

## To the Editor:

We would like to point out an omission in the AASLD Practice Guidelines on Chronic Hepatitis B published in the February 2007 issue of HEPATOLOGY.<sup>1</sup> In the section discussing the counseling and prevention of hepatitis B on pages 508-509 and in the accompanying table (Table 3), when discussing infants born to hepatitis B virus (HBV)-infected mothers, the authors neglected to discuss the issue of breast-feeding. This is certainly worth mentioning because some mothers feel breast-feeding to be an integral part of the care they provide to their infants, and mothers prohibited from breast-feeding may feel some sense of inadequacy. As you know, breast-feeding is not prohibited in HBV-infected mothers, as proven by several studies, some of which are listed here.<sup>2-4</sup> Furthermore, because infants should routinely receive HBV immune globulin and HBV vaccine, they are almost universally protected against postpartum maternal HBV transmission.

We think an additional 1-2 sentences should be included in the guidelines to address this issue.

RAVI JHAVERI<sup>1</sup>  
NANCY MURRAY<sup>2</sup>  
<sup>1</sup>*Division of Infectious Diseases  
Duke Children's Hospital  
Durham, NC*  
<sup>2</sup>*Duke Children's Primary Care  
Duke Children's Hospital  
Durham, NC*

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Published online in Wiley InterScience (www.interscience.wiley.com).

DOI 10.1002/hep.21756

Potential conflict of interest: Nothing to report.

## Reply:

We agree with Dr. Jhaveri and Dr. Murray that available data show that there is no evidence of hepatitis B transmission from infected mothers to infants who are breast-fed and that breast-feeding should not be prohibited, particularly for infants who receive appropriate prophylaxis with hepatitis B immune globulin and hepatitis B vaccine. Because of space constraints, it was not possible for the guidelines to include all aspects of hepatitis B management. We appreciate Dr. Jhaveri and Dr. Murray for bringing this to our readers' attention.

ANNA S. F. LOK<sup>1</sup>  
BRIAN J. MCMAHON<sup>2</sup>  
<sup>1</sup>*Division of Gastroenterology  
University of Michigan Medical Center  
Ann Arbor, MI*  
<sup>2</sup>*Liver Disease and Hepatitis Program  
Alaska Native Medical Center and Arctic Investigations Program  
Centers for Disease Control  
Anchorage, AK*

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Published online in Wiley InterScience (www.interscience.wiley.com).

DOI 10.1002/hep.21764

Potential conflict of interest: Nothing to report.

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## External Validation of FibroIndex

### To the Editor:

We read with interest the Koda et al. report on the description of a new panel of biomarkers for predicting significant fibrosis in patients with chronic hepatitis C (CHC) called FibroIndex.<sup>1</sup> This panel was derived from the platelet count, AST, and gamma globulin measurements. They built and validated their model on a cohort of 360 CHC patients with an estimation set (n = 240) and validation set (n = 120). The areas under the receiver operating characteristic (ROC) curves of FibroIndex for predicting significant fibrosis were 0.83 and 0.82 for the validation set, better than those of the Forns index and the aminotransferase-to-platelet ratio index (APRI). The ultimate utility of any noninvasive model for prediction of hepatic fibrosis depends on its practicality and validation by other investigators in a wide range of patients.<sup>2</sup> We studied the diagnostic accuracy of the FibroIndex and compared it to APRI, Forns index, and Fibrotest in a cohort of 125 CHC patients prospectively enrolled in Fibroscore, a French national multicenter study. Of the 125, 85 (68%) were men, and mean age was 47 ± 9 years. Signed informed consent was obtained from all patients before their inclusion. Liver biopsy and biochemical markers were done the same day. Liver biopsy was performed in each center and analyzed by the resident pathologist. For all patients, ultrasound ex-

amination was performed before liver biopsy. Information relating to the patient demographic data, risk factors, virological status, clinical examinations, biological data (platelets, prothrombin time ratio, serum albumin level) was prospectively recorded in each center on the day of biopsy. All data were anonymously recorded in the database. Diagnostic accuracies were measured using area under ROC curves (AUCs), sensitivities, specificities, and positive and negative predictive values. The Hanley-McNeil test<sup>3</sup> was used to compare AUCs;  $\chi^2$  or Fisher exact test were used to compare proportions. Serum samples were taken, on the day of biopsy, for determination of biochemical markers to assess FibroIndex, APRI, Forns index, and Fibrotest. Biochemical marker analysis was performed in accredited laboratories following the guidelines recommended for Fibrotest assessment by the authors of the initial publication.<sup>4</sup>

In the hospital-based cohort, gamma glutamyl transpeptidase and total bilirubin levels were measured using a Hitachi 917 Analyzer and Roche Diagnostics reagents (both from Mannheim, Germany). Alpha2-macroglobulin, apolipoprotein A1, and haptoglobin were measured using a Modular analyzer (BNII, Dade Behring; Marburg, Germany). Platelets were measured with a Beckman Coulter LH 750 hematology analyzer. Biochemical assays were performed on fresh serum, decanted, and stored for 72 hours maximum at 2°C/8°C while