<td>High risk of transmission</td>
</tr>
<tr>
<td>Low (HBV DNA &lt; 2,000 IU/ml)</td>
<td>Low risk of transmission</td>
</tr>
</tbody>
</table>

Legend:
* Health care workers (HCWs) who are performing or who have a reasonable expectation of performing exposure-prone procedures (EPP’s). Other workers whose occupation involves potential for exchange of bodily fluids (e.g., commercial sex workers)
** HCW’s who are not performing or who do not have a reasonable expectation of performing EPP’s
*** NonHCW. All other occupations that do not fall into Categories 1 or 2
**** HBV DNA determination not a prerequisite

Figure 1: Proposed Algorithm for the evaluation of HBsAg positive workers for employment

Legend:
* Hepatic decompensation or hepatocellular carcinoma
** Health care workers (HCWs) who are performing or who have a reasonable expectation of performing exposure-prone procedures (EPP’s). Other workers whose occupation involves potential for exchange of bodily fluids (e.g., commercial sex workers)
*** HCW’s who are not performing or who do not have a reasonable expectation of performing EPP’s and NonHCW
These recommendations are made with the intention to balance the risk of HBV transmission in the workplace and the probability of losing highly-skilled workers due to unduly stringent restrictions. To avoid the loss of highly-skilled workers and minimize the risk of HBV transmission in the workplace, particularly in the health care setting, a study has evaluated the use of antiviral therapy to allow HCWs to resume performing EPPs. Potent antiviral therapy for HBV is currently available and data extrapolated from vertical transmission studies suggest that antiviral therapy may be effective in reducing the risk of HBV transmission. However, data on this issue are sparse and inconclusive. No recommendation can be made at this time on the use of antiviral therapy to allow HBsAg-positive HCWs to resume the performance of EPPs. This should be made on a case-to-case basis in consultation with a specialist and the respective institutional advisory panel. In addition, there are currently no data on the use of antiviral therapy in infected workers who do not perform EPPs.

Policy Statement 1
A positive Hepatitis B surface antigen result should not be a basis to discriminate, restrict, or disqualify a job applicant from being gainfully employed. A Hepatitis B positive applicant should not be declared unfit to work and denied employment without appropriate medical evaluation and counseling.

Policy Statement 2
Hepatitis B screening in the pre-employment setting should NOT be made mandatory. Screening for hepatitis B should be performed only if applying for occupations known to be at high risk for transmission of hepatitis B in the workplace. No screening is recommended for low risk occupations.

Policy Statement 3
Minimum requirements for a confirmed HBsAg-positive person undergoing pre-employment evaluation should include all of the following tests:
- Serum HBeAg and AntiHBe
- Serum ALT
- Ultrasound of the liver

Policy Statement 4
If the HBsAg is positive, HBeAg is positive, and ALT is normal, the person is likely to have chronic HBV infection (Immune Tolerant Phase).

Policy Statement 5
If the HBsAg is positive, HBeAg is positive, and the ALT is greater than normal, then the person is likely to have HBeAg positive chronic hepatitis B (Immune Clearance Phase).

Policy Statement 6
If the HBsAg is positive, HBeAg is negative, and ALT is greater than normal, then the person is likely to have chronic HBV infection, inactive HBsAg carrier state. A serum HBV DNA <2,000 IU/mL strongly supports the diagnosis.

Policy Statement 7
Monitoring of the serum ALT every 6 to 12 months is recommended. Referral to a specialist should be considered when the serum ALT becomes persistently elevated. Other causes of elevated ALT levels should also be considered.

Policy Statement 8
If the ultrasonographic finding of the liver is abnormal, appropriate management should be instituted.

Policy Statement 9
A. For Category 1 occupations (refer to Table 5) All HBsAg-positive persons should have mandatory HBV DNA testing.
(Level of Evidence: II-3 - Multiple case series, dramatic uncontrolled experiments)

They are not allowed to perform EPPs. due to high risk of HBV transmission.

(Level of Evidence: III - Expert opinion, descriptive epidemiology)

b. If HBV DNA is <2,000 IU/ml, they are cleared for employment with no work restrictions due to low risk of HBV transmission.

(Level of Evidence: III-Expert opinion, descriptive epidemiology)

In all HBsAg positive HCWs performing EPP’s, annual HBV D DNA testing is recommended. If HBV DNA becomes ≤2,000 IU/ml they should not be allowed to perform EPPs.

(Level of Evidence: III-Expert opinion, descriptive epidemiology)

b. Serum HBV DNA testing is not a prerequisite for employment. (Level of Evidence: III-Expert opinion, descriptive epidemiology)

C. Further work restrictions based on the clinical status of the infected person should be made on a casetocase basis by the attending physician in consultation with a specialist. (Level of Evidence: III-Expert opinion, descriptive epidemiology)

Policy Statement 10

HBsAg-positive job applicants should be issued a medical certificate which must include the following:

A. Complete diagnosis stating the classification of hepatitis B infection according to the phase of infection. (Level of Evidence: III-Expert opinion, descriptive epidemiology)

B. Risk of transmission (refer to Table 6) which includes category of occupation and infectivity. (Level of Evidence: III-Expert opinion, descriptive epidemiology)

C. Recommendation for employability:

1. Cleared for employment with work restrictions (state limits of restriction) (Level of Evidence: III-Expert opinion, descriptive epidemiology)

2. Cleared for employment with no work restrictions (Level of Evidence: III-Expert opinion, descriptive epidemiology)

3. Not cleared for employment (state specific reason)

Policy Statement 11

The attending physician should educate the patient on the following:

- current status of hepatitis B infection,
- modes of transmission,
- adherence to standard precautions (refer to Table 1),
- risk of transmission, risk for complications,
- the need for monitoring,
- screening of first degree relatives, close personal and household contacts,
- options for treatment when deemed appropriate

Policy Statement 12

The hepatitis B status of a job applicant or employee should be kept confidential.

Policy Statement 13

Each healthcare institution is encouraged to form an Advisory Panel to discuss issues on Hepatitis B and employment particularly those not covered by these guidelines.

REFERENCES


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