State of Alaska Epidemiology **Bulletin**

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HEPATITIS A--RURAL SPREAD CONTINUES

Interim Recommendations for Control

Since our bulletin of July 17, 1987 documenting continued rural spread of hepatitis A, we have continued to identify new cases in rural Alaska. 156 cases have now been reported to the Section of Epidemiology since January, 1987. This includes 14 cases since our July bulletin. Of these 14 cases, 9 were documented in two villages close to Bethel; Kasigluk and Atmauthuak. These cases are occurring in school age children similar to the outbreaks identified earlier at Newtok and Toksook Bay.

Hepatitis A is now endemic in the Yukon-Kuskokwim Delta area. Fortunately, most cases of hepatitis A are not too serious. Common symptoms are nausea, vomiting, and loss of appetite for a few days or week. Often, the skin and eyes become yellow. On rare occasions hepatitis A may cause death. In general, children do not get as sick as adults.

There is no treatment for hepatitis A. Immune globulin (IG), if given immediately after exposure, can sometimes prevent illness in contacts. It is not fully protective however.

In an effort to limit the spread of hepatitis A, we are making the following interim recommendations:

1. It must be emphasized that the most important measures to protect against hepatitis A are good personal hygiene and proper disposal of human waste. Individuals can protect themselves.

2. IG will provide protection against hepatitis A when administered before exposure or during the incubation period of the disease. IG is recommended for all family, household contacts who have not already had hepatitis A only if it can be administered within 14 days of onset of disease. Casual contacts (e.g., people who occasionally eat meals in the house of a person with hepatitis even though related) are not candidates for IG.

3. 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.

4. For persons who require repeated IG prophylaxis, screening for hepatitis A IgG before travel may be useful to define susceptibility and eliminate unnecessary doses of IG in those who are already immune. The decision to administer IG prophylaxis should be based upon risk of exposure.

5. It is important to realize if a patient has had hepatitis A in the past, he will not get hepatitis A again and there is no need for him to receive IG.

6. Serological testing to confirm the diagnosis of hepatitis A in individuals acutely ill with symptoms is available free of charge from the Northern Regional Laboratory (474-7017).

All suspected or diagnosed cases of hepatitis A should be reported immediately to the Section of Epidemiology, 561-4406 or through the rapid telephonic reporting system (1-800-478-1700).