**Reviewer’s Comments**



**PREVALENCE OF HEPATITIS A VIRUS, HEPATITIS B VIRUS, AND HEPATITIS C VIRUS, AMONG PATIENTS WITH HEPATIC JAUNDICE IN SANA’A CITY, YEMEN: A HOSPITAL BASED STUDY**

ABSTRACT

**Background**: Hepatic jaundice results from abnormal metabolism of bilirubin in the liver. The main causes of hepatic jaundice are severe damage to hepatocytes due to infectious diseases, drugs/ medication induced, autoimmune diseases or, less commonly, hereditary genetic diseases. **Aim:** The aim of this study is to determine the prevalence of hepatitis A virus (HAV) and hepatitis B Virus (HBV), and hepatitis C virus (HCV), in patients with hepatic jaundice as causes of acute viral hepatitis (AVH) in Sana'a city, Yemen. **Materials and Methods**: Data of patients with hepatic jaundice tested for hepatitis B surface antigen, total anti-HCV antibody, and anti-HAV immunoglobulin M (IgM) by enzyme-linked immunosorbent assay were collected from Class I Viral Diagnostic Laboratories in Sana'a ( Department of Laboratories, University of Science and Technology Hospital, Al-Olagi Private Laboratory, and the National Center for Public Health Laboratories in Sana’a, Ministry of Health and Population) for 3 years. Then the statistical analysis of the data was used where the descriptive analysis was calculated: frequency and percentage, as well as the association of infection with sex and age group by means of detection odds ratio, 95% CI and X2 more than 3.9 and P<0.05 were considered statistically significant. **Results:** The study included 644 males (43.8%) and 826 females (56.2%), while most patients were less than 21 years old. The rate of Hepatitis viruses positive was 27.6% positive. Hepatitis A virus infection was the most common virus diagnosed among patients with jaundice accounting for 259 cases (17.6% of the total), while HBV was less common with 104 (7.1%) and HCV only 42 cases (2.9%).The highest incidence of hepatitis A was in 2-10 years patients (44.4%), with an associated OR 19.3 (p < 0.0001). While the rates of hepatitis A virus infection in the older age groups were very low and ranged between 0 and 6.8%. The highest incidence of hepatitis B was in 11-20 years patients (18.2%), with an associated OR 9.3 (p < 0.0001). The highest incidence of hepatitis C was in 31-40 years patients (7.3%), with an associated OR 3.3 (p < 0.0001). While the rates of hepatitis C virus infection in younger age group (2-10 years) was 0%. **Conclusions:** Alarmingly changing the epidemiology and dynamics of hepatitis A-C viruses in Yemen, a detailed study is required to understand the definite disease problem caused by these viruses. It is noticeable in this study the high prevalence of hepatitis A virus and hepatitis B virus in the Yemeni population with hepatic jaundice. Also, to our knowledge, this study is the first to report epidemiological transformation of hepatitis A virus in Sana'a, Yemen.

**Key words:** Hepatic jaundice, , Hepatitis A virus, Hepatitis B virus, Hepatitis C virus, prevalence, Sana’a, viral hepatitis, Yemen

**INTRODUCTION**

Hepatic jaundice results from abnormal metabolism of bilirubin in the liver. The main causes of hepatic jaundice are severe damage to the liver cells due to infectious agents such as viral hepatitis and leptospirosis, drug/drug-induced hepatitis, autoimmune etiologies or, less commonly, due to hereditary genetic diseases such as Gilbert's syndrome, Crigler-Najjar syndrome, type I and Crigler-Najjar syndrome type II 1,2. Liver disease caused by hepatitis virus is a major global public health problem influence millions of people worldwide 3,4. A distinctive group of hepatitis A (HAV), hepatitis B (HBV), hepatitis C (HCV), hepatitis E (HEV), hepatitis D virus (HDV), and newly classified hepatitis viruses such as hepatitis G (HGV) are responsible for liver disease. The whole of these viruses are connected with considerable mortality and morbidity in developed and developing countries5,6. In 2015, the World Health Organization expected 1.34 million deaths from viral hepatitis with hepatitis B, and HCV being a leading cause of death7. Clinical findings of viral hepatitis can range from subclinical to life-threatening infection6,8,9. HAV and HEV are transmitted by ingestion of contaminated food or water by human feces 10; While hepatitis B virus and HCV are transmitted mainly by perinatal route, including saliva exchange; by sexual contact, from mother to offspring by vertical transmission, and exposure to infected blood products 11. HAV and HEV typically have an effect on children and young adults correspondingly, and are endemic in numerous developing countries in Africa and Asia12; While HBV and HCV are mostly reported from adults and are found intermittently in North America, Western Europe, and other developed countries 13 HAV and HEV most cases are undetectable clinically or self-healing; while 70-80% of acutely infected with hepatitis B and HCV develop chronic hepatitis 14, 15. Only recently, there were few reliable commercial assays (sensitive and specific) for the detection of hepatitis viruses (HAV, HEV, HCV, and HBV) antigens and antibodies that could be used for routine diagnosis. Even though newly new assays have been developed that demonstrate high sensitivity and specificity, make available for more perfect detection/diagnosis of hospital cases. On the other hand, the high cost of these assays has limited evaluation in developing countries such as Yemen.

The prevalence of hepatitis viruses in Yemen has been estimated to be high, but detailed information regarding the current status of infection due to hepatitis viruses in Yemen is still insufficient to understand the burden of hepatitis disease due to the limitation of these studies in which only HBV, HCV and HGV were studies while there are no studies discusses the endemicity of HAV and HEV in Yemen16-26. The aim of this study is to determine the prevalence of hepatitis A virus (HAV) and hepatitis B Virus (HBV), and hepatitis C virus (HCV), in patients with hepatic jaundice as causes of acute viral hepatitis (AVH) in Sana'a city, Yemen.

**MATERIALS AND METHODS**

**Data collection:**

Data of patients with hepatic jaundice tested for hepatitis B surface antigen, total anti-HCV antibody, and anti-HAV immunoglobulin M (IgM) by enzyme-linked immunosorbent assay were collected from Class I Viral Diagnostic Laboratories in Sana'a ( Department of Laboratories, University of Science and Technology Hospital, Al-Olagi Private Laboratory, and the viral department in the National Center for Public Health Laboratories in Sana’a, Ministry of Health and Population) for 3 years. Then the statistical analysis of the data was used where the descriptive analysis was calculated: frequency and percentage, as well as the association of infection with sex and age group by means of detection odds ratio, 95% CI and X2 more than 3.9 and P<0.05 were considered statistically significant.

**Ethical approval**

Approval was obtained from the participants prior to including in the study. Ethical approval was obtained from the Medical Research and Ethics Committee of the Faculty of Medicine and Health Sciences, Sana’a University with reference number (223) on 10/01/2021.

**RESULTS**

Table 1 presents the demographic data of jaundice patients screened for hepatitis A, B and C viruses in the main laboratories in Sana'a city for a period of 3 years. It included 644 males (43.8%) and 826 females (56.2%), while most patients were less than 21 years old (2-10 years old 33.7% and 11-20 years old 29.9%), while patients over 40 years old only 5.4% of total patients. Hepatitis viruses (HAV + HBV + HCV) were 405 (27.6%) positive, while 1065 (72.4%) patients with jaundice were negative for HAV, HBV and HCV. When considering sex, the positive rates of the three viruses were approximately equal in males (27.8%) and females (27.4%). Table 2 shows the distribution of different hepatitis viruses among male and female jaundice patients. Hepatitis A virus infection was the most common virus diagnosed among patients with jaundice accounting for 259 cases (17.6% of the total), while HBV was less common with 104 (7.1%) and HCV only 42 cases (2.9%). Table 3 shows the distribution of the age groups of patients infected with hepatitis A virus. The highest incidence of hepatitis A at 2-10 years jaundice patients was 220 cases (44.4%), with an associated OR 19.3, with a 95% CI equal to 13.3-77.6 and this correlation was highly significant with X2 being 364, p < 0.0001. While the rates of hepatitis A virus infection in the older age groups were very low and ranged between 0 and 6.8%. Table 4 shows the distribution of the age groups of patients infected with hepatitis B virus. The highest incidence of hepatitis B at 11-20 years jaundice patients was 89 cases (18.2%), with an associated OR 9.3, with a 95% CI equal to 5.8-14.9 and this correlation was highly significant with X2 being 118, p < 0.0001. While the rates of hepatitis B virus infection in younger age group (2-10 years) was 0.2%, and in other older age groups were ranged from 2.5% to 6.7%. Table 5 shows the distribution of the age groups of patients infected with hepatitis C virus. The highest incidence of hepatitis C at 31-40 years jaundice patients was 7.3%, with an associated OR 3.3, with a 95% CI equal to 1.6- 6.6 and this correlation was highly significant with X2 being 13, p < 0.0001. While the rates of hepatitis c virus infection in younger age group (2-10 years) was 0%, and in other age groups were ranged from 3.8% to 6.3%.

**DISCUSSION**

The causes of hepatitis can be divided into the following main categories: metabolic, ischemic, infectious, genetic, autoimmune, and others more. Metabolic causes include prescription drugs, toxins (especially alcohol), and nonalcoholic fatty liver disease. Autoimmune and genetic causes of hepatitis include a genetic predisposition and tend to affect distinct populations. In the current study, hepatitis viruses (HAV + HBV + HCV) were positive in 405 (27.6%) patients with hepatitis (hepatic jaundice) while the remaining 1065 (72.4%) jaundiced patients were negative for HAV and HBV and HCV (Table 1). This result indicated that the majority of cases in the current study may be infected with other infectious agents including viruses, bacteria, and parasites or suffer from other previously mentioned causes of hepatitis27, 28. Viral hepatitis is the most common type of hepatitis worldwide29, and this fact differs from the current study in that 72.4% of patients with hepatitis may have other causes. These results can be explained by the fact that other viral hepatitis was not investigated in the current study and only 3 viruses were examined. Viral hepatitis is caused by five different viruses (hepatitis A, B, C, D, and E)30.

Hepatitis A virus infection was the most common virus diagnosed among patients with jaundice accounting for 259 cases (17.6% of the total) (Table 2). Therefore, hepatitis A, which is transmitted through fecal-oral, is more common in developing countries, and with its high prevalence, it is a self-limiting disease that does not lead to chronic hepatitis and its complications as liver cancer30. There are a number of hospital-based reports, sporadic cases and outbreaks of HAV in Yemen; but limited scholarly publication is available on the Internet31. Only one published report detected hepatitis A virus antibodies indicating that 86% of the tested population had total IgG antibodies indicating previous exposure and immunity31. While the results of the current study showed 17.6% of the tested patients had active infection (IgM positive) among children and adults. In the current study the highest incidence of hepatitis A was in children (2-10 years) (44.4%), with an associated OR 19.3, with a 95% CI equal to 13.3-77.6 (p < 0.0001) (Table 3). The current finding is similar to that in developing countries where they have higher circulating levels of HAV and most cases are reported in children while most adolescents and adults in developing countries have already contracted the disease and are thus immune32. On the other hand, we found that active infection with hepatitis A virus is present in adults in the current study, therefore, it is necessary to examine the immune status of adults and children in Yemen and to vaccinate non-immune children and people at risk of infection with the virus, as well as people suffering from other liver diseases in which active Hepatitis A infection might lead to liver failure33,34. Hepatitis A virus (HAV) infection is mostly associated with poor hygiene and spreads through the oral and fecal route. Although the HAV vaccine is available in the immunization programs of many countries of the world; However, this vaccine is not available at all in Yemen.

In the current study, the rate of HBV among patients with hepatic jaundice was 7.1%, and the highest rate was in 11-20 years of patients (18.2%). The prevalence of hepatitis B virus in previous studies in Yemen ranged from 1% among the general population to 20% among high-risk groups such as health care workers, dialysis patients etc16-23. Hepatitis B cases are still reported from different hospitals in Yemen, although the hepatitis B vaccine has been available for about 22 years in the country, there are still many people in Yemen who do not benefit from the protection available for this successful vaccine. This is due to its high cost and its low priority for the decision-maker at the governmental level, in addition to the ongoing war in Yemen over the past seven years.

In the current study, the rate of HCV among patients with hepatic jaundice was 2.9%, and the highest incidence of hepatitis C was in the 31-40 year old patients with jaundice (7.3%), with an associated odds ratio of 3.3 (p < 0.0001). While the infection rates of hepatitis C virus in the younger age group (2-10 years) were 0% (Table 5). The prevalence of hepatitis C virus in previous studies in Yemen ranged from 0.1% among the general population and blood donors to 19% among high-risk groups such as public health center cleaners, health care workers and dialysis patients16,17,23, 24. Although the exact reasons for the spread of HCV in this population remain unclear; Blood transfusion without proper screening, and the use of non-sterile syringes may be one of the factors for the spread of hepatitis C virus in Yemen. A detailed study should be done in the future because hepatitis C is one of the main causes of cirrhosis and hepatocellular carcinoma in chronic patients16, 17.

Even though the hospital-based data obtainable in this study will not characterize the entire country, the burden of disease from this viral infection appears to be alarming these days and relevant authorities should prioritize overcoming viral hepatitis in the country.

**CONCLUSION AND RECOMMENDATION**

Changing epidemiology and dynamics of hepatitis A-C viruses in Yemen is alarming and detailed study must be conducted to understand the actual disease burden caused by these viruses. This study, which was conducted on hospitals, noted the high prevalence of hepatitis A virus and hepatitis B virus in the Yemeni population with hepatic jaundice and elevated liver enzymes. The study found HAV is a major causative agent for hepatic Jaundice followed by HBV and HCV, indicating that group of hepatitis virus to cause a serious health problem in Yemen with a large population (about 30 millions). More accurate information on the overall prevalence of these viral infections may done by detailed studies, including well-designed systematic surveillance with random selection of people. We believe that an urgent standard public health approach should be followed in implementation such as provision of clean water, appropriate disposal of wastewater and improved hygiene of persons through health education and application of the HAV vaccine that may help control HAV infection in the future. Also, mass vaccination of hepatitis B virus should be started which should reach all rural and urban areas in Yemen to prevent future infection with hepatitis B virus because vaccination against hepatitis B virus has not been achieved by the Yemeni government as expected. This may be unaware of this vaccine or the financial district due to the high cost of the vaccine. In addition, regular quality control of the kit used in the blood bank will help prevent transfusion of hepatitis B and HCV-infected blood to the recipient. Since the hepatitis C vaccine is not available, raising awareness of the handling of blood and its derivatives may help reduce the spread of hepatitis C infection in Yemen

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**CONFLICT OF INTEREST**

No conflict of interest associated with this work.

**AUTHOR’S CONTRIBUTIONS**

All authors co-wrote the articles and reviewed the results.

**REFERENCES**

1-Torre DM, Lamb GC, Ruiswyk JV, Schapira RM. [Kochar's Clinical Medicine for Students](https://books.google.com/books?id=S0Jz_3WEPYMC&pg=PA101). Lippincott Williams & Wilkins 2009; p. 101. [ISBN](https://en.wikipedia.org/wiki/ISBN_(identifier)) [9780781766999](https://en.wikipedia.org/wiki/Special:BookSources/9780781766999).

2-Alastot, E., and H. Al-Shamahy. “Prevalence of leptospirosis amongst slaughterhouse workers and butchers in Sana’a city-Yemen”. Universal Journal of Pharmaceutical Research 2018; 3(2):17-20. doi:https://doi.org/10.22270/ujpr.v3i2.133.

3- Gupta BP, Adhikari A, Chaudhary S. Hepatitis viruses in Kathmandu, Nepal: hospital-based study. BMC Res Notes. 2018;11(1):627. Published 2018 Aug 30. doi:10.1186/s13104-018-3739-1

4- Popping S, El-Sayed M, Feld J, Hatzakis A, Hellard M, Lesi O, Ninburg M, Ward J, Boucher C. Report from the international viral hepatitis elimination meeting (IVHEM), 17–18 November 2017, Amsterdam, the Netherlands: gaps and challenges in the WHO 2030 hepatitis C elimination framework. 2018.

5-Saad Al-Dabis, E. M., H. A. Al-Shamahy, M. M. S. Al-Hadad, and E. H. Al-Shamahi. “Prevalence of hepatitis G virus among patients with chronic liver disease and healthy individuals, Sana’a city-Yemen”. Universal Journal of Pharmaceutical Research 2019; 3 (6):1-6. doi:https://doi.org/10.22270/ujpr.v3i6.216.

6-Lemon SM, Walker CM. Hepatitis A virus and hepatitis E virus: emerging and re-emerging enterically transmitted hepatitis viruses. Cold Spring Harb Perspect Med. 2018. https ://doi.org/10.1101/cshpe rspec t.a0318 23.

7-World Health Organization. Global hepatitis report 2017. Geneva: World Health Organization; 2017.

8-Wu VCC, Chen TH, Wu M, *et al*. Comparison of cardiovascular outcomes and all-cause mortality in patients with chronic hepatitis B and C: a 13-year nationwide population-based study in Asia. Atherosclerosis 2018;269:178–84.

9- Obiri-Yeboah D, Awuku YA, Adu J, Pappoe F, *et al.* Sero-prevalence and risk factors for hepatitis E virus infection among pregnant women in the Cape Coast Metropolis, Ghana. PLoS ONE. 2018; 13(1):e0191685.

10- Hofmeister MG, Foster MA, Teshale EH. Epidemiology and transmission of hepatitis A virus and hepatitis E virus infections in the United States. Cold Spring Harb Perspect Med. 2018. https ://doi.org/10.1101/cshpe rspec t.a0334 31.

11- Demsiss W, Seid A, Fiseha T. Hepatitis B and C: seroprevalence, knowledge, practice and associated factors among medicine and health science students in Northeast Ethiopia. PLoS ONE. 2018;13(5):e0196539.

12- Gupta BP, Lama TK, Adhikari A, Shrestha A, Rauniyar R, Sapkota B, Thapa S, Shrestha S, Gupta PP, Manandhar KD. First report of hepatitis E virus viremia in healthy blood donors from Nepal. VirusDisease. 2016;27(3):324–6.

13- Maucort-Boulch D, de Martel C, Franceschi S, Plummer M. Fraction and incidence of liver cancer attributable to hepatitis B and C viruses worldwide. Int J Cancer. 2018;142(12):2471–7.

14- Jung G, Olivas P, Díaz A, Lens S. Hepatitis E-induced acute-on-chronic liver failure and VI nerve paralysis. Liver Int. 2018. https ://doi.org/10.1111/ liv.13897 .

15-Moore MS, Bocour A, Tran OC, *et al.* Effect of hepatocellular carcinoma on mortality among individuals with hepatitis B or hepatitis C infection in New York City, 2001–2012. Open Forum Infect Dis. 2018. https ://doi.org/10.1093/ofid/ofy14 4.

16-Al-kadassy, A. M., A. F. S. Al-Ashiry, and H. A. Al-Shamahy. “Sero-epidemiological study of hepatitis b, c, hiv and treponema pallidum among blood donors in Hodeida city- Yemen”. Universal Journal of Pharmaceutical Research 2019; 4(2): 1-8. doi:https://doi.org/10.22270/ujpr.v4i2.256.

17-AL-Marrani, W. H. M., and H. A. Al-Shamahy. “Prevalence of hbv and hcv; and their associated risk factors among public health center cleaners at selected public health centers in Sana’a city-Yemen”. Universal Journal of Pharmaceutical Research 2018:3 (5):1-8. doi:https://doi.org/10.22270/ujpr.v3i5.204.

18-AL-Shamahy H. Prevalence of Hepatitis B surface antigen and Risk factors of HBV infection in a sample of healthy mothers and their infants in Sana’a, Yemen. Ann Saudi Medicine 2000; 20: 464-467. https://doi.org/10.5144/0256-4947.2000.464

19-Al-Shamahy HA, IA Rabbad, Al-Hababy A. Hepatitis B virus serum markers among pregnant women in Sana'a, Yemen. - Ann Saudi Med 2003; 23:87-89. <https://doi.org/10.5144/0256-4947.2003.87>

20-Al-Shamahy HA, Samira H Hanash, Iqbal A Rabbad, Nameem M Al-Madhaji, Hepatitis B Vaccine Coverage and the Immune Response in children under 10 years old in Sana'a Yemen. SQU Med J 2011; 11(1): 77-82.

21-Al-Shamahy, H. A., M. A. Ajrah, A. G. Al-Madhaji, B. B. M. Al-Fraji, M. A. A. Ajrah, M. M. A. Al- Hajj, and A. M. Al-Hadad. “Prevalence and potential risk factors of hepatitis b virus in a sample of children in two selected areas in Yemen”. Universal Journal of Pharmaceutical Research 2019; 4(3):1-6. doi:https://doi.org/10.22270/ujpr.v4i3.269.

22-Al-Shawkany, E. M., A.-A.-R. M. AlShawkany, S. S. Bahaj, A. M. Othman, H. A. Al-Shamahy, and A. A. M. Al-Ankoshy. “Prevalence of different hepatitis b virus genotypes and risk factors associated among selected Yemeni patients with chronic hepatitis B infection”. Universal Journal of Pharmaceutical Research 2021; 6 (3):1-8. doi:https://doi.org/10.22270/ujpr.v6i3.603.

23-Amran, O. A. A., H. A. Al-Shamahy, A. M. Al Hadad, and B. M. Jaadan. “Explosion of hepatitis B and C viruses among hemodialysis patients as a result of hemodialysis crisis in Yemen”. Universal Journal of Pharmaceutical Research 2019; 4(5):1-8. doi:https://doi.org/10.22270/ujpr.v4i5.311.

24-Hanash SH, Al-Shamahy HA, Bamshmous MHS. Prevalence and genotyping of hepatitis C virus in hemodialysis patients and evaluation of HCV-core antigen test in screening patients for dialysis in Sana’a city, Yemen. Universal J Pharm Res 2019; 4(2): 14-18. <https://doi.org/10.22270/ujpr.v4i2.251>

25-Al-Shamahy HA, Abdu SSA‏. [Genotyping of Hepatitis C Virus (HCV) in infected patients from Yemen‏](https://scholar.google.com/citations?view_op=view_citation&hl=ar&user=gmHYdbkAAAAJ&cstart=20&pagesize=80&citation_for_view=gmHYdbkAAAAJ:hqOjcs7Dif8C). Eur J Basic Med Sci 2014; 3 (4):78-82‏.

26-Rabbad IA, Al-Somainy AAM, Al-Shamahy HA, Nasser SM. [Prevalence of hepatitis G virus infection among chronic hepatitis B, chronic hepatitis C and HIV patients in Sana'a, Yemen.‏](https://scholar.google.com/citations?view_op=view_citation&hl=ar&user=gmHYdbkAAAAJ&cstart=20&pagesize=80&citation_for_view=gmHYdbkAAAAJ:WF5omc3nYNoC) Journal of Chinese Clinical Medicine 2014; 5 (11), 654-658‏.

27- ["Hepatitis"](https://www.niaid.nih.gov/diseases-conditions/hepatitis). NIAID. [Archived](https://web.archive.org/web/20161104002228/https:/www.niaid.nih.gov/diseases-conditions/hepatitis) from the original on 4 November 2016. Retrieved 2 November 2016.

28- Bernal W.; Wendon J. "Acute Liver Failure". New England Journal of Medicine 2013; **369** (26): 2525–2534. [doi](https://en.wikipedia.org/wiki/Doi_(identifier)):[10.1056/nejmra1208937](https://doi.org/10.1056%2Fnejmra1208937). [PMID](https://en.wikipedia.org/wiki/PMID_(identifier)) [24369077](https://pubmed.ncbi.nlm.nih.gov/24369077).

29- World Health Organization. ["Hepatitis"](https://www.who.int/topics/hepatitis/en/). World Health Organization. [Archived](https://web.archive.org/web/20131202223841/http:/www.who.int/topics/hepatitis/en/) from the original on 2 December 2013. Retrieved 25 November 2013.

30-Dienstag, JL. "Chapter 360: Acute Viral Hepatitis". In Kasper, D; Fauci, A; Hauser, S; Longo, D; Jameson, J; Loscalzo, J (eds.). Harrison's Principles of Internal Medicine 2015; 19e. New York, NY: McGraw-Hill. [ISBN](https://en.wikipedia.org/wiki/ISBN_(identifier)) [978-0-07-180215-4](https://en.wikipedia.org/wiki/Special:BookSources/978-0-07-180215-4).

31-D-Bawazir AA, Anthony Hart C, Sallam TA *et al.* Seroepidemiology of hepatitis A and hepatitis E viruses in Aden, Yemen. Transactions of the Royal Society of Tropical Medicine and Hygiene 2010;  104(12):801-5. DOI: [10.1016/j.trstmh.2010.08.007](http://dx.doi.org/10.1016/j.trstmh.2010.08.007)

32-Jacobsen, KH; Wiersma, ST. "Hepatitis A virus sero-prevalence by age and world region, 1990 and 2005". Vaccine 2010; **28** (41): 6653–7.  [doi](https://en.wikipedia.org/wiki/Doi_(identifier)):[10.1016/j. vaccine. 2010.08.037](https://doi.org/10.1016%2Fj.vaccine.2010.08.037).  [PMID](https://en.wikipedia.org/wiki/PMID_(identifier)) [20723630](https://pubmed.ncbi.nlm.nih.gov/20723630).

33-["Guidelines For Viral Hepatitis Surveillance And Case Management"](https://www.cdc.gov/hepatitis/statistics/surveillanceguidelines.htm). www.cdc.gov. [Archived](https://web.archive.org/web/20160310094046/http:/www.cdc.gov/hepatitis/statistics/surveillanceguidelines.htm) from the original on 2016-03-10. Retrieved 2021-08-12.

34-Longo DL, Fauci AS, Kasper DL, Hauser SL, Jameson J, Loscalzo J. eds. Harrison's Manual of Medicine 2013; 18e, Chapter 164: Chronic Hepatitis. New York, NY: McGraw-Hill.

Table 1: Demographic Data of Jaundice Patients Screened for Hepatitis A, B, and C Viruses in major Laboratories in Sana’a city for a Period of 3 Years

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Characteristics | Hepatitis viruses positive  HAV+HBV+HCV | | Hepatitis viruses negative  HAV+HBV+HCV | | Total tested | |
| No (%) | ~~%~~ | No (%) | ~~%~~ | No (%) | ~~%~~ |
| **Age groups** | | | | | | |
| 2-10 years | 221 (44.6) | ~~44.6~~ | 274 | 55.4 | 495 | 33.7 |
| 11-20 years | 124 | ~~28.2~~ | 315 | 71.8 | 439 | 29.9 |
| 21-30 years | 27 | ~~9.3~~ | 264 | 90.7 | 291 | 19.8 |
| 31-40 years | 25 | ~~15.2~~ | 140 | 84.8 | 165 | 11.2 |
| >40 years | 8 | ~~10~~ | 72 | 90 | 80 | 5.4 |
| **Gender** | | | | | | |
| Male | 179 | 27.8 | 465 | 72.2 | 644 | 43.8 |
| Female | 226 | 27.4 | 600 | 72.6 | 826 | 56.2 |
| **Total** | 405 | 27.6 | 1065 | 72.4 | 1470 | 100 |

Table 2: Distribution of different hepatitis viruses among male and female jaundice patients

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Characteristics | HAV positive | | HBV positive | | HCV positive | | Total positive | |
| No | ~~%~~ | No | % | No | % | No | % |
| Male | 111 | ~~42.9~~ | 43 | 41.3 | 25 | 59.5 | 179 | 12.2 |
| Female | 148 | ~~57.1~~ | 61 | 58.7 | 17 | 40.5 | 226 | 15.3 |
| **Total** | 259 | ~~17.6~~ | 104 | 7.1 | 42 | 2.9 | 405 | 27.6 |

Table 3: Age groups distribution of patients infected with hepatitis A virus

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Characteristics | HAV positive | | *OR* | *CI 95%* | *X2* | *P* |
| No | % |
| 2-10 years n=495 | 220 | 44.4 | 19.3 | 13.3-77.6 | 364 | <0.0001 |
| 11-20 years n=439 | 30 | 6.8 | 0.25 | 0.17-0.3 | 50 | <0.0001 |
| 21-30 years n=291 | 6 | 2.1 | 0.07 | 0.03-0.17 | 60.4 | <0.0001 |
| 31-40 years n=165 | 3 | 1.8 | 0.07 | 0.02-0.2 | 31.9 | <0.0001 |
| >40 years n=80 | 0 | 0 | 0 | 0-0.16 | 18 | <0.0001 |
| Total n=1470 | 259 | 17.6 |  |  |  |  |

Table 4: The distribution of the age groups of patients infected with hepatitis B virus.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Characteristics | HBV positive | | *OR* | *CI 95%* | *X2* | *P* |
| No | % |
| 2-10 years n=495 | 1 | 0.2 | 0.01 | 0.002-0.1 | 53 | <0.0001 |
| 11-20 years n=439 | 80 | 18.2 | 9.3 | 5.8-14.9 | 118 | <0.0001 |
| 21-30 years n=291 | 10 | 3.4 | 0.4 | 0.2-0.7 | 7.3 | 0.006 |
| 31-40 years n=165 | 11 | 6.7 | 0.9 | 0.4-1.7 | 0.04 | 0.82 |
| >40 years n=80 | 2 | 2.5 | 0.32 | 0.07-1.3 | 2.6 | 0.10 |
| Total n=1470 | 104 | 7.1 |  |  |  |  |

Table 5: The distribution of the age groups of patients infected with hepatitis C virus

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Characteristics | HBC positive | | *OR* | *CI 95%* | *X2* | *P* |
| No | % |
| 2-10 years n=495 | 0 | 0 | 0 | 0-0.1 | 21.9 | <0.0001 |
| 11-20 years n=439 | 14 | 3.2 | 1.1 | 0.6-2.2 | 0.24 | 0.61 |
| 21-30 years n=291 | 11 | 3.8 | 1.45 | 0.7-2.9 | 1.1 | 0.29 |
| 31-40 years n=165 | 12 | 7.3 | 3.3 | 1.6-6.6 | 13 | <0.0001 |
| >40 years n=80 | 5 | 6.3 | 2.4 | 0.9-6.2 | 3.5 | 0.06 |
| Total n=1470 | 42 | 2.9 |  |  |  |  |