National Institute for Clinical Excellence

Adefovir dipivoxil and pegylated interferon alfa-2a for the treatment of chronic Hepatitis B

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Current practice

There appears to be little consistency in practice in relation to treatment regimes for patients with chronic hepatitis B with dose schedules for interferon Alfa ranging from 5MIU daily to 9-10 MIU thrice weekly in HBeAg positive patients or 5-6 MIU thrice weekly for HBeAg negative patients. The duration of therapy is also variable (EASL consensus statement).

The indications for use of oral agents also lacks consensus in practice.

The EASL consensus statement suggests interferons should be used as first line treatment in the majority of cases however this has been debated in practice in some areas.

Populations

Clinical trials are highly selective and do not include the general population of patients seen in clinical practice. Groups that are excluded include:

Patients with severe psychiatric disorders
Pregnant women
Prison populations
Injecting drug users
Renal patients

Settings

To provide the optimal support for patients with chronic hepatitis B the use of model of care for patients with hepatitis C to be adopted with supervision by a physician with an interest in viral hepatitis and access to a clinical nurse specialist. Comprehensive information prior to initiation and throughout treatment will aid compliance and reduce withdrawal from treatment.

Advantages/Disadvantages

Equivalence of care nationwide
Clear guidance of indications for use
Access to alternate therapies if contraindications to standard treatment

Improved tolerability of pegylated interferon Alfa in comparison to standard interferons in practice. Once weekly dosing may also aid compliance. These benefits have been seen in

patients with chronic hepatitis C. Pegylated interferon has been shown in trials to be safe in patients with cirrhosis.

Lamivudine and Adefovir dipivoxil have been shown to be easily tolerated oral agents. Adefovir dipivoxil also provides a therapy with a low rate of resistance and has been shown in clinical trials to be effective against wild type and Lamivudine resistant hepatitis B (YMDD mutant). This is particularly advantageous for patients for whom interferons are contraindicated or have not responded to interferon therapy previously and for those who have developed YMDD mutant HBV on Lamivudine. Adefovir dipivoxil is also been used safely in patients with decompensated liver disease and post liver transplantation.

The frequency of follow up and assessment is less for patients on oral agents as opposed to intererons due to their tolerability however duration of treatment is longterm once initiated.

Trials have shown histological improvement in patients treated with pegylated interferon Alfa and Adefovir dipivoxil.

Implementation issues

Training would be required to ensure all staff in treatment centres are familiar with indications for use dependent on patients status.

Minimal additional education needs for staff due to use of pegylated interferon Alfa as it is the standard treatment in chronic hepatitis C. Patient information could be adapted from hepatitis C regimes.

Ease of administration of Adefovir dipivoxil and good tolerability making patient education straightforward.

Continuity of care essential in the longterm follow up for patients with chronic liver disease especially whilst receiving longterm therapy.

Potential increase in patient numbers receiving therapy with alternative options available. Need to ensure that there is adequate specialist nursing provision to accommodate patient numbers.

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