risk of acquiring hepatitis A as noted in the most recent ACIP recommendations. Because these recommendations were published concurrently with our article, they were not incorporated in our review. Nevertheless, the updated guidelines consider hepatitis A virus vaccination in settings that provide services to adults where a large proportion of persons have an increased risk of hepatitis A infection, including “for persons (e.g., residents and staff) in facilities where hygiene is difficult to maintain (e.g., group homes for persons with development disabilities, and homeless shelters).”

Third, while immunoglobulin can be used in the postexposure prophylaxis setting, we intended to highlight that an increase in dosage is recommended as of 2017, that the indications for immunoglobulin use are rare, and that immunoglobulin is often unavailable. As noted in our review, we agree that hepatitis A vaccination should be the cornerstone for postexposure prophylaxis, especially as it was shown to be noninferior to immunoglobulin.

Fourth, we concur with the updated ACIP recommendations that access to prevaccination testing should not be a barrier to receiving vaccination, particularly among high-risk groups. Vaccination is the mainstay of hepatitis A control in the United States.

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