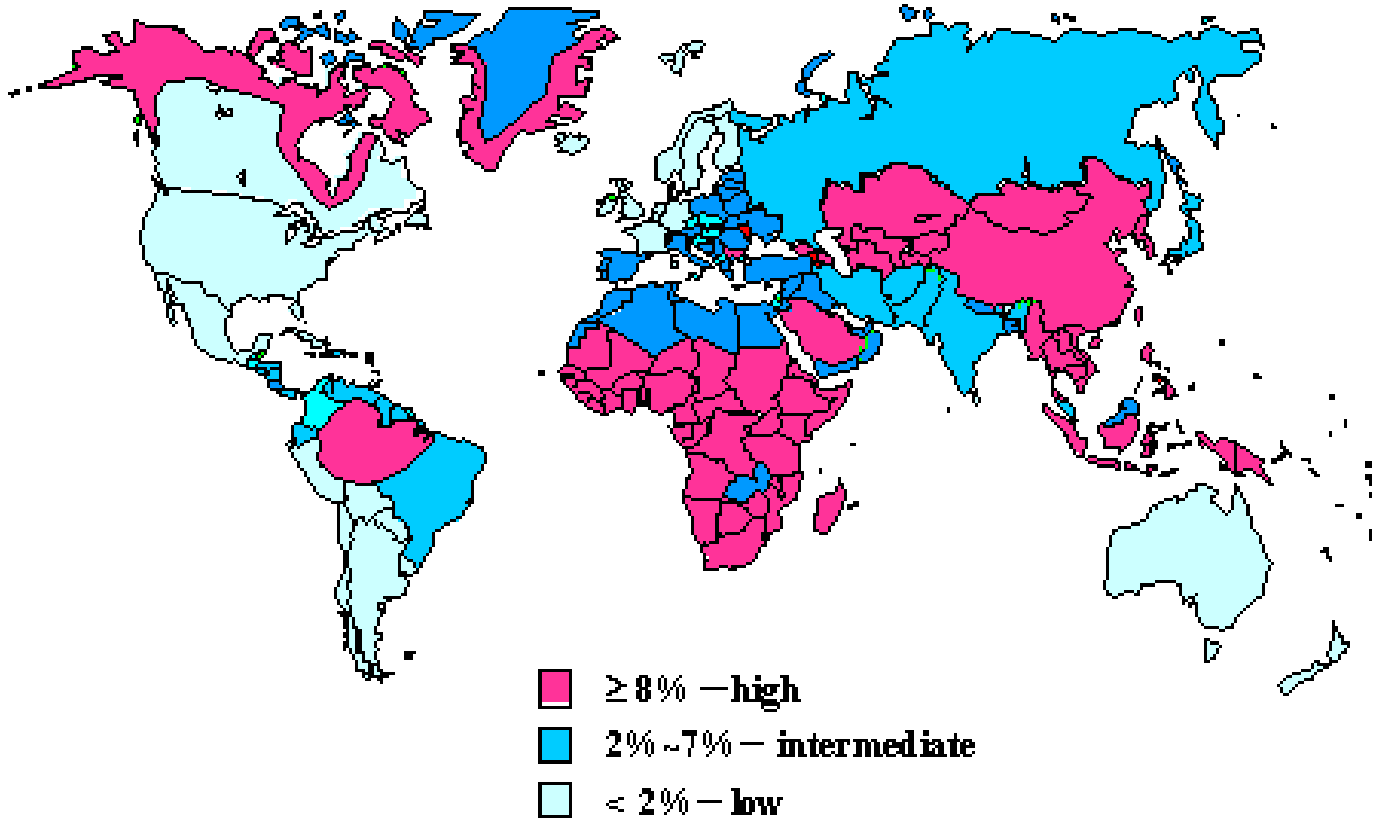
Global prevalence of chronic HBV



Hou, Int J Med Sci, 2005. Mast, MMWR, 2005.

Slide courtesy of Amit Singal, MD

Chronic HBV and hepatocellular cancer (HCC)

Worldwide, chronic HBV is the main cause of HCC

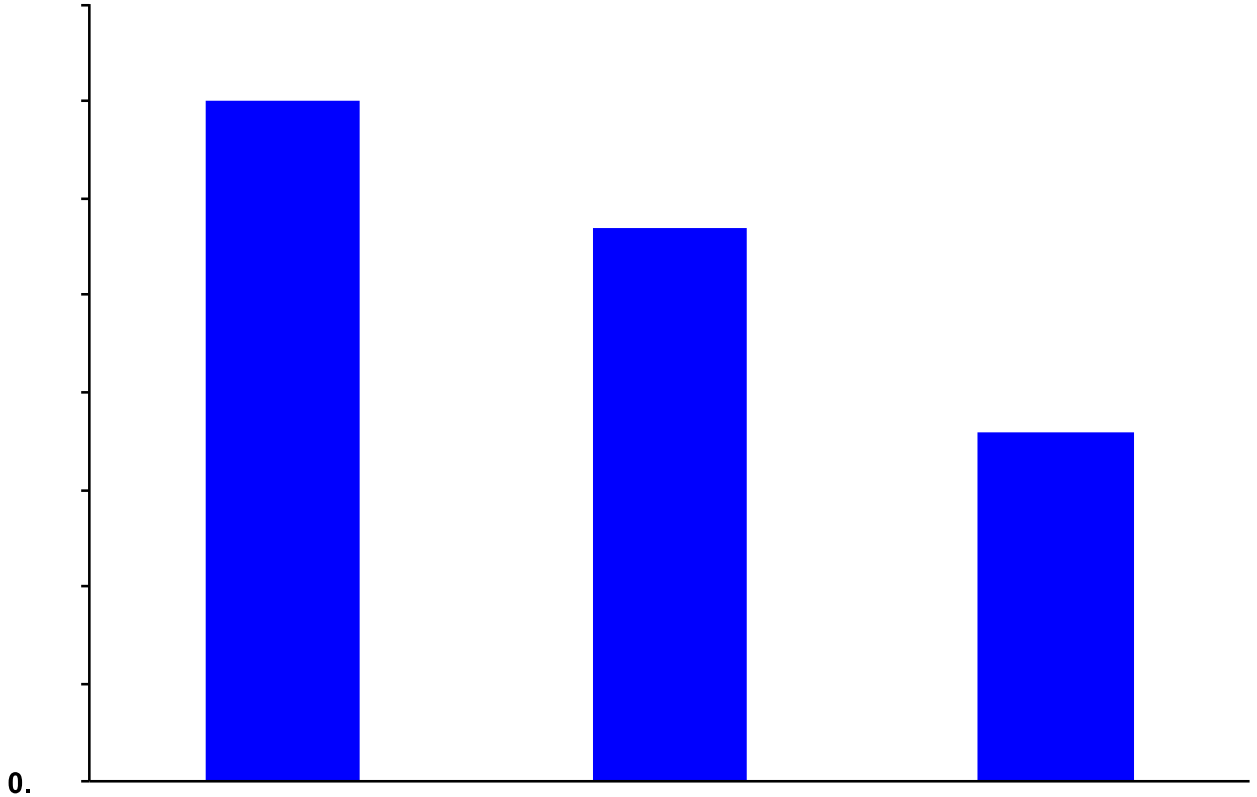
- Direct oncogenic effect regardless of degree of fibrosis or presence of cirrhosis[1,2]

WHO strategy to eliminate viral hepatitis by 2030

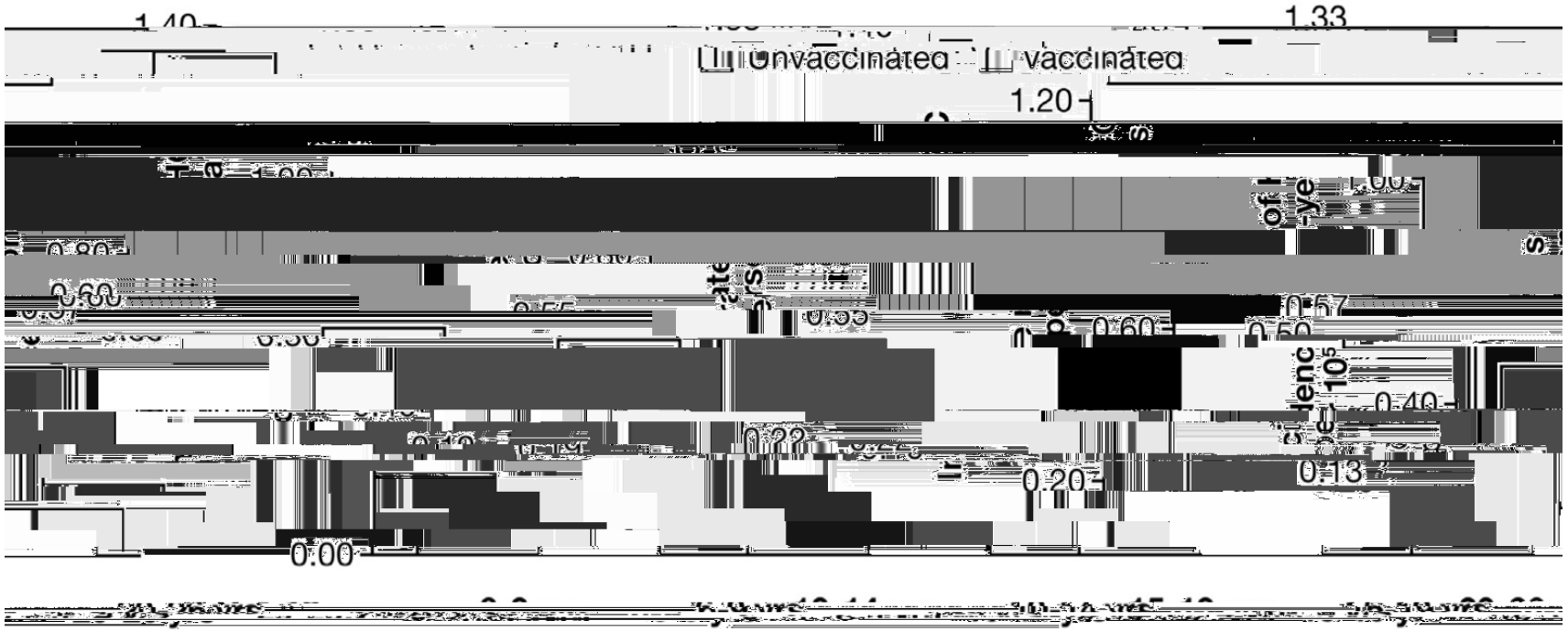
- Reduce chronic HBV incidence by 90%, mortality by 65%[3]
- Requires coordinated cascade of care plan
  - Vaccination
  - Screening
  - Treatment

[1]El-Serag, N Engl J Med, 2011. [2]Levrero, J Hepatol, 2016. [3]World Health Organization, Combating Hepatitis B and C to Reach Elimination by 2030, 2016.

HBV vaccination programs have led to reduced HCC incidence in Asia



Success of HBV vaccination programs



Chang, Gastroenterology, 2016

Slide courtesy of Amit Singal, MD

HBV vaccination - US

Key part of US strategy to eliminate HBV[1,2]

- Universal vaccination of all infants at birth
- Vaccination of adolescents and high-risk adults

3 doses results in protective antibody response at 1, 2, 6 months

- Recombivax, Engerix, Twinrix

2 doses approved in 2017, given 1 month apart

- Heplisav-B

Rise in acute HBV prevalence along with opioid crisis

- Immunity may be decreasing in young adults[3]
- Anti-HBc+ prevalence among injection drug use 20%[4]

[1]National Viral Hepatitis Action Plan, 2017-2020. [2]US Preventative Services Task Force Hepatitis B Virus Infection: Screening, 2014. [3]Yeo, Hepatology, 2019. [4]Shing, Clin Infect Dis, 2020.

HBV screening

Screening is essential and beneficial to

- Patients – linkage to care for HBsAg+ persons
- Society – through reduction of transmission by vaccination

3 HBV tests

- HBsAg, anti-HBc, and anti-HBs
- Chronic HBV: HBsAg+ (and anti-HBc+)

Only 32% of chronic HBV patients are aware of their infection[1]

- Most HBsAg+ persons are asymptomatic

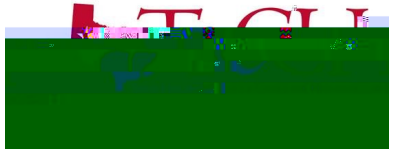
[1]Zhou, Clin Gastroenterol Hepatol, 2020

Risk-based HBV screening in the US

Screening is recommended for high risk groups[1,2,3]

- Born in country with HBV prevalence >2%
- US born, not vaccinated, parents from a country with HBV prevalence >8%
- Household contacts and sex partners of HBsAg+ person
-

Risk-based HBV testing in Europe was inaccurate and inefficient



51 primary care clinics in North Rhine Westphalia, Germany, 21k patients[1]

- Testing only if born in a country ≥2% prevalence
  - Missed 60% (65/93) HBsAg+ adults
- Testing only if any HBV risk factor present
  - Missed 33% (31/93) HBsAg+ adults

10 centers in Paris, 4000 patients[2]

- Testing only if any CDC HBV risk factor present
  - HBsAg: 100% sensitivity, 37% specificity
  - 70% of study population reported at least 1 risk factor and would need testing

[1]Wolfram, J Hepatol, 2015. [2]Bottero, PlosOne, 2014.

HBV testing recommendations for US pregnant mothers is not risk-based

2 large US studies focused on pregnant mothers

- >5000 mothers, Jackson FL, 1985[1]
- >4000 mothers, Cleveland OH, 1983-84[2]

Testing only if HBV risk factor present

- Missed 50% of HBsAg+ mothers[1,2]

Led to universal HBV screening for pregnant mothers in 2009[3]

[1]Jonas, Ann Intern Med, 1987. [2]Kumar, Ann Intern Med, 1987. [3]US Preventative Services Task Force Hepatitis B Virus Infection in Pregnant Women: Screening, 2019.

US study in cancer patients may be applicable to a broader population

Patients with HBV and cancer are at risk for HBV reactivation

- Accurate screening is required to prevent serious adverse liver outcomes after systemic anticancer therapy

Internally validated CDC survey among cancer patients[1]

- 2124 patients with cancer screened for hepatitis and completed 19 question hepatitis risk factors survey
- Using bootstrapping methods, models of up to 6 risk factors developed
- Over 90% of cancer patients who complete HBV survey would need to have HBV testing done
- Risk based screening is impractical

[1]Hwang, J Clin Oncol, 2018.

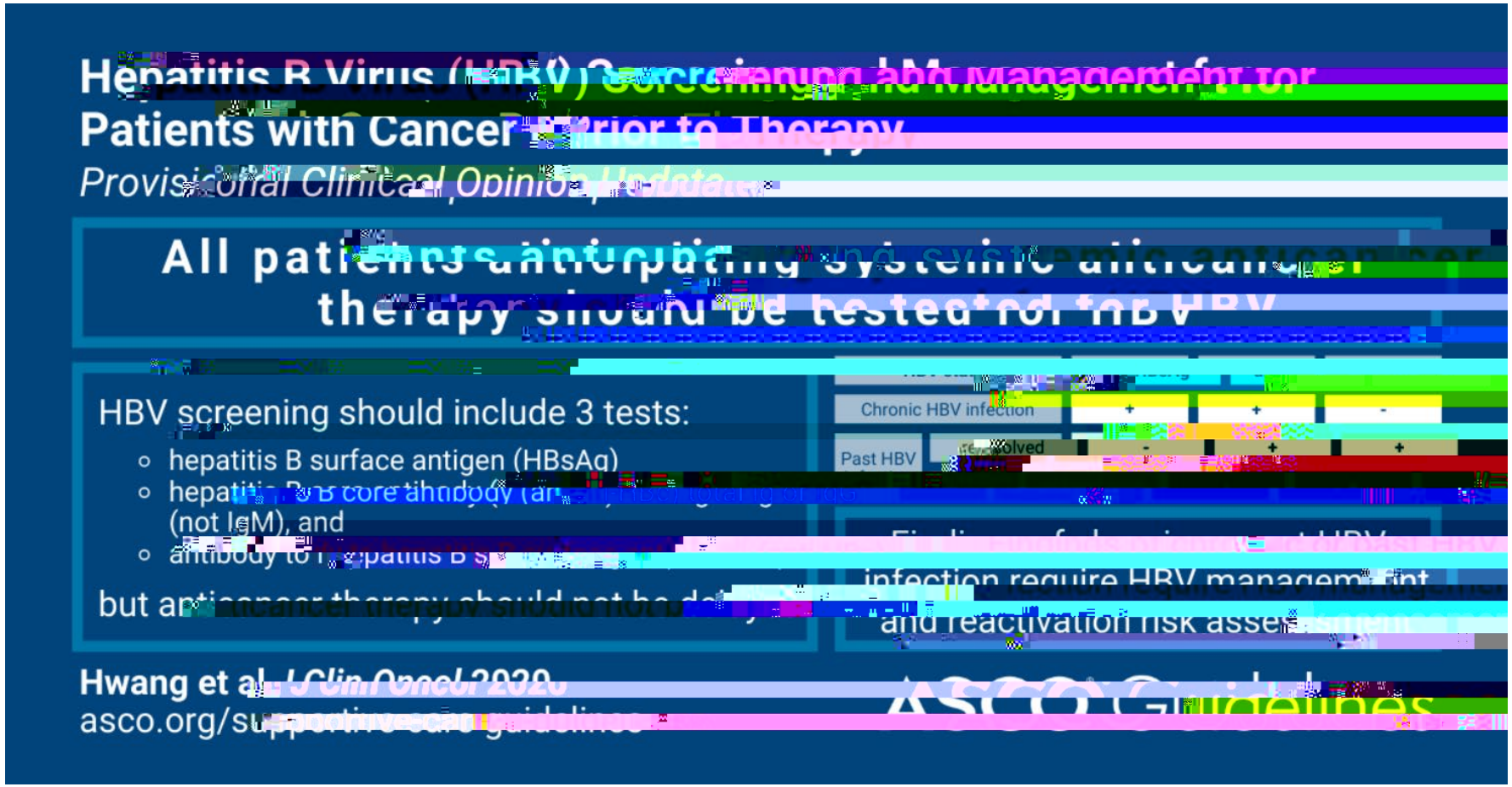
Risk-based testing for cancer patients may miss HBV patients

[1]https://www.cdc.gov/hepatitis/riskassessment/. [2]Percent with ≥1 affirmative answer to any question in HBV risk survey indicating need for blood testing.
Hwang, J Clin Oncol, 2018.

Risk-based testing for cancer patients is inefficient

[1]https://www.cdc.gov/hepatitis/riskassessment/. [2]Percent with ≥1 affirmative answer to any question in HBV risk survey indicating need for blood testing.
Hwang, J Clin Oncol, 2018.

ASCO recommends universal HBV testing



Optimal HBV screening strategies in US primary care setting

Results from oncology are likely applicable to the general population

Externally validate risk survey in our CPRIT Collaborative Action Program to Reduce Liver Cancer Mortality in Texas project

- CPRIT Award RP190513: Patient-Centered Liver Cancer Prevention in the Houston Community

Determine whether risk-based or universal HBV screening is more appropriate at HOPE Clinic, a federally qualified health center in Houston

Once completed, our CPRIT study could provide data to clarify optimal HBV testing strategies

HBV Treatment

Decision to start and stop antivirals for HBsAg+ patients depends on ALT and HBV DNA levels

Currently available antiviral therapies are not curative, require long duration of therapy to suppress virus

Preferred oral, antiviral therapy
- Tenofovir disoproxil fumarate
- Tenofovir alafenamide
- Entecavir

Non preferred oral, antiviral therapy
- Telbivudine
- Adefovir
- Lamivudine

HBV Therapy Generic	Brand Name	Dose	Approved	Comments
First Line				
Entecavir (ETV)	**Baraclude**	**0.5mg/1.0 mg po qd**	2005	Generic
Tenofovir (TDF)	**Viread**	**300 mg po qd**	2008	Generic in US 2018
Tenofovir alafenamide (TAF)	**Vemlidy**	**25 mg po qd**	2016	Less bone, renal toxicity
Peginterferon alfa-2a	**Pegasys**	**180 ug SQ q week**	2005	Finite tx, 48 weeks
Second Line				
Adefovir (ADV)	**Hepsera**	**10 mg po qd**	2002	Low potency, high rate of resistance
Telbivudine (LDT)	**Tyzeka**	**600 mg po qd**	2006	High potency, high rate of resistance
Third Line				
Lamivudine (LAM)	**Epivir**	**100 mg po qd**	1998	Low potency, high rate of resistance

US Food and Drug Administration, FDA-Approved Drugs, accessdata.fda.gov/scripts/cder/drugsatfda/

Slide courtesy of Su Wang, MD

HBsAg+

HBeAg-negative

ALT ≤ULN*

HBV DNA ≥2000 IU/mL

HBV DNA <2000 IU/mL

ALT > ULN but <2XULN*

HBV DNA ≥2000 IU/mL

HBV DNA <2000 IU/mL

ALT ≥2XULN*

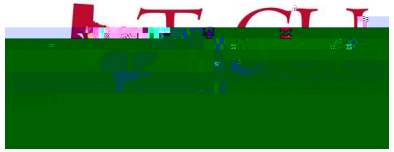
HBV DNA ≥2000 IU/mL

HBV DNA <2000 IU/mL

Treat

Do not treat. Monitor with ALT and HBV DNA levels every 3-6 months and HBsAg annually.

If ALT ≤ULN, monitor ALT and HBV DNA every 3 months for 1 year, then every 6 months.
If ALT >ULN, exclude other causes of ALT elevation and assess disease severity with non-invasive tests and/or liver biopsy.



Antiviral treatment reduces HCC incidence in persons with chronic HBV – US cohorts

Two US cohort studies found that antiviral therapy associated with decreased risk of HCC in HBsAg+ patients

2600 HBsAg+ patients in Chronic Hepatitis Cohort Study (CHeCS)[1]

- 1992-2011, median follow up 5.2 yrs, propensity-score matching
- 820 patients had antiviral therapy; 1851 patients did not
- adjusted HR 0.39 (95% CI 0.27-0.56)

3665 patients in US and Taiwanese REVEAL-HBV cohort[2]

- 1991-2014 N. California; 1992-92 Taiwan; median follow up 8.9 yrs
- 548 patients had antiviral therapy; 3117 patients did not
- adjusted HR, 0.24 (95% CI 0.15-0.58)

[1]Gordon, Clin Gastroenterol Hepatol, 2014. [2]

Summary

HBV vaccine prevents HCC and reduces mortality

Accurate and efficient screening of HBsAg+ persons is critical

- Linking patients to care
- Reducing transmission

Risk-based HBV screening has limitations

- Broader screening recommendations may be warranted

Antiviral therapy is effective in preventing HCC