Chronic Hepatitis B Treatment

Perinatal transmission prevention, antiviral therapy by disease phase, stopping nucleos(t)ide analogue therapy, and HCC surveillance in special populations.

2025 AASLD/IDSA Practice Guideline
Treatment of Chronic Hepatitis B
Hepatology 2025 (in press)

STRENGTH · Strong · Conditional

1 Prevention of Perinatal (Mother-to-Child) Transmission

STATEMENT	STRENGTH
R1 — HBV DNA >200,000 IU/mL at any point in pregnancy (regardless of HBeAg status): initiate TDF or TAF at gestational week 28 to prevent MTCT. TDF has the more extensive pregnancy safety record	Strong Certainty: Moderate

Implementation: continue TDF/TAF if already on therapy; switch entecavir/other antivirals to TDF/TAF. Start at week 16 (+ infant vaccination) if HBIG unavailable, or earlier if amniocentesis or preterm labor risk anticipated (DNA >2,000,000 IU/mL raises amniocentesis-related transmission risk). If treatment is solely for MTCT prevention, may discontinue at delivery — monitor HBV DNA/ALT q1–3 months ×6 months for withdrawal flare (ALT ≥5× ULN → reinitiate). TDF/TAF are safe during breastfeeding.

2 Antiviral Therapy by Disease Phase

STATEMENT	STRENGTH
R2 — Viremic, high-risk transmission scenario, not meeting disease-specific treatment indications: shared decision-making regarding antiviral therapy	Conditional Certainty: Very low
R3 — Immune-tolerant phase (HBeAg+, HBV DNA >10^7 IU/mL, normal ALT): treat if age >40y, or significant inflammation (≥G2) or fibrosis (≥F2); if <40y, shared decision-making weighing risks/benefits	Conditional Certainty: Very low
R4 — HBeAg-negative, indeterminate phase, no cirrhosis: shared decision-making on antiviral therapy; reassess at each follow-up visit if untreated	Conditional Certainty: Very low

Favors treatment: age >40y, male, low-normal platelets (<180k/mm³), advanced fibrosis (F3/F4 — treatment recommended). Noninvasive thresholds for advanced fibrosis: FIB-4 >1.45 or VCTE ≥8 kPa.

3 Discontinuing Nucleos(t)ide Analogue Therapy

STATEMENT	STRENGTH
R5 — HBeAg-negative, no cirrhosis, sustained undetectable HBV DNA on NA therapy: suggest **not** withdrawing NA therapy until HBsAg loss	Conditional Certainty: Very low

If discontinuation is considered, all should be met: ≥3y of NA therapy, undetectable HBV DNA ≥2y, no history of advanced fibrosis/cirrhosis or hepatic decompensation, and capacity for frequent post-stop monitoring. Weigh benefit (possible HBsAg loss) against risks (flare, decompensation, need for retreatment).

4 HCC Surveillance in Special Populations

STATEMENT	STRENGTH
R6 — After HBsAg loss: continue HCC surveillance if cirrhosis, family history of HCC, men who lost HBsAg after age 40, or women after age 50	Conditional Certainty: Very low
R7 — HBV-HDV coinfection: surveil all adults regardless of cirrhosis status; individualize in children given unknown risk	Conditional Certainty: Very low
R8 — HBV-HIV coinfection: surveil men ≥18y and women ≥40y	Conditional Certainty: Very low
R9 — HBV-HCV coinfection: treat HCV (DAA therapy) and surveil per HBV mono-infection criteria	Conditional Certainty: Very low

Surveillance protocol: ultrasound + serum AFP every ~6 months (per 2023 AASLD HCC guidance) — the most cost-effective approach. For multiple coinfections, follow the criteria for whichever coinfection carries the highest HCC risk (e.g., HBV-HDV-HCV → follow HBV-HDV criteria).

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