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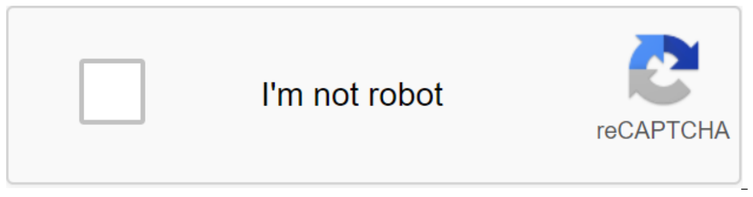

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WHO estimates that 257 million people worldwide were living with chronic hepatitis B virus (HV) infection in 2015 and that 900,000 people died from ERV infection, mainly as a result of cirrhosis or hepatocellular carcinoma. Most HBV-related deaths in adults are secondary to infections acquired at birth or in the first five years of life. In May 2016, the World Health Assembly approved a global health strategy to combat viral hepatitis, which provides for the elimination of viral hepatitis as a threat to public health by 2030 (defined as a 90% reduction in the incidence of new infections and a 65% reduction in mortality rate). measures to prevent the transfer of VVD from mother to child. These guidelines provide evidence-based guidance on the use of peripartum antiviral prevention in pregnant women infected with HBsAg to prevent mother-to-child transmission of HVT. Similar Brief Policy: Prevention of Mother-to-Child Hepatitis B Virus Transmission: Guidelines on Antiviral Prevention in PregnancyWeb Annex A. Systematic Review of the Effectiveness and Safety of Antiviral Therapy During Pregnancy - PDF, 13 MBWeb Appendix B: Systematic Review of the Effectiveness of the Hepatitis B Antigen Test, As an Alternative to HBV DNA, to Assess the Right to Initiate Antiviral Therapy during Pregnancy - PDF : Effect and profitability of VVD peripartum antiviral therapy - PDF, 1.2 MBAnnex D. Acceptability, feasibility, values and preferences for hiv-infected HIV pregnant women in addition to timely dose vaccination at birth - PDF, 420 KBAnnex E. Framework for regional verification of the global goal of monitoring the prevalence of antigen on the surface of hepatitis B in children by 2020 - PDF, 550 KBWeb App , 316B Global Programmes on HIV, Hepatitis and Sexually Transmitted Infections, WHO World Health Organization Infants born to mothers with hepatitis B have a more than 90% chance of developing chronic hepatitis B if they are not properly treated at birth. It is very important that pregnant women know their hepatitis B status to prevent transmission of the virus to their newborn baby during childbirth. If your doctor knows that you have hepatitis B, he or she can ensure the transmission of hepatitis B to your child is prevented by taking measure based on the results of blood tests and take steps to have proper medications in the delivery room to prevent infection of your baby. ALL pregnant women should be tested for hepatitis B. Testing is especially important for who fall into high-risk groups such as health care workers, women from ethnic communities or countries where hepatitis B is common, spouses or partners living with an infected person, etc. If you have tested positive for hepatitis B infection, then your newborn should be given proper prevention directly in the delivery room, clinic or bed: the first dose (so-called dose of birth) of the hepatitis B vaccine one dose of hepatitis B Immune Globulin (HBIG). HBIG is not recommended by WHO and may not be available in all countries. The most important thing is to make sure that the hepatitis B vaccine dose of birth is given as soon as possible! If these two medications are given correctly, a newborn born to a mother with hepatitis B has a more than 90% chance of being protected from hepatitis B infection. Although the U.S. CDC states that medications can be given within the first 12 hours of life and who states that a dose of birth vaccine can be given within 24 hours, there is no second chance to protect the baby once this window of opportunity is missed. The Hepatitis B Foundation therefore urges health professionals to administer a dose of hepatitis B vaccine immediately in the delivery room to avoid delays or errors. If you tested positive for a hepatitis B infection during pregnancy, your doctor should also do a blood test of viral load hepatitis B (HBV DNA) during pregnancy. In some cases, the results of laboratory tests can show a very high viral load. In these cases, your doctor may recommend that you take an oral antiviral drug in the third trimester to reduce your risk of infection at birth. If the hepatitis B viral load test is not available, WHO recommends that pregnant women be tested for the electronic hepatitis B antigen (HBeAg), and in the case of positive antiviral drug is recommended during the last trimester. Regardless of your viral load level or HBeAg status, the dose of hepatitis B vaccine birth and the completion of a series of vaccines are necessary to protect your child from hepatitis B virus infection. Additional links to resources: USA: Centers for Disease Control and Prevention: Viral Hepatitis, Perinatal Transmission (2018) EU/EEA: Prenatal Screening for HIV, Hepatitis B, Syphilis and Rubella Susceptibility in the EU/EEA (2016) Globally: Prevention of WHO Hepatitis B Virus Transmission from Mother to Child: Guidelines on Antiviral Prevention during Pregnancy (2020) 1. Research Agency in health care and quality. Screening for hepatitis B virus in Women: An updated systematic review for the U.S. Preventive Services Task Force. 2019. 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A 33-year-old pregnant doctor born in the U.S. comes to your office with the first antenatal visit. Her last menstrual period was six weeks ago and she has been taking vitamins for the past eight weeks. She was pregnant two years ago and at the time she was screening negative for the hepatitis B virus (HBV). She reports that a year ago, during a work-related medical examination, she was vaccinated against HPV and that she did not smoke, drink alcohol or use recreational drugs.1 Based on the recommendation of the U.S. Preventive Care Task Force (USPSTF), should you offer this patient HBV screening? A. Yes, because it works in high-risk environments (health care). Yes, because this is the first antenatal visit. No, because she had a previous negative hepatitis B antigen (HBsAg) test result during her first pregnancy. No, because she got vaccinated against VVD. No, because she doesn't have any risk factors for HBV.2. If you examine this patient, which of the following tests should you order? A. HBsAg.B. Antibodies to the Surface of Hepatitis B (HBsAb.C. Total Number of Major Hepatitis B Antibodies (HBcAb).D. Immune Globulin M (IgM) HBcAb.E. Hepatitis B Antigen E (HBeAg).3. If this patient screens positive for HBV, which of the following interventions significantly reduce the risk that her child will acquire HBV infection? A. HBV vaccination for maternal hepatitis B immune globulin (HBIG) to vaccinate the mother.C. HBV for baby HBIG for infant.1. Correct answer B. Based on the USPSTF recommendations, this patient should be offered HBV screening because this is her first prenatal visit.1 Screening should be performed in each pregnancy, regardless of previous HBV vaccination or previous negative HBsAg.2 test results. Correct answer: A. Screening for maternal HBV infection is conducted through HBsAg serological testing.1 HBsAb results may be positive due to pre-HBV infectionIn this see the full article, log in or gain access. The views expressed in this paper are those of the authors and do not reflect the official policy or position of Boston Medical Center, the U.S. Department of Health and Human Services, or the U.S. government.1 Davidson KW, Krist AH, Barry MJ, et al. Screening for hepatitis B virus u Reporter: The U.S. Preventive Services Task Force confirmed the recommendation. Jama. 2019;322(4):349–354.2. Henderson JT, Webber EM, Bean SI. Screening for B Viral Infection in Pregnant Women: An Updated Evidence Report and a systematic review for the U.S. Preventive Services Task Force. Jama. 2019;322(4):360–362.3. Shilly S,, Vellozzi S, Reinhold A. and others Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices. MMWR Recomm Rep. 2018;67(1):1-31.This PPIP quiz is based on USPSTF recommendations. For more information, please visit the USPSTF Recommendation Statement and supporting documents on the USPSTF ( ) website. Recommendations for practice in this activity are available series coordinated by Kenny Lin, MD, MPH, Deputy Editor. The Warning in Practice collection, published in THE AFP, is available on . Page 3 DREW ASHBY, MD; FRANKLIN NIBLOCK, MD, MPH; KENNETH HERRING, MD; and LOGAN MIMS, MD, University of Colorado, Denver, ColoradoAm Pham Doctor. 2020 January 15;101(2):117-118.A 39-year-old man with a history of mild intermittent asthma and limited medical care provided to assess shortness of breath and bilateral swelling of the lower extremities. He reported three weeks of symptoms, including coughing, congestion, rhinorrea, and subjective fever. During this time, he increased shortness of breath, shortness of breath on loads and inability to button working pants. His social history included sexual activity with several female partners and weekly use of methamphetamine through a tube. He reported a lack of intravenous drug use or alcohol use. A physical examination revealed a jugular venous reduction to the level of the lower jaw, normal findings on cardiac examination, crackling on the bases of the lungs, and 3 pitting swelling in the bilateral lower limbs to the middle. The electrocardiogram showed a normal sinus rhythm, a long adjusted PERIOD of CT, and no signs of ischemia. Whey troponins were not elevated. Transtoracal echocardiogram revealed a strong decrease in the systolic function of the left ventricle with a 21% emission fraction. Left ventricle revealed hypokinesis. The chest radiography was performed (Figure 1). Based on the patient's history, physical examination and prior preliminary the findings, which one of the following is the most likely diagnosis?A. HIV-associated cardiomyopathy.B. Hypertrophic cardiomyopathy.C. Ischemic cardiomyopathy.D. Methamphetamine-associated cardiomyopathy.E. Viral myocarditis. Answer D: methamphetamine-related cardiomyopathy. Chest X-ray shows cardiomegalia with associated pulmonary edema, which concerns advanced cardiomyopathy. Cardiomyopathy with a markedly reduced emission fraction in a young methamphetamine user largely leads to methamphetamine-related cardiomyopathy. Patients with methamphetamine-related cardiomyopathy have a significantly reduced emission fraction, with one study showing an average left ventricular ejection rate of 19%.1-3 Echocardiography

demonstrates global hypokinesis from systemic exposure to catecholamines, And direct toxic exposure to methamphetamine.4 Recovery forecast is good, but depends on the cessation of methamphetamine use.1.5 One study reported that the emission fraction returned to normal within six weeks in one-third of patients who abstained from using methamphetamine.1Methetamphetamine, which is known by street names such as the handle, crystal, ice, speed and go, is one of the most common illegal substances in the world. It is structurally similar to amphetamine and indirectly increases the release of dopamine, norepinephrine, epinephrine and serotonin. This leads to euphoria, increased alertness and reduced appetite. Rapid heartbeat and cardiac arrhythmia are common, with 27% of patients showing a long adjusted period of CT on electrocardiography.6 Prolonged use of methamphetamine can lead to myocardial infarction as well as cardiomyopathy. 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JacC JACC Heart 2017;5(6):435–445.6. Haning W, Gobert D. Electrocardiographic anomalies in methamphetamine addicts. Addiction. 2007;102 (suppl 1):70-75.7. Georgiade M, Bonow RO. Chronic heart failure in the United States: a manifestation of coronary heart disease. Circulation. This series is coordinated by John E. Delzell Jr., M.D., MSPH, Associate Medical Editor. A compilation of photo quizzes published by THE AFP is available published Photo quizzes are now posted in the mobile app. Find out more . AFP editors welcome the materials for the photo quiz. Guidelines for the preparation and dispatch of the Photovisation manuscript can be found in the authors' Guide to . In order to be considered for publication, submissions must comply with these guidelines. Emailing afpphoto@aafp.org. The © in 2020 by the American Academy of Family Physicians. This content is owned by AAFP. A person browsing it on the Internet can make one printout of the material and can only use this printout for their personal, non-commercial reference. Otherwise, this material cannot be downloaded, copied, printed, stored, transferred or reproduced in any environment, regardless of whether it is known or later invented, except where it is permitted in writing by AAPP. Contact afpserv@aafp.org copyright issues and/or requests for permission. Page 4KYAW NAING, MD, PhD, and SONAL SHAH, MD, School of Medicine, University of Southern Illinois, Carbondale, IllinoisAm Pham Physician. 2020 January 15;101(2):119-120.Do preprocedure drugs affect the pain of the intrauterine device (IUD) insertion? Topical lidocaine drugs, including gels, creams and sprays, can slightly reduce pain when placing a tenaculum, but not during IUD insertion. (SOR recommendation strength: A based on meta-analysis of randomized controlled trials (RCTs).) The use of a paravarvic block with inconsistent lidocaine does not reduce pain in any of the steps. (SOR: A based on the meta-analysis of RCTs.) However, a parawarv unit using buffer lidocaine can reduce pain with uterine sounding and iud placement, as well as overall pain. (SOR: B, based on RCT.) Tramadol and naproxen reduce pain when placing IUD. (SOR: A based on the meta-analysis of RCTs.) A meta-analysis of 11 RCTs in 2018 (N No. 1458) assessed the effect of the lidocaine parawark block or the use of lidocaine to the genital mucosa before IUD insertion in non-fragile and sailing women.1 Copper IUDs and left-eastern-releasing intrauterine system (Mirena) were used. The pain was assessed using 0-10 visual scales, with higher numbers indicating more pain. Lidocaine drug 2.5% gel (three trials) or 2.5% cream (one test), or a combination of 2.5% lidocaine and 2.5% prilocaine cream (two tests) was applied to to ectocervix, in the cervical canal, or both. Lidocaine 10% spray (two tests) was applied as four pumps (40 mg) to ectocervicus, and paraceric blocks (four tests) were performed as unbuffered 1% of lidocaine injections on both sides of the cervix and on the tenakulum site. Control interventions were placebo or no intervention. As a group, genital applications of the lining of lidocaine reduced pain with the placement of tenaculum (six trials; n No 764; average difference (MD) - 1.0; 95% KI, 1.9 to 0.09) compared to placebo or no intervention, but there was no significant difference with the insertion of IUD (seven trials; n No. 828; MD No1.0; 95% KI, from 2.0 to 0.01 euros). There was to see the full article, log in or gain access. Disclosure of the author: There is no appropriate financial affiliation. Copyright © Family Doctors Requests Network. Used with permission. Kyaw Naing's correspondence address, MD, PhD, knaing@siumed.edu. Reprints are not available to authors.1. Perez-Lopez FR, Martinez-Dominguez SJ, Perez-Ronsero GR, et al. Use of matcoin or paravartic lidocaine to control pain during the insertion of intrauterine devices: a meta-analysis of randomized controlled trials. Eur J Contraceptive Reprod Healthcare. 2018;23(3):207–217.2. Modi SK, Farala JP, Jimenez B, et al. Paraparvical Unit for the placement of intrauterine devices among pregnant women. Obstet Gynecol. 2018;132(3):575-582.3. Lopez LM, Bernholz A, Tseng Y, et al. Interventions for pain in insertion of intrauterine devices. Cochrane Database Syst Rev. 2015; (7):CD007373. The answers provided by the Family Physicians Network (FPIN) provide answers to questions submitted by family practitioners. Network members select questions based on their importance to family medicine. The responses are taken from an approved set of evidence-based resources and are peer-reviewed. The strength of the recommendations and the level of evidence for individual studies are assessed using criteria developed by the Evidence-based Working Group on Medicine ( ). The complete database of questions and answers based on evidence is protected by the copyright of FPIN. If you are interested in submitting questions or writing answers for this series, go to or email: questions@fpin.org.This series is coordinated by John E. Delzell Jr., MD, MSPH, Associate Medical Editor. The FPIN Support Answers Collection, published in AFP, is available at 5JOANNE WILKINSON, MD, MSc, Brown University, Pawtucket, Rhode IslandRONALD TUTALO, PharmD, BCACP, Rhode Island Primary Care Physicians Corporation, Cranston, Rhode Island Fam Doctor. 2020 January (Yupelri) is a once-daily, nebulized, long-acting muscaritic antagonist labeled for the treatment of moderate to severe chronic obstructive pulmonary disease (COPD). Revefanacin is usually safe with systemic side effects.1 As with other long-term treatments, revefenacin should not be used to treat acute symptoms. Like other inhalation treatments, it has a theoretical risk of immediate hypersensitivity and acute bronchodilance. Revephenacin is anticholinergic and can cause narrow-angle glaucoma or worsen urine retention. Revefenacin has not been studied in pregnant women or infants. The manufacturer recommends not to use it in patients with liver disorders or those who take rifampin or cyclosporine (Sandimmune). It has been shown that revefanacin is well tolerated in clinical trials. In two 12-week placebo-controlled trials of 1,225 patients with moderate to severe COPD, side effects leading to discontinuation were more common in patients receiving a placebo (19%) than revefanacin (13%).2Revefanacin outperforms placebo in improving forced output in one second (FEV1) for patients with moderate to severe COPD. 28-day randomized, The double-blind study compared placebo and revefenacin in 355 patients with COPD, an average age of 62 years, and an average VEEV1 of 44% projected. Ferguson G, Pudi KK, Feldman G, et al. Efficiency and Safety of Revefenacin (REV), a long-acting muscaritic antagonist for nebulization: replication results of randomized, double-blind, placebo-controlled, parallel group 3 trials in participants with moderate to very severe COPD. Eur Respir J. 2017;50 (suppl 61):1812.3. Pudi KK, Barnes CN, Moran EJ, et al. 28-day randomized, double-blind, placebo-controlled, parallel group study of unbulated revefenacin in patients with chronic obstructive pulmonary disease. Respir Res. 2017;18(1):182.4. Ferguson GT, Feldman G, Pudi KK, et al. Improvement of lung function with unbulized revephenacin in the treatment of patients with moderate to very severe COPD: the results of two clinical trials of the third phase. Chronic Obstr Pulm Dis. 2019;6(2):154-165.STEPS new drug reviews cover safety, tolerability, efficiency, price and simplicity. Each independent review is provided by authors who have no financial connection to the drug manufacturer. This series is coordinated by Allen F. Shaughnessy, PharmD, MMedEd, Assistant Medical Editor. The STEPS collection, published in AFP, is available . The © in 2020 by the American Academy of Family Physicians. This content is owned by AAFP. Face it's online, can make a single printout of the material and can only use this printout for its own personal, non-commercial reference. Otherwise, this material cannot be downloaded, copied, printed, printed, or reproduced in any medium, whether now known or later invented, except as permitted in AAFP writing. Contact afpserv@aafp.org copyright issues and/or requests for permission. Page 6This guide to atrial fibrillation (AF) management from the American Heart Association (AHA), the American College of Cardiology (ACC), and the Heart Rhythm Society (HRS) is an update of the 2014 version and is based on new data from clinical trials and the U.S. Food and Drug Administration (FDA). Treatment recommendations apply to paroxysmal, persistent and permanent AF, as well as atrial flutter. This update changed the anticoagulation, catheter ablation and AF management sections that complicate acute coronary syndrome, and added new sections describing weight loss and AF detection; however, this summary focuses on new and revised recommendations for anticoagulant selection and new recommendations for preventing stroke through non-pharmacological options and catheter ablation. Based on high-quality evidence, oral anticoagulants should be prescribed for women with AF and CHA2DS2-VASc (congestive heart failure; Hypertension; age at least 75 years (twice); diabetes; previous stroke, transient ischemic attack, or thromboembolism (twice); vascular disease; age 65 to 74; sexual category) score at least 3 and for men with at least 2. Direct oral anticoagulants, including dabigatran (Pradaxa), rivaroxaban (Xarelto), apixaban (Eliquis), and edoxaban (Savaysa), prefer warfarin (Kumadin) if the patient has accompanying moderates To see the full article, log in or gain access. Coverage of the guidelines from other organizations does not imply approval by the AFP or AAFP. This series is coordinated by Sumi Sexton, MD, Editor-in-Chief. A collection of practice guidelines published in the AFP is available . The © in 2020 by the American Academy of Family Physicians. This content is owned by AAFP. A person browsing it on the Internet can make one printout of the material and can only use this printout for their personal, non-commercial reference. Otherwise, this material cannot be downloaded, copied, printed, stored, transferred or reproduced in any environment, regardless of whether it is known or later invented, except where it is permitted in writing by AAPP. Contact afpserv@aafp.org copyright issues and/or requests for permission. Page 7 Am Fam Doctor. 2020 January 15;101(2):70-71.Original article: Lung Cancer Screening: Pros and Cons (Lown Right Care) Release date: June 15, 2019Acacces: Editor: We read with article by Dr. Lariss and Roth. They report that no study other than the National Lung Screening Test (NLST) has shown benefit from lung cancer screening. Two other randomized trials Italian Lung Detection MILD, a Dutch-Belgian randomized lung cancer screening study) reported a reduction in lung cancer deaths more than was found in NLST.1.2 A third study (German lung cancer screening trial) showed the same conclusion in women. A greater reduction in lung cancer mortality in these studies may be due to longer screening protocols compared to 24 months in the NLST. The MILD trial continued screening for up to 10 years and showed the largest reduction in lung cancer (39%) and lung cancer (39%). and overall mortality (20%)1 The authors emphasize important risks including false positives and overdiagnosis. Compared to NLST, the widely implemented American College of Lung Radiology Imaging Reporting and Data System (Lung-RADS) reduced false rates to 10% to 12% on the initial screening survey and 5% on subsequent scans.3 The use of the original lung-RADS system would reduce the number of false-positive results in the NLST by more than 50% and the corresponding invasive procedures by 23%. Lazris and Roth used liberal criteria for positive surveys (i.e. any node larger than 2 mm) to promote a high false rate.4 Long-term follow-up rates in THE NLST indicate that overdiagnosis does not occur except for carcinoma on the spot. Under the current care standard, these patients return to annual surveillance without any further interventions if the lesion grows aggressively.5 A recent update to lung-RADS increased the size threshold for such lesions from 20 mm to 30 mm, further reducing the risk of overdiagnosis.5Real-world evidence highlights the effectiveness of well-organized screening programs. A survey of 165 lung cancer screening programs in the United States, the most in public settings, demonstrated similar results as in academic centers.6 Lung cancer screening can be successfully performed in the real world and is increasingly performed, with a survey of 10 states finding that 14.4% of patients eligible for a low dose of COMputed tomography in the last 12 months. Lung cancer screening is effective for reducing the first cause of cancer death in men and women. It is time to make lung cancer screening part of routine primary health care for patients who are at risk. Disclosure author: No relevant financial affiliations.show all links1. Pastorino W., Silva M, Sestini S. et al. Long-term lung cancer screening reduced 10-year mortality in the MILD trial: a new confirmation of the effectiveness of lung cancer screening. Anne Oncol. 2019;30(7):1162–1169....2. International Association for the Study of Lung Cancer. Study shows that CT screening to control the volume of the nodules reduces lung cancer mortality by 26 percent in men. Access to June 30, 2019. Year. McKee BJ, Regis S, Borondy-Kitts AK, et al. NCCN guidelines as a model of advanced criteria for lung cancer screening. J Natl Compr Cank Neto. 2018;16(4):444–449.4. Kinsinger LS, Anderson C, Kim J, et al. Introduction of Lung Cancer Screening at the Veterans Health Department. JAMA Intern Med. 2017;177(3):399-406.5. American College of Radiology. Version 1.1 lung-RADS. Access to June 30, 2019. . Copeland A, Criswell A, Ciupek A, et al. Effectiveness of the introduction of lung cancer screening in public places in the United States. J Oncol Practical. 2019;15(7):e607-e615. In response: We appreciate the letter from Drs. Lim, Kitts, and Tremblay. After our article was sent to the press, several new studies were published that further highlighted the potential benefits of annual screening. However, these new studies do not fundamentally change our conclusion that there are both risks and benefits for low-dose COMputed tomography screening, and lingering uncertainty as to how effective screening is for different populations. The authors cite a 39% reduction in lung cancer mortality among screening participants over 10 years in the MILD trial. Although technically correct, the relative numbers (39%) are correct. don't help doctors and patients make general decisions because these numbers don't tell us the absolute benefit of screening. In the MILD test, 1.7% of participants died of lung cancer over 10 years in screened arms, and 2.3% died in the control arm, leading to a reduction of six lung cancer deaths out of 1,000 people screened. This is similar to the NLST findings showing that long-term screening can somewhat improve benefits, with consistently high false rates. The German lung cancer screening trial does show a reduction in lung cancer mortality in women (seven out of 1,000 fewer lung cancer deaths after five years of screening), but there is no survival benefit for men. Finally, Lung-RADS reduces false speed; However, the authors noted a decrease in sensitivity to lung cancer detection, which can lead to lower survival rates during screening.1 There are still many unanswered questions. Why have men improved survival in some studies rather than others? Do the benefits of survival differ according to other characteristics? The Centers for Medicare and Medicaid Services is organizing a real study to assess the prevalence, survival benefits and risks of screening in the community, and many doctors and organizations are waiting for this data before conducting an organized screening program. Until then, NLST results and new trials provide some information that will help doctors and patients reach a decision on whether to carry out cancer screening Disclosure of the author: There is no appropriate financial affiliation. To see the full full log in or gain access. Send emails to afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Lywood, KS 66211-2680. Include your full address, email address and phone number. Letters must be less than 400 words and are limited to six links, one table or a figure and three authors. Letters submitted for publication to THE AFP should not be submitted in any other publication. Possible conflicts of interest should be disclosed at the time of submission. The submission of the letter will be interpreted as granting AAFP permission to publish the letter in any form of the letter. Editors can edit letters to meet the requirements of style and space. This series is coordinated by Kenny Lin, MD, MPH, Deputy Editor of AFP Online. 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