HEPATITIS B IN PREGNANCY AND THE POSTNATAL PERIOD

Developed in response to: Intrapartum NICE Guidelines
Contributes to CQC Outcome No 11, 12

Consulted With: Post/Committee/Group: Date:
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Policy to be followed by (target staff) Midwives, Obstetricians, Paediatricians
Distribution Method Intranet & Website.
Notified on Staff Focus

Related Trust Policies (to be read in conjunction with) 04071 Standard Infection Prevention
04072 Hand Hygiene
06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records
06031 Receiving and Communicating Test Results in Maternity by both Hospital and Community
09062 Maternity Care
09127 Interpreting and Translating Policy
08056 Guideline for the management of HIV in pregnancy
08045 Management of amniocentesis for antenatal diagnosis
07011 Confidentiality Policy

Review No: Reviewed by: Issue Date:
1.0 Nicky Leslie February 2012
1.1 Nicky Leslie – neonatal alert form and process update July 2012
1.2 Nicky Leslie – clarification to point 6.0, 7.0 February 2013
2.0 Nicky Leslie, Antenatal Newborn Screening Co-ordinator March 2015
3.0 Emma Neate – Full review 16th June 2018
INDEX

1. Purpose
2. Equality and Diversity
3. Rational
4. Aetiology
5. Routine Screening in Antenatal Clinic
6. Declined Screening
7. Failsafe of Screening Results
8. Women Presenting in Labour without an Antenatal Screening Blood Result
9. Action to be taken for women who move out of the area
10. Antenatal Management of Hepatitis B Positive Mothers
11. Women already known to be HIV Positive and / or Hepatitis B Positive
12. HIV and Hepatitis B and C Co-infected Patients
13. Intrapartum Management
14. Neonatal Management
15. Staff and Training
16. Infection Prevention
17. Audit and Monitoring
18. Guideline Management
19. Communication
20. References
21. Appendices

Appendix A - Receiving Hepatitis B Blood Results
Appendix B - Internal MEHT Referral Form to Hepatology (Dr C Oza)
Appendix C - Infant Hepatitis B Vaccination Notification Form
Appendix D - NHS Infection Diseases in Pregnancy Screening Programme
Appendix E - Management of Hepatitis B Positive Women in Pregnancy
Appendix F - Neonatal Alert Form
1.0 Purpose

1.1 To provide a guideline on the management of hepatitis B in pregnancy and to prevent perinatal transmission from mother to baby; as hepatitis B can have serious maternal and neonatal consequences.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Rational

3.1 The aim of pregnancy screening is to contribute to the reduction of perinatal hepatitis B infection. The risk of perinatal transmission is dependent on the status of the maternal infection. About 70 - 90% of babies born to mothers who are positive for both HB surface antigen (HBsAg) and HB e-antigen will become chronically infected (without immunisation).

3.2 The rate of chronic infection is less than 10% in babies born to women positive for HBsAg and antibody to e antigen (AntiHBe). It is recognised that, without intervention, the earlier in life the infection occurs the greater the risk that it will lead to chronic infection, liver disease and early death.

3.3 Immunisation of the baby within 24 hours of delivery, and at 1, 2 and 12 months has been shown to be effective in preventing transmission of infection from mother to baby. In babies born to women with a higher risk of transmission, the addition of Hepatitis B Specific Immune Globulin (HBIG) can help reduce the risk further.

3.4 Since August 2017, all babies receive additional Hepatitis B vaccination; as part of the newly introduced Hexavalent vaccine schedule. This means that babies born to mothers with Hep B will now receive 6 Hep B vaccines in the first year of life, including the follow-up blood test at 1 year.

3.5 With this strategy, transmission can be prevented in over 90% of babies exposed to maternal infection.

3.6 The objectives of the screening programme are to:
   - Ensure that all HBV positive women are identified
   - Provide counselling and support and where appropriate, testing and immunisation to the family
   - Refer all HBV positive women for assessment and management by an appropriate specialist (e.g. a hepatologist / gastroenterologist) within 6 weeks of the screening test result being received by maternity services even if the woman has already been referred previously and is being followed up/getting treatment as they may be unaware of her pregnancy and the management plan may need to be reviewed.
   - Ensure that the infant immunisation schedule is offered for their babies, that the first dose is administered within 24 hours of delivery and that arrangements for completion of the schedule are initiated.
4.0 **Aetiology**

4.1 Hepatitis B virus (HBV) is a viral infection carried in the blood causing inflammation of the liver and potentially long term damage. It is transmitted through infected blood and other body fluids:

- Unprotected sexual activity
- Contaminated blood e.g. needle sharing
- Transmission from mother to child, which can occur in utero or during delivery.

4.2 The average incubation period for hepatitis B is 40 to 160 days. Some people experience flu-like symptoms including sore throat, tiredness, joint pains and nausea. Acute infection can be severe and cause abdominal discomfort and jaundice. There is also a liver-damaging chronic state of hepatitis B that is infectious and may be asymptomatic (without symptoms). Some people with hepatitis B go on to develop cirrhosis or liver cancer.

5.0 **Routine Screening in Antenatal Clinic**

5.1 All pregnant women are offered a screening at their booking for infectious diseases regardless of the results of screening in previous pregnancy:

- Human immunodeficiency virus (HIV)
- Syphilis
- Hepatitis B

5.2 In order for women to make informed choice, the following should be discussed:

- The route of transmission of the infection and implications of positive results on maternal and fetal health.
- The benefits to mother and baby of identifying and managing results
- How the woman will get her results – both negative and positive

5.3 Informed consent must be obtained prior to the specimen being taken

5.4 All pregnant women should be provided with written information ‘Screening tests for you and your baby’ prior to their booking appointment. This is available in English and 12 other languages, via [www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief](http://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief).

For women who do not have English as a first language, they must be offered interpreting services to help them make an informed choice about screening. It is not acceptable to use friends or family to translate.

5.5 The midwife completing the booking and offering blood tests MUST ensure bloods are taken at booking or within 5 days of the booking (where not possible at booking).

It is the booking midwife responsibility to review bloods within 10 days of the sample being taken and for them to follow up women when samples are not taken or a repeated is required.
5.6 The midwife should clearly document whether the screening has been accepted or declined and whether a blood sample has been obtained in the handheld notes.

5.7 All women with a positive result require a second confirmatory blood sample and will be contacted by the Screening Team and urgently referred to an appropriate specialist (Sexual Health Department).

5.8 **Women already known to be HBV positive**
Even if the woman is known to be HBV positive and under appropriate clinical care, they should still be screened in pregnancy; to allow for the current status of the infection to be fully assessed by an appropriate specialist, to enable the correct management for the pregnancy and the baby.

6.0 **Declined Screening**

6.1 Where women decline screening tests, the midwife who offered the initial screening should inform the Screening Team.

6.2 Women should be contacted by the Screening team as soon as possible and ideally before 20 weeks to discuss their decision to decline screening and ensure that they are fully aware of the benefits of screening for infectious diseases for them and their baby.

6.3 Reoffer the screening test and arrange testing and follow up of results.

6.5 The onus of the reoffer is to facilitate an informed choice and not to coerce women to accept screening.

6.6 **Un-booked women / Late Bookers**
Women who book after 24 weeks of pregnancy should have blood samples marked as urgent and sent to the laboratory. Test results should be available after 24 hours of receipt of sample at laboratory.

7.0 **Failsafe of Screening Results**

7.1 Maternity Phlebotomist will review all women on the daily scan list for 1st trimester scans, they review all the screening results and check for completion of screening – these results are checked by a Antenatal Clinic or Screening Midwife, if any results are missing; these bloods will be taken with consent after the scan.

7.2 The Failsafe Officer will carry out a failsafe check following the woman’s 1st trimester scan to ensure all screening results are available and to highlight any that are abnormal to the screening midwives; this acts as a failsafe for abnormal results also. If any results are found to be missing, the following steps are followed.

- Screening team will send one letter to the woman regarding the need to have bloods taken.
- Screening team will develop a missing bloods list – send to ANC, WJC, St Peter’s, Chelmsford community team each month and for the teams to contact and arranging screening for the women within the following 2 weeks.
8.0 Women Presenting in Labour without an Antenatal Screening Blood Result

8.1 Women presenting in labour, who have not been previously for antenatal care, at the Trust are recommended to be offered testing for HIV, Hep B, and Syphilis on first contact. The sample should be marked as urgent. Results should be available within 24hrs.

9.0 Action to be taken for women who move out of the area

The screening team will keep a record of all pregnant Hepatitis B women. If these women move out of area the local midwife should advice the Screening team so that a clear record can be kept.

10.0 Antenatal Management of Hepatitis B Positive Mothers

10.1 High risk blood results should be referred to the Antenatal Screening team, who will contact the women and arrange an appointment to discuss results face to face.

10.2 A second blood sample is required to confirm a Hepatitis B positive result. Repeat samples should be sent to the laboratory within 10 working days of the request being received by the maternity services.

10.3 All women requiring second confirmatory blood samples will be referred to the gastroenterology team (see Appendix B), for counselling, appropriate testing and assessment.

10.4 Where women are having repeat blood tests for infectious diseases during pregnancy the request repeat must be indicated, so that it can be identified as second sample to the laboratory. All confirmed screening test results should be received by the maternity services within 10 working days of the repeat specimen being taken.

10.5 Women seen by the Screening team, requiring a second confirmatory blood sample to be taken, should also have a blood sample taken for full Hep B serology profile (Hep B Surface Antigen, Hep B core antigen and core antibody, Hepatitis B e antigen, e antibody), HBV DNA PCR, HDV serology this will then allow the gastroenterology team to review the blood results at the first hepatologist appointment.

10.6 Women with two screen positive results should be effectively managed by a multidisciplinary team in the appropriate environment.

10.7 All Hepatitis B Positive Women are referred for assessment and management by an gastroenterologist within 6 weeks of the screening test result being received by maternity services, as per National Screening Programmes key performance indicator. (Refer to Appendices A and B). The Gastroenterologist will make a plan of care and send to screening team regarding whether medication is required.

10.8 If the woman is Hepatitis B positive she should be referred to the Obstetric Consultant lead for Infectious Diseases for review and obstetric plan of care.

10.9 The Antenatal Screening team will complete the proforma for the management of Hepatitis B positive woman in pregnancy.(Refer to Appendix C)
The women’s named midwife and GP should be informed to provide additional support for the woman.

A Neonatal Alert form should be completed and sent to the Antenatal Screening team located in the Antenatal Clinic, who will photocopy the alert form for her records. Screening Midwife will forward the neonatal alert form to the named consultant paediatrician for a plan of care post-delivery. (Refer to Appendix D)

Hepatitis B vaccine is kept as a stock item. Babies also prescribed immunoglobulin will have the completed prescription chart sent to pharmacy, to allow the prescription to be stored on the neonatal unit drug fridge prior to the birth of the baby.

When the named paediatric consultant has completed the neonatal alert form with a care plan, a copy will be retained in the neonatal folder. A further copy will be sent to the Screening team; who will then provide a subsequent copy for the Labour Ward folder. Screening team will provide a copy which should be filed in the patient’s lilac folder.

Invasive prenatal testing in the first or second trimester can be carried out in patient who carry Hepatitis B or C. (Refer to the guideline entitled 'Management of amniocentesis for antenatal diagnosis'; register number 08045)

Women who have high viral loads (i.e. HBV DNA >10^7 IU/ml) should be considered for therapy after 28 weeks of pregnancy. The risks and benefits and the limited evidence for this approach should be discussed with the women.

Women who may be at above average risk of transmission (i.e. those who have previously infected an infant during childbirth) may be offered antiviral therapy (as above) with or without HBlg. The risks and benefits and the limited evidence for this approach should be discussed with the patient.

In line with MEHT guidance, patient confidentiality must be adhered to. Documentation in the handheld records, including printed blood results must be with woman’s consent. All other documentation must be placed in the hospital records. (Refer to ‘Confidentiality Policy’; register number 07011)

Women already known to be HIV Positive and / or Hepatitis B Positive

Laboratory request forms should be labelled ‘high risk’ and documentation of prior diagnosis if known

The Antenatal Screening team needs to be informed of the pregnancy to arrange a multidisciplinary team approach for care.

HIV and Hepatitis B and C Co-infected Patients

All co-infected women should be treated with combination antiretroviral therapy i.e. highly active anti retroviral therapy (HAART), short term anti-retroviral therapy (START). Women co-infected with Hepatitis B should be treated with a combination which includes drugs with activity against Hepatitis B. Women co-infected with Hepatitis C should be offered elective (lower segment caesarean section) LSCS.
13.0 Intrapartum Management

13.1 Each case should be reviewed on an individual basis by an obstetrician. Any antenatal discussion and planning of care in labour should be noted.

13.2 Elective caesarean delivery as a means of reducing mother to child transmission, this mode of delivery does not appear to have a significant effect on vertical transmission of the Hepatitis B virus.

13.3 The delivery should be managed to minimise the risk of vertical transmission, by avoiding fetal blood sampling and foetal scalp electrodes in most circumstances.

14.0 Neonatal Management
(Refer to the guideline for the administration of Hepatitis B in neonates’; register number)

- The Delivery Suite Midwife / Postnatal ward Midwives are responsible for ensuring that the Neonatal Doctors prescribe and administer the Hepatitis B vaccine and (where applicable) Immunoglobulin, as soon as possible after birth (within 24 hours).

- Antenatal Hepatitis B results must be checked before any vaccination or immunoglobulin is prescribed.

Table 18.5 Vaccination of babies according to the hepatitis B status of the mother

<table>
<thead>
<tr>
<th>Hepatitis B status of mother</th>
<th>Baby should receive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hepatitis B vaccine</td>
</tr>
<tr>
<td>Mother is HBsAg positive and HBeAg positive</td>
<td>Yes</td>
</tr>
<tr>
<td>Mother is HBsAg positive, HBeAg negative and anti-HBe negative</td>
<td>Yes</td>
</tr>
<tr>
<td>Mother had acute hepatitis B during pregnancy</td>
<td>Yes</td>
</tr>
<tr>
<td>Mother is HBsAg positive and anti-HBe positive</td>
<td>Yes</td>
</tr>
<tr>
<td>Mother is HBsAg positive and known to have an HBV DNA level equal or above 1x10^6 IU/ml in any antenatal sample during this pregnancy (regardless of HBeAg and anti-HBe status)</td>
<td>Yes</td>
</tr>
<tr>
<td>Mother is HBsAg positive and baby weighs 1500g or less</td>
<td>Yes</td>
</tr>
</tbody>
</table>


Current immunisation schedule

Where a pregnant woman is identified through the screening process as infected with HBV, The Department of Health currently recommends the baby is vaccinated using the accelerated schedule comprising of vaccinations given:
Timely administration of vaccines is always important; however, for Hepatitis B vaccinations it is crucial. A complete course is required for full protection. Even the timely administration of the full course of vaccinations will not stop infection in all cases. However, where administered in line with the Green Book schedule, targeted immunisation can prevent persistent hepatitis B infection.

### Antenatal Hepatitis B results must be checked before vaccination or immunoglobulin is prescribed

14.1 A Paediatrician Registrar will take responsibility for the management of the neonate in collaboration with the Obstetrician and the genito-urinary physician. The Paediatrician should already be aware of the delivery.

14.2 For women who are HBeAg negative the infant should receive active vaccination after delivery i.e. the infant should receive a vaccine based on HBsAg.

14.3 For women who are HBeAg positive the infant should receive both active and passive vaccination after delivery i.e. the infant should receive a vaccine based on HBsAg and Hepatitis B immunoglobulin. (If required this would be ordered by Neonatal Consultant at 32/40+ stored in NICU drug fridge).

14.4 Current Immunisation Schedule - clear documentation in:-

- baby’s notes
- Drug chart
- Child health record book
- Immunisation notification form
• Discharge summary

This to be emailed to – provide.childhealth@nhs.net (Appendix C)

15.0 Staffing and Training

15.1 All midwifery and obstetric staff must attend yearly mandatory training which includes maternal antenatal screening tests.

15.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

16.0 Infection Prevention

16.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively ‘decontaminate their hands’ before and after each procedure.

16.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

17.0 Audit and Monitoring

17.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women’s and Children’s Clinical Audit Group will identify a lead for the audit.

17.2 As a minimum the following specific requirements will be monitored:

• Designated lead for antenatal screening in the maternity service
• Antenatal screening tests, which follow the UK National Screening Committee guidance
• System for ensuring that appropriate tests are undertaken within appropriate timescales
• System for ensuring that appropriate tests are undertaken when patients book late
• Process for the review of the results
• Process for reporting all results to patients
• Process for reporting results to other relevant healthcare professionals
• Process for ensuring that women with screen positive test results are referred and managed within appropriate timescales
• Maternity service’s expectations for staff training, as identified in the training needs analysis
• Process for audit, multidisciplinary review of results and subsequent monitoring of action plans

17.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 17.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

17.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

17.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

17.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

17.7 Key findings and learning points will be disseminated to relevant staff.

18.0 Guideline Management

18.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

18.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

18.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. ‘Spot checks’ are performed on all clinical guidelines quarterly.

18.4 Quarterly Clinical Practices group meetings are held to discuss ‘guidelines’. During this meeting the practice development midwife can highlight any areas for further training; possibly involving ‘workshops’ or to be included in future ‘skills and drills’ mandatory training sessions.

19.0 Communication

19.1 A quarterly ‘maternity newsletter’ is issued and available to all staff including an update on the latest ‘guidelines’ information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

19.2 Approved guidelines are published monthly in the Trust’s Focus Magazine that is sent via email to all staff.
19.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

19.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

20.0 References


UK National Screening Committee. Infectious Diseases in Pregnancy Screening Programme : Programme Standards (2010).

Infectious Diseases Screening in pregnancy. Screening Pregnancy Standards 2nd Edition 2012
Receiving Hepatitis B Blood Results

Negative Results

Signed by a midwife in Antenatal Clinic/Community

Filed in notes

Equivocal Results

Inform the Antenatal Screening Team of the result Monday – Friday 9.00 a.m. – 5.00 p.m.

The blood test should be repeated by the Antenatal Screening Team. Two blood samples are required before a confirmed Positive/Negative Hep B status is given to the patient

Confirmed negative Hep B status

Sign result and file in maternity records

Confirmed positive Hep B status

Inform Antenatal Screening Team of positive result Monday – Friday 9.00 a.m. – 5.00 p.m.

Positive Results

Inform the Antenatal Screening Team of result who will contact patient and arrange Gastroenterology review Monday – Friday 9.00 a.m. to 5.00 p.m

This blood test should be repeated. Two blood samples are required before a confirmed Hep B Positive result is given to the patient

Confirmed negative status

Sign result and file in maternity notes

Confirmed positive status

Inform antenatal screening team of positive result Mon-Fri 9.00 – 5.00

Reassure patient

Reassure patient

Antenatal and Newborn Screening Team will arrange

Obstetricians antenatal appointment

Specialist obstetric consultant antenatal appointment and consultant gastroenterologist appointment

Inform Paediatricians by Neonatal Unit alert

Follow Hep B guideline

Appendix A
Hepatitis B Positive Pregnant Woman Notification Form

Internal MEHT Referral to Hepatology (Dr C Oza)

Please complete ALL the details below and then email it to both: provide.childhealth@nhs.net and MEHTGeneralMedgastroSecretaries@mehi.nhs.uk

Appointments Team – to book in Dr Oza OPA within 6 weeks of date of referral
(COZHEPB/COZHERGB clinic)

<table>
<thead>
<tr>
<th>WOMAN'S DETAILS</th>
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<tbody>
<tr>
<td>NHS Number:</td>
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<tr>
<td>Surame:</td>
</tr>
<tr>
<td>Forename(s):</td>
</tr>
<tr>
<td>Date of birth:</td>
</tr>
<tr>
<td>Hospital Number:</td>
</tr>
<tr>
<td>Telephone Number:</td>
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<tr>
<td>Current address:</td>
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<tr>
<td>GP name and address:</td>
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<tr>
<td>Hospital name:</td>
</tr>
<tr>
<td>Estimated delivery date:</td>
</tr>
<tr>
<td>Responsible Obstetrician:</td>
</tr>
<tr>
<td>Date of Referral to Hepatology:</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>WOMAN'S HEPATITIS B STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of initial blood test:</td>
</tr>
<tr>
<td>Date of confirmatory blood test:</td>
</tr>
<tr>
<td>Hepatitis B surface antigen (HBsAg): Positive □ Not known □</td>
</tr>
<tr>
<td>Hepatitis B immunoglobulin (HBIG) required for baby? Yes □ No □</td>
</tr>
</tbody>
</table>

Form completed by: EMMA NEATE Date: 

Thank you for your cooperation.

Version 1 CHS March 2010
Hepatitis B: what does my positive screening result mean?
What does my positive screening result mean?

Your recent blood test shows that you have screened positive for hepatitis B.

Most people with the hepatitis B virus remain well, with no symptoms, but they can still pass the virus to others. Some people will develop cirrhosis (scarring) of the liver which over time can cause serious health problems. In rare cases, this can lead to liver cancer.

How did I become infected?

Hepatitis B virus is carried in the blood and is very infectious. The main ways it can be passed to others are:

- from person to person during unprotected sex
- from a mother to her baby during pregnancy or birth
- by sharing needles and/or any drug injecting equipment or non-sterile equipment used for dental, medical procedures, tattooing or body piercing
- from sharing toothbrushes or razors

Hepatitis B is not spread by everyday contact such as coughing or kissing, or sharing bathrooms, toilets, food, cups and towels.

Can I be treated?

Currently, there is no cure for hepatitis B. Blood tests taken in pregnancy will show the amount of virus present in your blood (viral load testing). If your viral load is very high you may be offered medication to reduce the level of virus.
How can I protect my baby?

Babies born to mothers with hepatitis B are at risk of becoming infected.

A course of 4 vaccinations is strongly recommended because this greatly reduces the chances of your baby becoming infected and offers the baby future protection against hepatitis B infection.

The vaccine is extremely effective and has an excellent safety record. Your baby will need a vaccination:
- within 24 hours of birth – your baby may also need an injection of antibodies (immunoglobulin)
- at 1 month
- at 2 months
- at 12 months – with an additional blood test to check the vaccinations have been successful

A vaccine booster will be recommended at 5 years.

Having hepatitis B should not affect your pregnancy care and overall experience. It does not mean you will need a caesarean section and you will still be able to breastfeed safely.

What happens next?

1. A specialist midwife will talk to you about your result and answer any questions you and your partner have.
2. An appointment will be made with a hepatitis specialist who will perform additional investigations/blood tests to check the status of infection and plan your care.
3. Your team will also discuss any testing or treatment required for your partner and any children or family members.

It is important that you attend all your appointments during pregnancy to keep you fit and well and reduce the risk of your baby becoming infected.
Who needs to know I have hepatitis B?

It is important that everyone involved in your care is made aware of your result. This will enable them to ensure that you and your baby receive safe and effective treatment and care.

Confidentiality

Your information will not be shared with anyone other than the professionals involved in your care, such as your family doctor and midwife, without your permission.

The NHS collects information about you and your baby so as to monitor health trends and improve services and care. The NHS has strict confidentiality and data security procedures in place to ensure that personal information is not given to unauthorised persons.

Where can I get more information?

You can find out more about hepatitis B from:

- NHS Choices www.nhs.uk/conditions/hepatitis
- Patient.co.uk www.patient.co.uk/health/hepatitis-b-leaflet
- Hepatitis B Foundation UK www.hepb.org.uk
- British Liver Trust www.britishlivertrust.org.uk

If you have any other questions or concerns talk to your doctor or midwife or health visitor.

Local contact:

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# Management of Hepatitis B Positive Women in Pregnancy

<table>
<thead>
<tr>
<th>First Name</th>
<th>Surname</th>
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<tbody>
<tr>
<td>NHS No</td>
<td>Hospital No</td>
</tr>
<tr>
<td>EDD</td>
<td>Date of Diagnosis</td>
</tr>
</tbody>
</table>

## Antenatal Newborn Screening Co-ordinator
- **Contacted / seen by Antenatal Newborn Screening Co-ordinator**: [No] [Yes]
- **Second confirmatory blood sample required**: [No] [Yes]
- **Previous Diagnosis**: [No] [Yes]
- **Referral to GUM / Gastroenterologist**: [No] [Yes]

Consultant(s) name and contact details:

<table>
<thead>
<tr>
<th>Date Taken</th>
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<td>________________</td>
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**Print Name** ________________  **Date** ________________
**Signature** ________________

## Antenatal Care Plan
- **Antenatal Clinic Appointment 16-18 weeks gestation**: [No] [Yes]
- **Neonatal Alert form completed and sent with maternal blood results and prescription chart**: [No] [Yes]
- **Medication prescribed in antenatal period**: [No] [Yes]
  - *if immunoglobulin is required*
- **Medication ordered from pharmacy**: [N / A] [No] [Yes]

**Print Name** ________________  **Date** ________________
**Signature** ________________

## Antenatal Discussion
- **Leaflet provided**: [No] [Yes]
- **Able to breast feed**: [No] [Yes]
- **Vaccination timeframes**: [No] [Yes]

**Print Name** ________________  **Date** ________________
**Signature** ________________

## Postnatal Vaccinations
- **Prescribe Hep B Vaccine**: [No] [Yes]
  - *(immunoglobulin already prescribed, if required)*
- **First Hep B Vaccination as soon as possible after birth**: [No] [Yes]
  - *(within first 24 hours after delivery)*
- **Advise follow up vaccinations at 1 month, 2 months and 12 months after birth**: [No] [Yes]
- **Document in the personal child health record, page 4**: [No] [Yes]

**Date** ________________
Neonatal Alert Form

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<tr>
<th>First Name</th>
<th>Surname</th>
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Background history & problem summary

Delivery Plans

- Broomfield Hospital
- Not Decided
- Other Hospital

Neonatal Alert Form Criteria

Please use the neonatal alert form for the following conditions:

- Multiple pregnancy (higher order > 2 fetus)
- Hepatitis B positive mother
- HIV positive mother
- Previous baby with GBBS sepsis / meningitis
- Significant structural abnormalities diagnosed on ultrasound scan
- All cases that require referral to specialist units for treatment or advice
- Mothers with high antibody titres e.g. Anti-D, C and Kell
- Severe oligohydramnios / IUGR
- Abnormal dopplers
- Genetic / hereditary conditions in the immediate family that may affect the fetus
- Social e.g. drug abuse, alcohol abuse in this pregnancy
- Any other condition that will require paediatric input at birth

Postnatal Plan (paediatric)

Designation ___________________________ Date ___________________________
Print Name ___________________________ Signature ___________________________