Hepatitis A Booster Vaccination in People Living with HIV: An Audit from a Large HIV Clinic

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Introduction

Hepatitis A infection is generally a mild, and self-limiting illness with the Hepatitis A virus (HAV). Humans are the predominant reservoir, and infection is transmitted faeco-orally by close personal contact, contaminated food and water, or rarely via blood exposure. Infection can be spread during sexual contact in gbMSM.

While fulminant hepatitis A infection is rare, it carries a mortality of 45%. Older patients, and those with chronic liver disease are at the highest risk of severe illness. Those at particular risk of infection include household and sexual contacts of infected individuals, gbMSM, PWID, and travellers to countries of high incidence.

The HAV vaccine is an inactivated vaccine. Immunogenicity in PLWH is generally reduced compared to the general population. 70% of PLWH show seroconversion with 2 doses of vaccine. The primary course consists of 2 to 3 doses, with the 3rd dose recommended for those with a CD4 count <350 cells/microl. NIAC and BHIVA recommend that those at continued risk of exposure receive a booster vaccine every 10 years.

Methods

This was a retrospective chart review of the electronic patient record. We included all those patients living with HIV attending our clinic who received a hepatitis A vaccine in the years 2012 to 2014. We then recorded what proportion of these had received a hepatitis A booster vaccine where indicated.

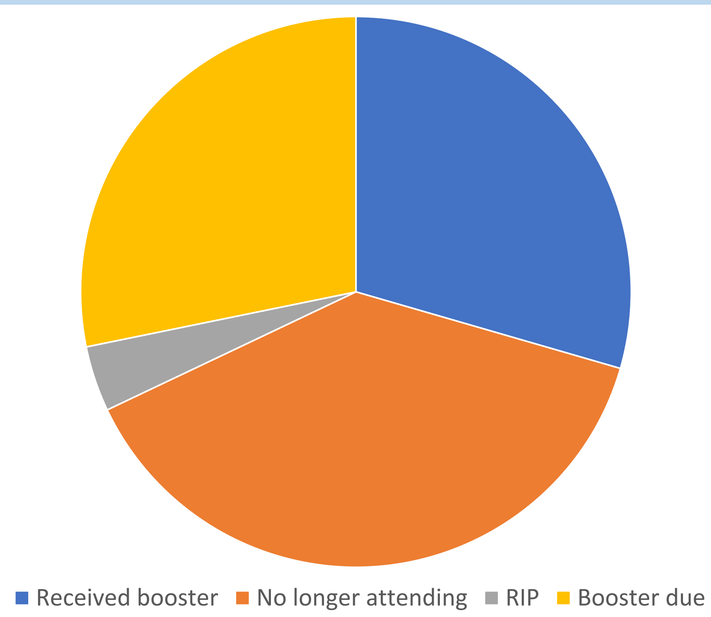

Figure 1. Pie chart illustrating the proportion who received booster vaccination

Results

78 patients were included. Only 23 (29.5%) of these had received a booster as indicated. Of the remainder, 30 patients are no longer attending our clinic, 3 have died, and 22 are due to receive their booster this year.

When those patients who were no longer attending the clinic were excluded, the percentage of vaccinated patients was 47.9%.

Limitations

Given the lack of access to vaccine records, the design of this study did not capture those patients who may have received their hepatitis A vaccination outside of our institution. Given the volume of transfers of care, this likely represents a large group of people.

It is likely that there is a proportion of people who have received hepatitis A vaccination elsewhere, who never receive booster vaccination as HAV IgG positivity is presumed to represent past infection. We were unable to measure this in this audit.

Conclusion

There was a low rate of hepatitis A booster vaccination in this group. A large proportion of patients no longer attended the clinic, and this accounted for the biggest unvaccinated group. Hepatitis A vaccine is safe, and international guidelines recommend a 10-year booster vaccination in PLWH. Booster vaccination rates in our clinic are suboptimal.

As a result of this audit, we instituted an EPR reminder to providers to consider hepatitis A booster in this group. We will re-audit in time to assess the efficacy of this intervention.

References

1. National Immunisation Advisory Committee (NIAC) Guidelines. Chapter 08 – Hepatitis A. Updated Dec 2022.
2. British HIV Association guidelines on the use of vaccines in HIV-positive adults 2015