

March/April 2007 HepTalk Listserv

Current News is our focus for March and April. **The Surveillance Summary for Acute Viral Hepatitis** released in March indicates declining rates of all three common types of Hepatitis, A, B, and C. Underlying the good news is the continuing importance of making sure that adults, especially in segments of the population still living outside of the reach of most health care systems, are screened, offered B vaccination, educated about risks, and tested as necessary (see **bold red text** below—our emphasis).

We also include two new articles: **Connecting The Dots: When the Risks of HIV/STD Infection Appear High But the Burden of Infection Is Not Known-The Case of Male Latino Migrants in the Southern United States**, and **Convenience is the key to hepatitis A and B vaccination uptake among young adult injection drug users**. These articles are about understudied and difficult to reach--but key--groups in the fight to reduce hepatitis: young adult injection drug users, and young male Latino migrants.

1. Surveillance for Acute Viral Hepatitis --- United States, 2005

MMWR Surveillance Summaries

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full text <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5603a1.htm?s_cid=ss5603a1_e>

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Abstract

Problem/Condition: In the United States, acute viral hepatitis most frequently is caused by infection with hepatitis A virus (HAV), hepatitis B virus (HBV), or hepatitis C virus (HCV). These unrelated viruses are transmitted through different routes and have different epidemiologic profiles. Safe and effective vaccines have been available for hepatitis B since 1981 and, for hepatitis A, since 1995.

Reporting Period: Cases in 2005, the most recent for which data are available, are compared with those from previous years.

Description of the System: Cases of acute viral hepatitis are reported to CDC via the National Notifiable Diseases Surveillance System.

Results: Since 1995, the incidence of reported acute hepatitis A has declined by 88%, to the lowest rate ever recorded (2005: 1.5/100,000 population). Declines were greater among children and in states where routine vaccination of children was recommended beginning in 1999, compared with the remaining states. The proportion of cases among adults has increased. Since 1990, reported acute hepatitis B incidence has declined by 79%, to the lowest rate ever recorded (2005: 1.8/100,000 population). Declines occurred among all age groups but were greatest among children aged <15 years. Since the late 1980s, acute hepatitis C incidence also has declined. In 2005, as in previous years, the majority of these cases occurred among adults, and injection-drug use was the most common risk factor.

Interpretation: The greater declines in hepatitis A rates among the states and age groups included in the 1999 recommendations for routine childhood hepatitis A vaccination suggest that this strategy reduced rates. Universal hepatitis B vaccination of children has resulted in substantially lower rates among younger age groups. **Higher rates of hepatitis B continue among adults, particularly males aged 25--44 years, which emphasize the need to vaccinate adults at risk for HBV infection.** The decline in hepatitis C incidence is primarily attributed to a decrease in incidence among injection-drug users (IDUs). The reasons for this decrease are multifactorial and are probably related to risk-reduction practices among IDUs.

Public Health Actions: The recent expansion of recommendations for routine hepatitis A vaccination to include all children in the United States aged 12--23 months is expected to further reduce hepatitis A rates. Ongoing hepatitis B vaccination programs will ultimately eliminate domestic HBV transmission, and increased vaccination of adults who have risk factors will accelerate progress toward elimination. **Prevention of hepatitis C relies on identifying and counseling uninfected persons at risk for hepatitis C (e.g., IDUs) regarding ways to protect themselves from infection.**

Introduction

Viral hepatitis is caused by infection with any of at least five distinct viruses, of which the most commonly identified in the United States are hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV). All three viruses can cause an acute illness characterized by nausea, malaise, abdominal pain, and jaundice. HBV and HCV also can produce a chronic infection that is associated with an increased risk for chronic liver disease and hepatocellular carcinoma.

HAV is transmitted through the fecal-oral route, spreading primarily through close personal contact with an HAV-infected person. Hepatitis A has been one of the most frequently reported notifiable diseases in the United States; during 1987--1997, an average of 28,000 cases of acute hepatitis A was reported for each year. However, effective vaccines to prevent HAV infection have been available in the United States since 1995. These vaccines have provided the opportunity to reduce substantially disease incidence and potentially eliminate transmission.

Since 1996, hepatitis A vaccine has been recommended for persons at increased risk for infection, including international travelers, men who have sex with men (MSM), injection- and noninjection-drug users, and children living in communities with high rates of disease (1). In 1999, the Advisory Committee on Immunization Practices (ACIP) recommended that 1) routine hepatitis A vaccination be implemented for children living in 11 states (10 in the West and one in the South) where the average hepatitis A rates during 1987--1997 were at least 20/100,000 population (2) and that 2) hepatitis A vaccine be considered for children in six states where rates were at least 10/100,000 but less than 20/100,000.

HBV is transmitted parenterally; therefore, the virus can only be transmitted through exposure to the blood or body fluids of an infected person. Transmission occurs through exposures such as injection-drug use, sexual contact with an infected person, and from an infected mother to her infant during delivery. Beginning in 1991, a comprehensive strategy for the elimination of HBV transmission was implemented in the United States (3). The four elements of this strategy are 1) universal vaccination of infants beginning at birth; 2) prevention of perinatal HBV infection through routine screening of all pregnant women for HBV infection and by providing immunoprophylaxis to infants born to infected women or to women of unknown infection status; 3) routine vaccination of previously unvaccinated children and adolescents; and 4) vaccination of adults at increased risk for infection, including health-care workers, dialysis patients, household contacts and sex partners of persons with chronic HBV infection, recipients of certain blood products, persons with a recent history of multiple sex partners or a sexually transmitted disease, MSM, and injection-drug users (IDUs).

HCV, also transmitted parenterally, is the most prevalent bloodborne infection in the United States; approximately 3.2 million persons are chronically infected with HCV (4). No vaccine for this infection is available. **National recommendations issued in 1998 for prevention and control of HCV infection (5) emphasize primary prevention activities to reduce the risk for HCV transmission. These activities include screening and testing blood donors, viral inactivation of plasma-derived products, risk-reduction counseling for persons at risk for HCV infection, and routine practice of infection-control precautions in health-care settings.** This report describes the burden of acute hepatitis attributed to infection with HAV, HBV, or HCV and summarizes trends in the incidence of these diseases through 2005.

2. Connecting The Dots: When the Risks of HIV/STD Infection Appear High But the Burden of Infection Is Not Known-The Case of Male Latino Migrants in the Southern United States.

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Between 1990 and 2000, the number of Latinos in Alabama, Arkansas, Georgia, North Carolina, South Carolina, and Tennessee, states that had no or small Latino populations in 1990, increased by more than 300% on average. Several of these states (referred to as rapid growth states) have high AIDS/STD case rates. Compared to Latinos in states with well-established Latino populations and Latinos nationwide, those in rapid growth states are more often males, young, foreign-born, and recent arrivals who travel without females. The typical Latino in rapid growth states is a young male migrant. Although these migrants may be at risk of HIV/STD infection, little is known about the risk factors that affect them. To clarify this picture, a database search was conducted to identify studies of HIV/STD infection and/or risk factors among rural and urban-based Latino migrants in the six rapid growth states. This qualitative review examines ten studies that were conducted in Alabama, Georgia, North Carolina, and South Carolina. Five of the studies screened for HIV and/or syphilis infection and provide some information on risk factors; five studies describe risk factors only. Most of those studies that describe risk factors provide evidence that male Latino migrants in rural and urban settings of rapid growth states are vulnerable to HIV/STD infection through heterosexual contacts. However, many of the studies fail to provide sufficient information on other risk factors, and all but one of the studies that screened migrants for HIV or STD infection were conducted between 1988 and 1991. There is an urgent need for updated information on HIV/STD infection and the social-behavioral and situational risk factors that affect male Latino migrants in rapid growth states of the South.

3. Convenience is the key to hepatitis A and B vaccination uptake among young adult injection drug users.

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BACKGROUND: Despite CDC recommendations to vaccinate injection drug users (IDUs) against hepatitis A virus (HAV) and hepatitis B virus (HBV) infections, coverage remains low. Vaccination programs convenient to IDUs have not been widely implemented or evaluated. We assessed whether convenience and monetary incentives influenced uptake of free vaccine by 18-30-year-old IDUs in five U.S. cities. **METHODS:** IDUs recruited from

community settings completed risk behavior self-interviews and testing for antibodies to HAV (anti-HAV) and hepatitis B core antigen (anti-HBc). Vaccine was offered presumptively at pre-test (except in Chicago); on-site availability and incentives for vaccination differed by site, creating a quasi-experimental design. RESULTS: Of 3181 participants, anti-HAV and anti-HBc seroprevalence was 19% and 23%, respectively. Although 83% of participants were willing to be vaccinated, only 36% received ≥ 1 dose, which varied by site: Baltimore (83%), Seattle (33%), Los Angeles (18%), New York (17%), and Chicago (2%). Participation was highest when vaccine was available immediately on-site and lowest when offered only after receiving results. Monetary incentives may have increased participation when on-site vaccination was not available. CONCLUSION: IDUs were willing to be vaccinated but immediate, on-site availability was critical for uptake. Convenience should be a key consideration in designing strategies to increase vaccine coverage among IDUs.

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HepTalk is a project of the Migrant Clinicians Network and Community Health Education Concepts. HepTalk is funded by the Centers for Disease Control and Prevention. The goal of HepTalk is to help clinicians serving migrants and recent immigrants engage in productive discussions about hepatitis risks with their clients and help them make prevention plans. The HepTalk listserv is a support service for clinics participating in the project. This is a post-only listserv and postings will come from HepTalk staff about once a month. If others at your clinic would like to be on the listserv, or if you have questions about the listserv or resources listed here, or if you would like to add something to the posts, please contact Kathryn Anderson, HepTalk training and education coordinator and listserv administrator, at dempander@earthlink.net. You can also contact the listserv administrator if you would like to unsubscribe from the list.