

## **Post-its from Practice**

### **Hidden menace**

#### **Don't forget hepatitis B, says Dr Chris Ford**

Eddie registered as a patient a few weeks ago. He was jaundiced and looked very unwell. He had lived in the area for a while but hadn't registered with a GP because he hadn't yet had a reason to. At 24 years old, he was still enjoying his drug use. He had discovered the right combination of injecting heroin and cocaine which allowed him to stay in work and out of debt. Following a few days of pale diarrhoea and vomiting, that morning his eyes had gone yellow, prompting him to go the doctor.

After examining him I decided really that he needed to go to hospital but he refused. He had experienced hospital twice before and although I explained there were guidelines for care of drug-users for our local hospital he refused. So I set about trying to make a diagnosis and provide him with the appropriate care. It was obvious to me that he had acute viral hepatitis and as he injected, although denied sharing any sort of injecting equipment and had never been vaccinated against hepatitis B I thought it would most likely be hepatitis B or a rare case of acute hepatitis C.

I took some blood tests and explained the treatment was rest, a good diet, pain relief as required and no alcohol. Eddie had come with his partner so I offered her a hepatitis B vaccination which she accepted. Eddie's results confirmed acute hepatitis B and over the next six weeks his symptoms settled and his liver function tests returned to normal.

Hepatitis B is a potentially fatal liver disease caused by the hepatitis B virus (HBV). HBV infection can cause both acute and chronic disease. Acute hepatitis B, like Eddie had, results in liver inflammation lasting one to six months and can very occasionally lead to liver failure. Chronic hepatitis B (CHB) comprises a lifelong infection characterised by liver inflammation and damage that can lead to morbidity and in some cases mortality from cirrhosis and liver cancer. HBV is second only to tobacco as a human carcinogen, causing 50% of primary liver cancer in the world (1). Patients with CHB are 100 times more likely to develop hepatocellular carcinoma than those not infected.

It is estimated that 180,000 people (which is 0.3 per cent of the UK population) have chronic hepatitis B infection. Around 1,300 new cases of acute hepatitis B and 7,700 new cases of chronic hepatitis B are reported in the UK each year. Of the latter, 96 per cent are found in people who have entered the UK from areas of high prevalence (1).

HBV is transmitted in a variety of ways and is more infectious than HIV. The virus is found in the blood and other bodily fluids, and may survive in dried blood for up to a week. The main route of transmission in the UK is via unprotected sex and injecting drug use. The transmission profile is similar to

HIV which means that many people in high risk groups may be co-infected. Worldwide the most common route of infection is transmission from mother to child at birth (1). Other routes of transmission include needlestick injuries in healthcare professionals, transfusion of infected blood products in countries with inadequate screening, and piercing or tattooing with unsterilised equipment.

There is an effective vaccine to prevent HBV infection which has been available since 1982 and the World Health Organisation recommends that 'routine vaccination of all infants against HBV infection should become an integral part of national immunization schedules worldwide'. The UK does not offer universal HBV vaccination at birth or in childhood purely for economic reasons. There is a vaccination programme available to high-risk groups in UK, but as in like Eddie's case, it is not a catch-all.

Acute hepatitis B is often self-limiting and usually only requires relief of symptoms. Treatment of CHB aims to prevent progression to hepatocellular carcinoma or cirrhosis. There are now a number of drugs licensed for the treatment of CHB including peginterferon (2).

Eddie successfully cleared his acute hepatitis B and is back at work. He and his partner Janet have remained patients and now use the surgery for general medical care, needle exchange and counseling. Janet has completed her hepatitis B vaccinations but as yet neither of them wants substitute medication. Eddie and Janet have managed to have their immediate healthcare needs met, can continue to stay in contact with us and are making the changes they want for now.

Supporting and encouraging people while respecting their own choices and timescales is one of the many reasons I love being a GP.

***Dr Chris Ford GP Lonsdale and Clinical Director for SMMGP***

### **References**

1. Hepatitis B: Out of the shadows, Foundation for Liver Research, October 2004. [www.britishlivertrust.org.uk](http://www.britishlivertrust.org.uk)
2. National Institute for Clinical Excellence, February 2006, Adefovir dipivoxil and peginterferon alfa-2a for the treatment of chronic hepatitis B. Technology Appraisal 96