

HEPATITIS A: Notes about the Disease

Before the hepatitis A virus (HAV) was finally isolated in 1973, the disease associated with it was commonly called “infectious hepatitis” because of its obvious transmissibility as a fecal-oral agent. Infection is usually mild, particularly in children, and there is no chronic carrier state as there is with hepatitis B and C. Hepatitis A is found worldwide.

A decade ago, hepatitis A was more common on the west coast of the United States than in eastern states like North Carolina. The licensure of inactivated hepatitis A vaccine in 1995 and its subsequent selective use in areas and populations of high endemicity has largely reduced these regional differences. More recently, it has been recommended as a routine immunization for all children beginning at 12 months of age, as well as for other previously defined high-risk groups. Even so, hepatitis A is still one of the more problematic enteric diseases for public health workers here.

Although some evidence exists for occasional percutaneous transmission of HAV during the viremic stage of infection, the great majority of cases result from fecal-oral transmission. This is most often by direct person-to-person spread, particularly among and from young children who—more often than not—are asymptotically infected. However, common source outbreaks of hepatitis A do occur from time to time via fecal contamination of food or water by a careless food handler or improperly managed sewage disposal. These can be quite large outbreaks with broad geographic distribution.¹

Silently infected young children, particularly when grouped together in settings like day care centers, present an obvious disease control problem; recognition of outbreaks originating in such groups is often delayed until symptomatic cases start appearing in adults in contact with these children. Another problem in control is generated by the beginning and peak of HAV fecal shedding occurring before onset of signs and symptoms, even in adults. All too often, public health workers are confronted with the frustrating problem of deciding how to deal with possible HAV transmission from an infected food handler when diagnosis and reporting of the case occurs days after the period of virus shedding began. In collaboration with staff of the General Communicable Disease Control Branch, the decision of whether or not to alert the public and recommend passive immune globulin (IG) prophylaxis for those who may have consumed food or drink handled by a recently infected food handler should be made carefully after consideration of several factors.^{2,3}

It is important to remember that laboratory confirmation of a recent HAV infection rests upon demonstration of IgM antibody directed against the virus (IgM anti-HAV) in the patient’s serum. Since it can persist for years, a positive test for total anti-HAV antibody does not confirm a recent infection; it simply means that the patient has had HAV infection or immunization at some undefined point in the past.

Basically, control and prevention of hepatitis A rests upon promotion of personal hygiene, immunization, and proper food and water sanitation.

1. Centers for Disease Control and Prevention. [Epidemiologic Notes and Reports: Foodborne Hepatitis A—Alaska, Florida, North Carolina, Washington]. *MMWR* 1990;39(14):[228-32], www.cdc.gov/mmwr/preview/mmwrhtml/00001599.htm.
2. AE Fiore, “Hepatitis A Transmitted by Food,” *Clin Infect Dis* 38 (2004): 705-15, www.cdc.gov/NCIDOD/diseases/hepatitis/a/fiore_ha_transmitted_by_food.pdf.
3. Centers for Disease Control and Prevention. [Public Health Dispatch: Potential Hepatitis A Exposure Among Interstate 95 Travelers—North Carolina, 1999]. *MMWR* 1999;48(32): 717, www.cdc.gov/mmwr/preview/mmwrhtml/mm4832a5.htm.