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Hepatitis A Recommendations

Hepatitis A continues to spread in rural Alaska. During 1987, 222 cases were reported to the Section of Epidemiology. Of these 222 cases, 109 (49%) were reported from 13 villages in the Yukon-Kuskokwim Delta region. Cases of hepatitis A were documented in 34 villages and towns in Alaska in 1987. New cases continue to be reported weekly.

Intensive efforts have been undertaken during the past six months to follow-up contacts of identified cases and to offer IG to household contacts when appropriate. In spite of these intensive efforts, and as anticipated, hepatitis A has continued to spread both among village residents and to new villages.

Experience from the last major epidemic in Alaska during 1972-1977 showed that IG was not effective in stopping the outbreak. Because of this, we are making the following recommendations:

1. In some villages, so many individuals have become infected that routine recommendations for IG administration to family contacts cannot be implemented. When faced with these circumstances, physicians and other health care providers will need to make clinical judgments about the potential benefits, if any, of offering IG to contacts of hepatitis A cases. These decisions must be based on numbers of individuals affected in the villages, age of those affected, and available resources of manpower and funds.
2. One of the most effective ways to prevent spread of hepatitis A is through careful and frequent handwashing and meticulous personal hygiene. The role of handwashing should be emphasized. Even though it may be very difficult in rural Alaska to wash hands frequently, handwashing is the single most protective measure to decrease the risk of infection.
3. In order to have an understanding of the spread of hepatitis A in the region, surveillance and prompt reporting of cases is of utmost importance.
4. No special trips by PHNs or physicians should be taken to obtain blood specimens or to give IG. Routine blood drawing in villages to diagnose cases cannot be justified. Individuals with symptoms of hepatitis who are seen at hospitals or in other circumstances where obtaining a blood sample is easy should be tested. The purpose of this, however, is only to document the diagnosis of hepatitis A. Once hepatitis A has been confirmed in a village, no further blood drawing should be undertaken routinely on new cases.
5. As the outbreak continues to spread, close communication between community health aides and village physicians must occur. Community health aide activities should be reviewed frequently to prioritize activities and to assure that important routine duties are not compromised. Hepatitis A follow-up should not divert other important functions or activities of the CHA in the village.
6. Adults who are not from the Yukon-Kuskokwim Delta area and have never had hepatitis A may want to consider obtaining IG prophylaxis before traveling to the Yukon-Kuskokwim area. The decision to administer IG prophylaxis should be made based upon risk of exposure. For such travelers, workers, or visitors, a single dose of IG of 0.02 ml/kg is recommended if travel will be less than two months. For prolonged travel, 0.06 ml/kg should be given every 5 months.
7. For persons who require repeated IG prophylaxis, screening for hepatitis A before travel may be useful to define susceptibility and eliminate unnecessary doses of IG in those who are already immune.
8. 8. If an individual had hepatitis A in the past, he will not get hepatitis A again, and there is no need for IG.