

VIRAL HEPATITIS PART III: NON-A, NON-B HEPATITIS

Health professionals have been increasingly aware that a third category of viral hepatitis exists, that which is currently designated as non-A, non-B hepatitis. It is defined as an acute viral hepatitis for which type A and type B etiologies are ruled out. Hence, the diagnosis of non-A, non-B hepatitis is one of exclusion until specific serological testing becomes routinely available. Non-A, non-B hepatitis was first described as a transfusion-transmitted hepatic syndrome, and today probably 80% to 90% of transfusion hepatitis is known to be due to non-A, non-B infection. It is estimated that non-A, non-B hepatitis also accounts for as much as 13% to 25% of all sporadic hepatitis, 20% of all hepatitis infections occurring in medical personnel, 5% of all hepatitis in homosexually active males, and 5% of hepatitis acquired while traveling abroad.

Laboratory investigations and experimental inoculation studies in primates have provided evidence for a minimum of three non-A, non-B agents. In this country at least two agents have been associated with blood and blood products. Evidence for the presence of two viruses has come from studies in which chimpanzees, after inoculation with serum from one non-A, non-B patient, were challenged with material from a second patient. The chimpanzees developed hepatitis, indicating that they had no protective immunity from the first exposure.

The epidemiology of these transfusion-transmitted agents is somewhat similar to that for hepatitis B, at least in the United States. The incubation period varies from 15-180 days with an average of approximately 60 days. The onset is insidious as is that for type B, and the course of the disease is prolonged. In general, these are somewhat milder infections than typical acute hepatitis B cases. Non-A, non-B hepatitis infections are more commonly anicteric than hepatitis B infections, and the level of SGOT and SGPT enzymes (AST and ALT respectively) may not be as high as with hepatitis B. However, as many as 10% to 40% of non-A, non-B hepatitis cases will go on to develop some form of chronic liver disease, and epidemiologic evidence suggests that a carrier state exists for those non-A, non-B viruses transmitted through transfusion and percutaneous inoculation.

A third non-A, non-B hepatitis agent has been described in epidemics in India. This virus more closely resembles hepatitis A in its epidemiology (fecal-oral transmission, epidemic presentation). It differs from hepatitis A, however, in that it is more prevalent in adults, and the severity of the disease, especially among pregnant women, is much greater than that for hepatitis A. This virus infection also differs from the transfusion-associated non-A, non-B infection in that there is a striking absence of chronic sequelae among patients of epidemic non-A, non-B hepatitis. As with the agents transmitted by parenteral means, much more work needs to be done to clarify the nature of this A-like virus so that a definitive serological test can be developed.

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Since non-A, non-B hepatitis in this country commonly is associated with transfusiontransmitted hepatitis, it has been suggested that blood banks and hospitals routinely screen for these agents. Unfortunately, such test methodology is not available at present.

Recently, two major studies (Transfusion Transmitted Viruses Study and a National Institute of Health [NIH] study) provided evidence for an association between the transfusion of donor blood with elevated liver enzymes (ALT) and post-transfusion ALT elevations in recipients. These studies suggest that post-transfusion hepatitis might be reduced by as much as 30% if all donor blood were tested for ALT levels and those units with elevated ALT discarded. Presently, it is not practical for routine checks on enzyme levels to be performed, except in emergency situations when blood banks of hospitals may have to resort to the use of commercial blood donors. Other investigators recently examined the costs and benefits of a proposed nationwide ALT screening program for blood banks. The overall cost of such a program was estimated to be \$42.2 million, and the researchers concluded that a definitive policy statement could not be made at this time.

There is, in general, a lack of solid information about the natural history (frequency and severity) and medical consequences of non-A, non-B hepatitis. Thus, solid estimates of costs involved in the treatment and management of cases cannot be provided at this time for comparision with the costs of screening. In addition, no randomized prospective study has shown that the exclusion of blood from donors with elevated ALT levels lowers the incidence of either symptomatic or asymptomatic post-transfusion hepatitis. If future studies do show a decrease in incidence of non-A, non-B hepatitis in transfusion recipients as a result of excluding units with elevated ALT levels, there may be a positive economic gain from screening. It is clear that further debate and additional clinical and economic studies on this issue need to continue.

There are, however, alternative solutions to this problem today. These include a more judicious use of blood and blood products, more effective inventory controls, better use of autotransfusion procedures, and, perhaps most importantly, an even stronger commitment to supporting all-volunteer blood donor programs in the community.

Health professionals are reminded that hepatitis is a reportable disease in Texas. The surveillance information gathered is employed routinely to help prevent further cases and may help to bring about an earlier understanding of this disease.

For epidemiologic or consultative assistance, contact the Bureau of Epidemiology, Texas Department of Health (TDH) at (512)458-7328 or STS 824-9328.

This report was prepared by Lynne Sehulster, Ph.D., Staff Epidemiologist, Bureau of Epidemiology, TDH.

We are indebted to Dr. James Shorey, Liver Unit, Dallas VA Medical Center, Dallas, Texas 75216 for current information on non-A, non-B hepatitis.

References for this article are available upon request from the Bureau of Epidemiology, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756.

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## WARNING

Parents of very small children are cautioned not to hang glass Christmas tree ornaments on the lower branches of the tree within reach of these children. It is fairly easy for a child to remove an ornament, place the ornament in its mouth, and bite.

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ANEBIASIS	7	3 4	455	66 <b>360</b>				
ANTHRAX	Ó	Ū,	435	560				
BOTULISM	õ	õ	ũ	2				
BRUCELLOSIS	0	٥	27	71				
CHICKENPOX	224	57	10491	14299				
CHOLERA	٥	0	٥	0				
DIPHTHERIA	0	0	1	õ				
ENCEPHALITIS, ST. LOUIS	0	1	18	2				
ENCEPHALITIS, WESTERN EQUINE	0	0	4	1				
ENCEPHALITIS, VENEZUELAN EQUINE	D	0	Û	0				
ENCEPHALITIS, ALL OTHER	5	2	150	105				
LEPROSY (HANSENS DISEASE)	0	٥	27	32				
LEPTOSPIROSIS Malaria	1	0	14	0				
MALARIA ACQUIRED OUTSIDE USA	0	0	0	0				
HREARIN ACQUIRED DUISIDE DSA	2	0	52	44				
NUMPS	27	6	243	211				
PERTUSSIS PLAGUE	0	0	72	87				
POLIOHYELITIS, PARALYTIC	0	0	1	0 0				
PSITTACOSIS	1	0	8	5				
	•	ų	8	5				
Q FEVER	0	0	1	0				
RABIES IN MAN	٥	0	0	0				
RELAPSING FEVER	ņ	a	4	0				
RHEUMATIC FEVER	1	0	12	12				
RUBELLA CONGENITAL SYNDROME	Û	0	٥	0				
SALMONELLOSIS	21	51	2320	2281				
SHIGELLOSIS	13	55	2066	1833				
STREP THROAT & SCARLET FEVER Reye syndrome	1102	716	44682	35147				
TETANUS	8	· 0	,	18				
TETANUS	Q	U	6	6				
TRICHINOSIS	· 0	0	2	1				
TULAREMIA	1	1	11	10				
TYPHOID FEVER	2	0	34	48				
TYPHUS, EPIDEMIC	٥	0	0	0				
YELLOW FEVER	ð	0	0	٥				

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RABIES IN ANIMALS

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