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Immigration and knowledge, education, and practices regarding chronic hepatitis B in pregnancy

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I read with interest the article by Niu *et al* [1] and I wish to make the following comments. First, the overall knowledge of enrolled cases regarding measures of hepatitis B virus (HBV) is shown to be low, which may be related to the study methodology; however, the main limitation in this study was a low response rate that prevents drawing any conclusions.

Second, the global distribution of HBV infection varies significantly between countries, being low in the USA, Western Europe and Canada and high in some parts of Asia and Africa, with higher rates of vertical transmission in these regions. Socioeconomic and political factors, as well as internal wars in some parts of Asia and Africa, have lead to massive migration to areas in the world with low endemicity for HBV [2]. This event has significantly changed the burden of HBV in the USA and other countries with a low prevalence of HBV infection. Therefore, physicians should have knowledge of enrolled cases, including higher-risk and pregnant patients, and in particular people who have immigrated from countries with a high prevalence of HBV infection. Finally, there were no data regarding HBV vaccination in the enrolled cases; if the patients' HBV vaccination history and their ant-HBs antibody title had been reported, it would have been easy to predict their health precaution in practice and their knowledge regarding hepatitis B in pregnancy [3].

References

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Authors' reply

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We thank Dr. Alavian for his comments on our study. To address each of his points:

Firstly, the level of knowledge regarding hepatitis B virus (HBV) was indeed lower than we had expected [1]. Our surrogate for measuring knowledge included several questions where respondents to our survey were asked to interpret hepatitis B serologies. The results show that 78.8-94% of trainees and 80-94% of program directors answered correctly. This may be due to the low prevalence of HBV in the United States as compared to certain other countries. We agree that the low response rate is a limitation. However, we believe we captured a diverse group of respondents, across geography, experience, and practice setting.

Secondly, immigration from endemic areas has certainly changed the landscape of HBV in the US. While it is a disease important for all healthcare workers to be aware of, it is especially important for those healthcare workers to screen HBV in specific populations. It is very encouraging to see that almost all of the obstetricians and gynecologists who were surveyed do report screening for HBV in pregnant patients. With respect to knowledge and comfort with HBV, when analyzing data from different regions in the US (not reported in our paper), we were not able to find significant differences among practitioners. This may be due to the low response rate, as we would expect those in coastal cities to have encountered more patients with HBV, given the higher percentage of immigrants in those cities.

Lastly, it is customary in the US for healthcare workers to be tested for hepatitis B surface antibody titers prior to starting employment. If the titers are low or undetectable, the healthcare worker would be required to receive either a booster or the entire series of hepatitis B vaccination.

Overall, our study provided a look at the practice and knowledge of HBV among obstetricians and gynecologists in the US. It would be very interesting to expand it to include practitioners around the world.

Reference

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