HEPATITIS Non – A, Non – B

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Hepatitis Non-A Non-B

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In our last issue, we covered Hepatitis A and B. In this issue, we shall cover Hepatitis Non-A Non-B which will complete the article on Hepatitis.

Hepatitis Non-A Non-B is diagnosed by excluding other viral hepatitis. It may cause about 25 per cent of sporadic cases of acute viral hepatitis and it is known to cause the majority of post transfusion hepatitis.

Let us now turn to chronic hepatitis. This is liver dysfunction that lasts 6 months following an acute viral infection. It can be caused by several viruses including Hepatitis B, Hepatitis Non-A Non-B. Chronic hepatitis is not uncommon. It occurs throughout the world, affects all races and a wide age range. Female to male ratios is 3:1 and higher incidence rates tend to occur in young women. It usually presents with non-specific features such as fever and fatigue. The presence of jaundice and right upper abdominal pain points to a liver problem. In severe cases, the abdomen distends with fluid ascitis; the spleen enlarges and patients may vomit blood due to enlarged vessels in the wall of the oesophagus. The liver itself may be enlarged and dilated blood vessels under the skin may show and the palms may appear bloodshot.

The diagnosis of chronic hepatitis is sometimes difficult where the patient does not remember any acute attack of hepatitis! Frequently though, a positive history of acute hepatitis combined with clinical features

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reveals useful hints confirmed by tests of liver function.

Ultra sound and CT scans may occasionally be done when and where affordable. No specific treatment is known. Supportive measures are similar to those instituted for acute hepatitis. Use of some drugs is now being advocated but there is no room for their use without a doctor's instructions. Liver transplants if and when possible and practical provide potentially viable remedies but they are not without their disadvantages.

The commonest and most feared complications of chronic hepatitis include cirrhosis, liver failure and liver cancer. The five-year survival varies from 50-97 per cent and causes of death include complications of cirrhosis, bleeding and cancer of the liver.

Prevention

Starting with hepatitis A, the virus is present in the stool at least a few days before onset of jaundice and certainly before the diagnosis is made. It is probably gone from stool one week after the onset of jaundice. Therefore the person with fever of unknown origin or undiagnosed gastro-intestinal complaints may be much more infectious than the patient diagnosed to have viral hepatitis. Thus, it is far better to understand that all faeces are potentially infectious. Prevention of the disease depends heavily on control of transmission which is based on improved hygiene, sanitation and general socio-economic status. Public food handlers must be checked and confirmed to be free of the virus frequently, wash their hands and utensils thoroughly; and sewage pollution of waterways must be stopped. While we appreciate that measures may be beyond one individual, only the contribution of each individual will constitute that of the community, a nation and/or population at large.

The association of Hepatitis B with chronic hepatitis, cirrhosis and liver cancer underlines for each one of us the importance of the prevention of the disease, and hence the control of its transmission. Screening of all blood for transfusion, proper sterilisation of equipment used in surgery, use of disposable needles, limitation of indiscriminate sex or at least the use of condoms, all contribute heavily to the control of Hepatitis B.

The difficulty in putting boundaries lies in the fact that agents which are usually transferred through blood can also infect through the mouth. It would therefore indeed be true to say, "Keep clean and avoid the injection needle" to control hepatitis.

Hepatitis B can also be prevented or at least minimised by intramuscular injections of an immune blood protein, specially prepared. When and where available, this is usually given to people who have been exposed to infected blood in circumstances likely to cause infection. These include incidental needle puncture; gross personal contamination with infected blood or exposure to infected blood in presence of cuts and grazes. It is given at most within a week of exposure.

Better still, a Hepatitis B vaccine is now available and produces active immunisation. The vaccine gives a high degree of protection and has proved safe but it is expensive and the supplies limited. Its use is recommended and is now highly advisable in those at special risk of infection who are not already immune. These include the haemophiliacs, drug addicts, homosexuals, spouses of chronic hepatitis B carriers, patients on long term renal dialysis, media medical staff where there is a special risk as in emergency rooms, intensive care units, renal, liver and oncology units. The vaccine is ineffective in those already infected by the Hepatitis B virus.

Conclusion

Viral hepatitis and especially the B type, causes severe acute liver dysfunction which commonly progresses to chronicity. Both the acute and chronic forms could cause the potentially lethal liver failure. This danger is compounded by the inherent potential for transformation of the chronic liver disease into cancer of the liver, a lethal cancer. The disease has no known definite cure and all lies in attempts to prevent it. Let us join hands with the medical personnel in improving our hygiene and avoiding unnecessary injections.