

HEPATITIS A

CRUDE DATA	
Number of Cases	888
Annual Incidence ^a	
LA County	9.7
California	12.8
United States	8.6
Age at Onset	
Mean	22.5
Median	14.5
Range	3 mos-95 yrs
Case Fatality	
LA County	0.0%
United States	N/A

^aCases per 100,000 population.

ETIOLOGY

Hepatitis A virus.

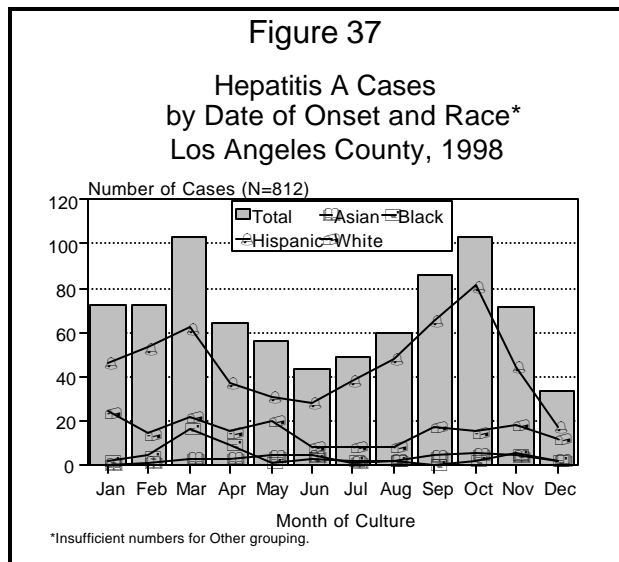
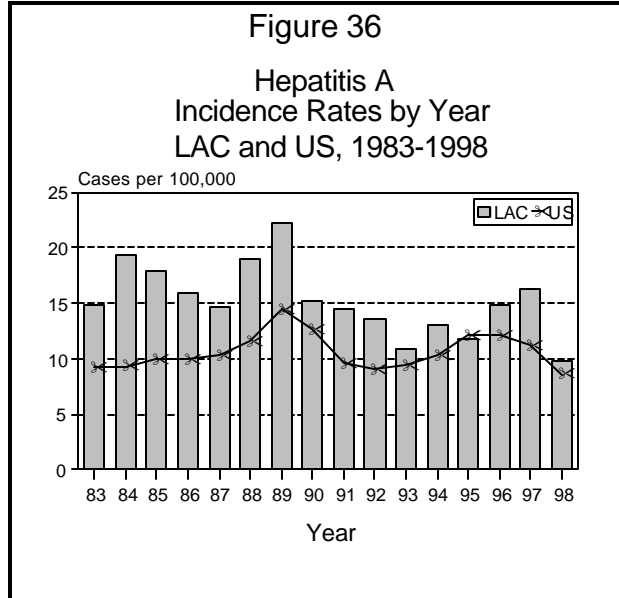
DISEASE ABSTRACT

Hepatitis A is an RNA viral disease usually transmitted by the fecal-oral route. Age, race, and gender each can influence disease incidence. Hepatitis A is the most common etiologic agent of viral hepatitis.

STRATIFIED DATA

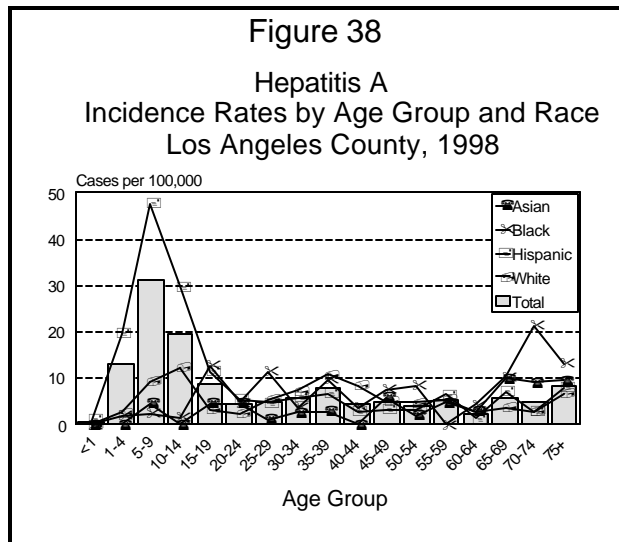
Trends: Hepatitis A rates increased steadily in Los Angeles County from 1993 to 1997 but the 1998 hepatitis A crude rate (9.7 per 100,000 population) decreased 40% over the 1997 rate of 16.4 per 100,000. In 1998, LAC rates were more in accordance with the national rate of 8.6 per 100,000 (Figure 36).

Seasonality: With an exception of a peak in March, the increase in hepatitis A cases historically observed in late summer and early autumn was observed again in 1998 (Figure 37). A large portion of this increase was due to



the disease occurrence among Hispanics. Cases among Whites and Asians were distributed throughout the year while hepatitis A cases among Blacks peaked early in the year. Small case numbers in the “Other” grouping precluded detailed analysis.

Age: The overall mean age for hepatitis A cases in 1998 was 22.5 years. The mean age for Hispanic cases was 15 years, while Black, White, and Asian cases had means of 35, 36, and 40 years, respectively. The age-specific rate was highest in the 5- to 14-year-olds (27.1 per 100,000 population) mostly due to the incidence of the Hispanic cases (39.9 per 100,000) in that age group. Asian rates peaked in the 65 and older group, (9.5 per 100,000), the White rate peaked in the 35- to 39-year-old group (10.8 per 100,000) while Black incidence peaked in the older 70- to 74-year-old group (21.4 per 100,000) (Figure 38). The increased rates for Blacks and Asians in the older age groups could be a result of a change in methodology for the 1998 population estimates (see Demographic Data section).



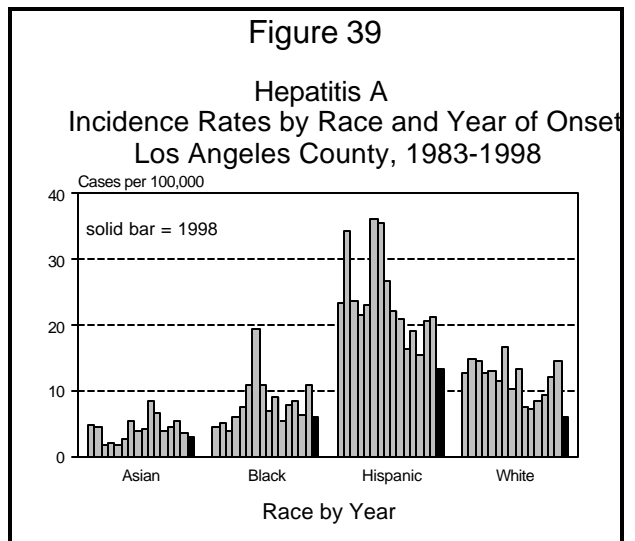
Sex: The overall hepatitis A male-to-female rate ratio was 1.2:1. The gender rate ratio for Asian, White and Hispanic case rates had a higher proportion of males, 1.8:1, 1.7:1, and 1.1:1, respectively. The difference of case rates between males and females for Blacks was minimal.

Race/Ethnicity: The overall crude rates decreased for all races in 1998. The observed highest 1998 rate, as seen in prior years, was among Hispanics. Case frequency among Black, Asian, and Other groups (48, 34, and 3, respectively) limited statistical confidence. The ranking of rates by race/ethnicity did not change from previous years except that Whites and Blacks had similar rates of disease (Figure 39).

Location: Map 5 shows district-specific hepatitis A rates for 1998. The highest rates were in Southeast (30.5 cases per 100,000 population), Northeast (14.8 cases per 100,000 population), Hollywood-Wilshire (13.9 cases per 100,000 population), East Los Angeles (13.6 cases per 100,000 population), Harbor (13.0 cases per 100,000 population), and San Antonio (12.9 cases per 100,000 population) Health Districts.

Severity of Illness: Of the cases reported in 1998, 61% reported jaundice and 9% were hospitalized for their illness. No fatalities were reported.

Risk factors (two to six weeks prior to



illness): Recent travel (24%) was the most common risk factor reported by 1998 hepatitis A cases. Of the cases that traveled, 86% (163/190) traveled outside of the United States to South/Central America (including Mexico). Most of the cases traveled for more than seven days (79%). The second most frequently reported factor was contact to a confirmed or suspected hepatitis A case (22%) with the type of contact being reported as 61% household (non-sexual), 8% sexual (most described themselves as heterosexual), and 31% other. Other factors reported in greater than or equal to 5% of the cases were consuming shellfish (7%), being a child or employee of a nursery, day care or preschool (5%), and being a household contact to a child or employee in childcare (5%). Very few individuals reported being a food handler (14), being part of common-source foodborne or waterborne outbreak (12), or using needles for injection of street drugs (6).

PREVENTION

Good hygiene remains the primary preventive measure for hepatitis A. Vaccine for pre-exposure situations has been available since 1995. The vaccine remains a special population group vaccine and widespread usage in community settings has not occurred in LAC although expanded availability and usage is expected for 1999. Immune globulin is used for post-exposure and/or short-term pre-exposure situations; however, availability has been limited. The benefits of hepatitis A vaccine in post-exposure prophylaxis remains unclear.

COMMENTS

There was a dramatic drop in the number of cases for 1998 (888) compared to 1997 (1,546). This decrease may be a result of a special study done on hepatitis A and extra vigilance in cleaning and validating the surveillance records. To examine the effect, we selected a random sample of 102 case reports from 1997 and applied the 1998 case definition to the 1997 cases. For the 1998 data, we used the case definition for hepatitis A produced by the Council of State and Territorial Epidemiologists. Twenty-two percent of the 1997 cases did not fit the 1998 case definition, which at a minimum excludes 340 cases from the 1997 total leaving 1206 cases. However, even using a stricter case definition there still remains a 27% decrease in the frequency of hepatitis A from 1997 to 1998. It should also be noted that a similar unexplained 30% decrease from 1997 to 1998 was also observed in other enterics like salmonellosis, campylobacteriosis, and shigellosis. Under-reporting may be a factor.

MAP 5. Hepatitis A

Rates by Health District, Los Angeles County, 1998*

