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This document is best viewed online. There are embedded hyperlinks that appear as underlined words in print versions.

Unless otherwise stated the content of this guideline has been adapted from BCCDC Communicable Disease Control Hepatitis A Guideline (August 2018)

1.0 INTRODUCTION

This guideline aims to meet the needs of Yukon health care professionals who are following-up individuals with newly identified hepatitis A virus (HAV) infection or those who have a probable HAV infection.

This document presents information in a flexible way, to encourage client engagement with the health care system. Yukon Communicable Disease Control (YCDC) is responsible for the follow-up case investigation and collaborating with primary care providers where appropriate.

1.1 Authority

Infection with HAV is a reportable condition under the Yukon Public Health and Safety Act (2002).

Yukon Public Health and Safety Act (2002) is available at:
https://laws.yukon.ca/cms/images/LEGISLATION/acts/puhesa.pdf

1.2 Rationale for HAV follow-up

Follow-up of newly identified HAV infections can contribute to positive outcomes for the individual, their partners, their families and the community. Clients who test positive for HAV can be engaged into care to support:

- Transmission prevention
- Site assessments and prevention recommendations
- Follow-up clinical care
- Immunizations
- If appropriate, STI screening
- If appropriate, engagement into counselling and care related to risk factors and comorbid conditions

1.3 Goals

To support public health personnel and primary care providers to reduce cases and transmission of HAV.

Using principles of health equity (e.g., trauma informed practice and culturally informed care) to:

1. Provide targeted immunization of all:
    - High-risk groups, as specified in the Yukon Immunization Program (YIP)
2. Public Health measures:
    - Passive surveillance of hepatitis A to help guide vaccination recommendations
    - Rapid response to identified hepatitis A outbreaks

- Exclusion of cases and contacts from high-risk occupations and/or settings
- Provide post-exposure immunoprophylaxis as indicated for contacts of known hepatitis A cases

3. Increasing public awareness regarding:
   - The use of hepatitis A vaccine prior to travel
   - Adequate living standards as the most important measures for prevention of hepatitis A
   - Further risks and recommendations related to case management
4. Educate and counsel infected individuals and their contacts about:
   - Coinfection with human immunodeficiency virus (HIV) and other types of hepatitis
   - Immunization for hepatitis B and other vaccines where appropriate
   - Transmission prevention
   - Liver health (e.g., alcohol)

2.0 DEFINITIONS

Alanine aminotransferase (ALT)/Aspartate Aminotransferase (AST) - Enzymes produced by the liver. Increased levels indicate inflammation of the liver, but do not always correlate with the severity of the disease process.

Case – Defined here for the purpose of surveillance reporting of confirmed and probable HAV infections.

- **Confirmed Case**
  Laboratory confirmation of infection in the absence of recent vaccination (Anti-HAV IgM has been detected up to two to three weeks after one dose of hepatitis A vaccine):

  Laboratory confirmation
  Detection of immunoglobulin M antibody to hepatitis A virus (anti-HAV IgM)

  AND

  Acute illness with discrete onset of symptoms and jaundice or elevated serum aminotransferase levels

  OR

  An epidemiologic link to a person with laboratory confirmed hepatitis A infection

- **Probable Case**
  Acute illness in a person who is epidemiologically linked to a confirmed case

Contact - A person who has exposure to a case during the time the case is infectious. The contact may acquire infection by the fecal-oral route, by either person-to-person contact or ingestion of contaminated food or water. Refer to Section 6.2 Contact Management for details.

Susceptible Contact – Refer to Section 6.4, Immunoprophylaxis for Contacts

Documentation – Recording of results and follow-up care provided to those testing for HAV.

Hepatitis A Outbreak - An outbreak of hepatitis A occurs when two or more epidemiologically–linked cases occur within two incubation periods (i.e., 100 days) within a community or closed setting

Post-exposure prophylaxis (PEP) (immunoprophylaxis) – Administration of hepatitis A vaccine and/or immune globulin (Ig) as soon as possible after a known exposure to an individual with confirmed acute HAV infection

3.0 HEPATITIS A VIRUS

Hepatitis A is an RNA picornavirus virus that can cause acute liver disease. HAV is excreted in bile and shed in the feces of an infected person. It is transmissible via contaminated food and water or through a HAV infected person's blood and/or body fluids.

3.1 Clinical Description

Hepatitis A infection is an acute, often self-limited illness. Chronic infection with hepatitis A does not occur. On average, symptoms occur 28 days after exposure (range 15-50 days). Symptoms can include fever, fatigue, malaise, jaundice, anorexia, abdominal discomfort, nausea and vomiting, dark urine and grey- colored stools.

The severity of hepatitis A virus infection generally increases with age. Children younger than 6 years of age often have no symptoms or present with mild disease without jaundice. Among older children and adults, infection is usually symptomatic (70% or more have symptoms) and typically lasts several weeks. About 25% of adult cases in Canada are hospitalized, but deaths are rarely reported. Prolonged or relapsing disease, lasting as long as 6 months, can occur. Fulminant hepatitis is rare but is more common in people coinfected with another hepatitis virus and with underlying liver disease.

The clinical features of hepatitis viruses can be non-specific with respect to other viral diseases affecting the liver, making it difficult to diagnosis without lab results.

3.2 Epidemiology

Worldwide

Hepatitis A occurs worldwide. In high endemic regions including parts of Africa and Asia, hepatitis A is associated with inadequate sanitation and limited access to clean water, while infection in low endemic areas (such as the United States and Western Europe) is found in people in high-risk groups or as communitywide outbreaks. In less endemic countries, hepatitis A is among the most common vaccine preventable infections acquired during travel. Travelers from low endemic regions who travel to high and medium endemic regions are at most risk when they live in or visit rural areas, trek in backcountry areas or frequently eat or drink in settings with poor sanitation (Centers for Disease Control and Prevention, 2019).

Yukon

Yukon has a low occurrence of hepatitis A. Three sporadic infections were diagnosed in Yukon between 2006 and 2023, with one infection acquired during travel, and no source of infection identified in the other two.

Canada and British Columbia

Since 2010, Canada and British Columbia report about 0.5 to 1 new Hepatitis A infection per 100,000 people per year.

Over the last few decades, BC reports outbreaks of HAV infection in First Nations communities. Surveillance and epidemiological analysis demonstrate higher rates of HAV in Indigenous Peoples of BC, compared to non-Indigenous.

3.3 Risk Factors

In both the Yukon and Canada, the majority of HAV cases have a history of travel to or immigration from HAV endemic countries, and many have been associated with the consumption of contaminated frozen fruit in recent years. While many reported cases do not have any identifiable risk factors, common risk factors associated with the acquisition of acute HAV infection include:

- Travel to HAV endemic countries (refer to https://www.who.int/images/default-source/maps/global_hepa_ithriskmap.png?sfvrsn=a54529dd_0)
- Contact with someone who has HAV infection
- Household contact of a diapered child attending a daycare center
- Residence in communities at risk of HAV outbreaks or where HAV is endemic, BC reports outbreaks of HAV in First Nations communities.
- Household or close contacts of children adopted from hepatitis A endemic countries
- Males who have sexual contact with other males
- Illicit drug use (injecting or non-injecting)
- Occupational exposure (e.g., research on HAV or hepatitis A vaccine, and people handling non-human primates)
- Living in a correctional facility or residential/institutional settings
- receiving repeated replacement of plasma-derived clotting factors

3.4 Transmission

HAV is transmitted through the fecal-oral route. HAV transmission through infected blood or blood products is also possible, however the concentration of HAV virus in the serum is significantly less than it is in the feces. The most common mode of transmission is through oral ingestion of food or water contaminated with infected feces. It can also occur through close physical or household contact with an infected person that results in oral ingestion of contaminated feces. Hepatitis A is not transmitted through casual contact with an infectious person.

The incubation period is 15 to 50 days, with an average of 28 days. The shedding of HAV in the feces can begin 10-12 days after infection. The period of infectivity for hepatitis A is the latter half of the incubation period (usually 14 days), continuing for 14 days after symptom onset or 7 days after the onset of jaundice, whichever is longer. Prolonged viral excretion up to 6 months has been documented in infants and children.

4.0 LABORATORY AND TESTING INFORMATION

Refer to the BCCDC eLab Handbook and website for information on requisitions, testing, and sample collection and processing instructions.

Practitioner Alert!

Please ensure that your local laboratory is sending anti-HAV IgM reactive specimens to the BCCDC PHL, indicating that they are "acute hepatitis A". Once confirmed, all anti-HAV IgM reactive specimens are then forwarded by BCCDC PHL to the National Microbiology Laboratory (NML) for further genotyping by PCR and DNA sequencing, which can assist in the evaluation of potential outbreaks.

4.1 Hepatitis A Testing

Hepatitis A serology testing is available for determination of acute infection or immune status (refer to Table 4-1). For anti-HAV IgM reactive specimens, the BCCDC PHL reflexively performs an anti-HAV total and supplemental anti-HAV IgM testing on a different platform to confirm acute infection. If the anti-HAV Total is non-reactive, then the initially reactive anti-HAV IgM should be considered a "false positive".

Table 4-1. Hepatitis A serology testing

HAV Serologic Marker	Term	Clinical Correlation
Anti-HAV IgM	Immunoglobulin M (IgM) antibody to HAV	Requires confirmation with clinical history and can indicate: • Recent acute infection with HAV • Recent immunization with hepatitis A vaccine* • False-positive test result • Remote resolved infection with HAV (can remain detectable for years after acute infection)
Anti-HAV Total	IgM + IgG antibody to HAV	In the absence of a reactive anti-HAV IgM result, can indicate: • Prior immunization • Resolved infection (immune status)

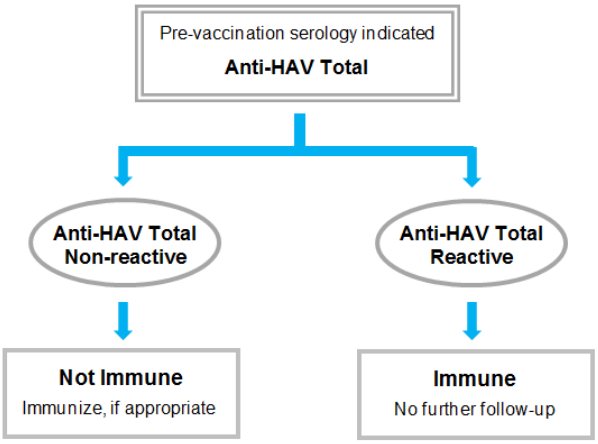
* Around 5% of people immunized with hepatitis A vaccine will develop a reactive anti-HAV IgM

4.2 Pre-vaccination Testing/Screening

Pre-vaccination testing is not routinely recommended. It is ***only*** indicated for certain populations where there may be higher levels of pre- existing immunity or infection may exist.

If pre-vaccination serology has been ordered, refer to figure 4-1 for interpretation of the results.

Figure 4-1. HAV pre-vaccination testing



4.3 Post-vaccination Testing and Boosters

HAV laboratory testing is designed to detect natural infection. Anti-HAV tests have poor sensitivity and may not be able to detect low, but protective levels of vaccine-induced antibody. While a reactive anti-HAV Total result reflects immunity to HAV, a negative test after vaccination does not always indicate that an individual is susceptible. As well, almost 100% of immune competent vaccine recipients will develop protective antibody concentrations after receiving 2 doses of hepatitis A vaccine.

Individuals who are anti-HCV positive respond well to hepatitis A vaccine and do not require post-vaccination testing. Refer to the https://yukon.ca/en/immunization-manual for further information on immunizing special populations.

4.4 Investigation of Acute Hepatitis

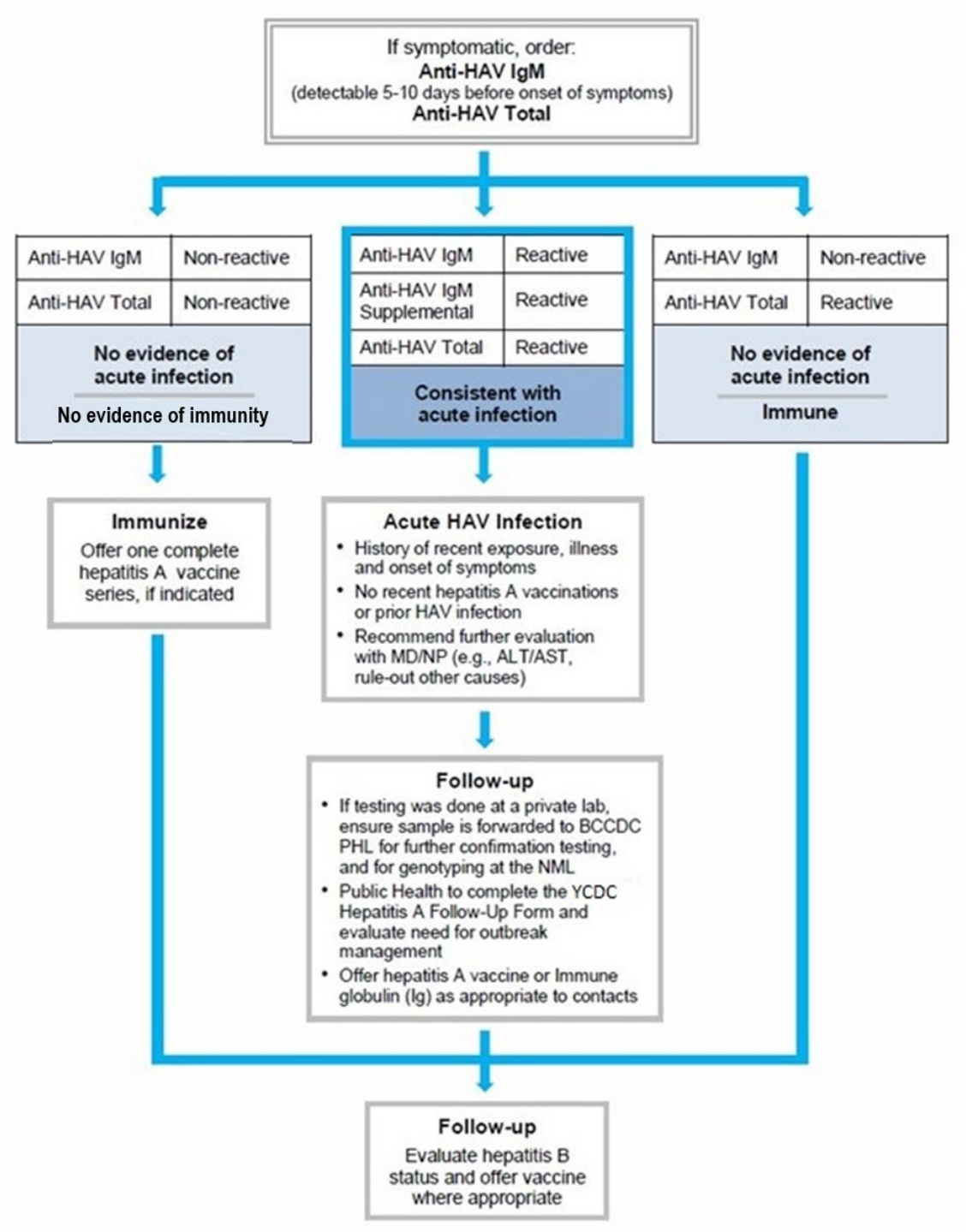
Health care providers should use their judgment when investigating acute hepatitis, considering infectious and non-infectious causes. Tests to investigate suspected acute viral hepatitis, however, should include:

- Anti-HAV IgM also called Hepatitis A Serology (acute)
- Anti-HAV Total antibody also called Hepatitis A Serology (Immunity)
- HBsAg
- Anti-HBc Total
- Anti-HCV

Health care providers should also consider liver enzymes and liver function tests. At minimum, clinicians should order serum ALT when considering viral hepatitis. Other less common causes of viral hepatitis include cytomegalovirus, Epstein-Barr virus, and enteroviruses.

Acute/recent infection should be confirmed with a clinical history and serum aminotransferase levels or by repeating anti-HAV IgM after one week. If appropriate, refer individual to a physician/NP for further follow-up. Refer to Figure 4-2.

Figure 4-2. Testing for acute HAV infection and result follow-up



* For the YCDC Hepatitis A Follow Up form, refer to Appendix A.

5.0 CASE INVESTIGATION AND MANAGEMENT

Health care provider to report to YCDC by the fastest means possible before contacting the client. Individuals with acute hepatitis A infection should be referred to a physician or nurse practitioner for further evaluation. The YCDC 'Hepatitis A Follow-up Form' may be used to guide the case investigation. See Appendix A.

Practitioner Alert!

Report all suspect, probable and confirmed cases of hepatitis A to YCDC by fastest means possible.

For concerns related to Hepatitis A after YCDC hours, please contact the MOH on call.

5.1 Summary of Case Management

Case Identification

- Lab notification received confirming HAV infection (refer to Section 4.0)
- Review clinical and laboratory criteria, exposure risks and medical history to determine if this is an acute HAV case.

Reporting

- Notify YCDC of all suspect, probable and confirmed cases. If reporting outside of YCDC hours including over the weekend, contact the MOH on call.
- Confirm diagnosis with YCDC and/or the MOH.
- YCDC will complete the 'Hepatitis A Follow-up Form'

Case Management

- Connect client with YCDC and their primary care provider to arrange for further clinical evaluation
- As per the Medical Officer of Health (MOH) direction, discuss any exclusion recommendations
- Identify contacts (refer to Section 6.0)
- Review transmission information and prevention
- Advise the case of their period of infectivity (refer to Figure 6-1)
- Review process for contact follow-up and if applicable, outbreak management (refer to Section 7.0)
- Offer further clinical support, information and support relevant to identified risk factors.

Counsel the case regarding ways to prevent transmission to others and ways to expedite recovery. Refer to the Hepatitis A Health File (www.healthlinkbc.ca/healthlinkbc-files/hepatitis-vaccine).

5.2 Case interview

Give a rationale as to why the case report information is being collected to provide reassurance regarding privacy and confidentiality. Advise the case of their estimated period of infectivity and the process involved with contact tracing. Provide education on ways to prevent transmission and to expedite recovery.

Recommended information to consider includes:

- Obtain a history of the illness from the case, including date of onset of symptoms
- Calculate the infectious period for the case
- Determine the occupation of the case. The following groups are of particular concern due to the increased risk of transmission to others:
  - Food handlers
  - Daycare workers
  - Health care providers
- Determine if the case prepared food for others or shared common food with others while in the infectious period
- In order to determine the degree of risk posed to others, question the case about handwashing practices (i.e., prior to preparing food or eating and after using the bathroom)
- Ascertain source of infection. This could be person-to-person, food, or waterborne (refer to Section 3.3). Determine if the case donated or received blood product in the two months prior to the acute infection (refer to Section 5.5)
- Identify contacts of the case
- Consider systematic food history if likelihood of food borne transmission in Yukon exists

5.3 Exclusion of cases

Each case should be reviewed by YCDC and the local MOH to determine the appropriateness of excluding the case from work and any related outbreak management.

The period of infectivity must be established (refer to Figure 6-1). For 14 days prior to the onset of illness, to 14 days after presentation of first symptoms or 7 days after the onset of jaundice (whichever is longer), it is recommended that the MOH:

- Exclude the case from occupations involving the handling of food or drink, and
- Consider the exclusion of health care workers when the nature of their health care work poses a risk of hepatitis A transmission

The MOH should also consider the exclusion of children and adults with hepatitis A from a childcare facility during the period of infectivity, or until hepatitis A vaccine and/or immune globulin (Ig) has been provided to all the children and staff at the centre.

Also refer to Section 6.3 Exclusion of Contacts.

5.4 Food handlers

If the case is a food handler, YCDC and/or MOH will require an in-depth exposure assessment. This includes determining if:

- The person was infectious while working, **AND**
- Handled foods prior to consumption which were not cooked after handling, **AND**
- The food handler's practices were not hygienic, OR the food handler had diarrhea, **AND**
- The contacts can be identified and receive immunoprophylaxis within 14 days of the last exposure to the case while the case was in the infectious period

5.5 Transfusion Transmission

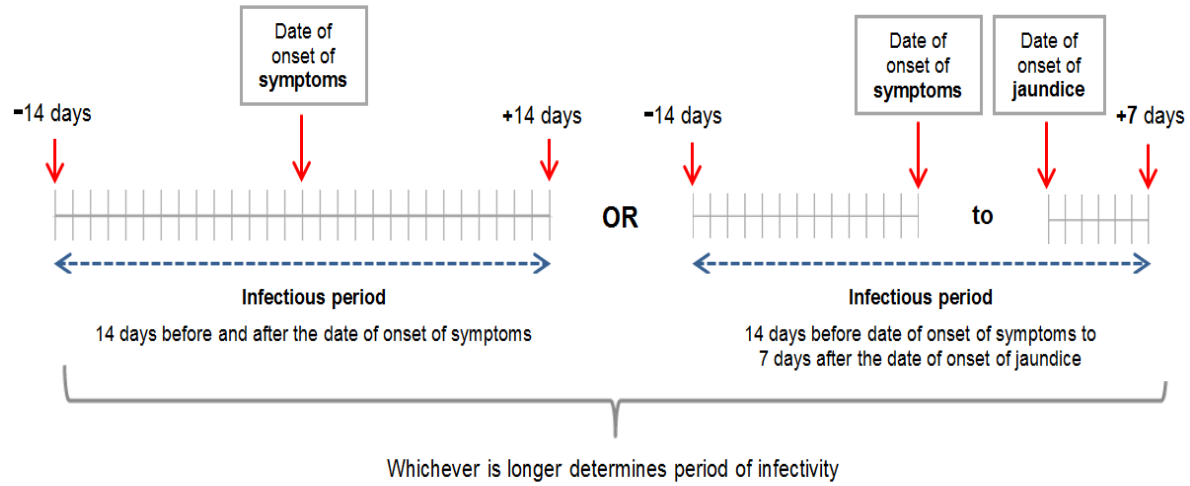
If risk factors indicate the possibility of a transfusion transmissible infection, where the client has been a donor or recipient, notify YCDC.

6.0 CONTACT MANAGEMENT

6.1 Identify contacts

For contact tracing purposes, identify all persons with whom the case has had contact, refer to Section 6.2. The period of infectivity is established by determining the longest period of time from the latter half of the incubation period (usually 14 days), to 14 days after presentation of first symptoms, or 7 days to the onset of jaundice, whichever is longer (refer to Figure 6-1).

Figure 6-1. Determining period of infectivity



6.2 Contact Management

Contacts with symptoms suggestive of hepatitis A infection should be tested as soon as possible. For asymptomaticcontacts, provide information about enteric precautions, disease transmission, and symptoms. Advise contacts to seek medical attention and to be tested if symptoms develop. Contacts who are immunocompromised are at higher risk of severe outcomes, and management should be reviewed with an infectious diseases specialist.

Contacts to Hepatitis A include people who,during the infectious period of the index case:

- Live with or spent 24 hours or more in the same household as the index case
- Have close personal contact with the index case, including:
    - sexual contact, including MSM
    - regular babysitter/childcare provider
- Live with, or spend extensive time in a communal setting where hygiene is difficult to maintain, or where residents are at high risk of severe outcomes (e.g. those in correctional facilities, those utilizing the same homeless shelter, or those living in long-term care facilities) Consume food prepared or handled by the index case
- Share potentially contaminated items with the case (i.e., items handled by the case that could spread HAV through fecal-oral contamination),
- Provide services to the index case where contact with feces may occur and standards of infection prevention and control have not been met (e.g., services for diapered children or others who are incontinent, health care providers with lapse in universal or special precautions)
- Share illicit drugs with index case
- Work in high risk settings/occupations with index case (food handler, health care, childcare or similar facility where standards of personal hygiene are difficult to implement and where activities may promote disease transmission)

Refer contacts to the Hepatitis A Health File (www.healthlinkbc.ca/healthlinkbc-files/hepatitis-vaccine)

6.2.1 Health Care Workers

Health care workers who followed routine infection control practices when in contact with an infected patient, do not require administration of hepatitis A vaccine and/or Ig.

Remind health care workers of the importance of routine infection control practices when there is a possibility of contamination from any body fluid. Use a point of care risk assessment to determine the need for personal protective equipment (e.g., glove and gowns):

- Wear gloves:
    - If in contact with any body fluids or contaminated materials
    - When discarding contaminated articles
    - When bagging contaminated articles to send for cleaning, and avoid touching your body
- Wash hands after removal of gloves and when in contact with the case, or potentially contaminated articles
- Wear a gown if there is a potential for any contact with body fluids or contaminated materials with your clothing
- Clean and disinfect area using a hospital grade disinfectant with a drug identification number (DIN), ensuring contact time is met

Refer health care workers to agency infection control practitioner for further educational support.

6.2.2 Workplace contacts in non-high risk settings/occupations.

The use of hepatitis A vaccine and/or Ig is not indicated for workers in contact with a case in offices or factories, unless there is evidence of possible transmission of hepatitis A virus by the fecal-oral route.

6.2.3 School contacts

The use of hepatitis A vaccine and/or Ig is not indicated in schools for pupils or teachers in contact with a case unless there is evidence of classroom or school transmission.

6.3 Exclusion of contacts

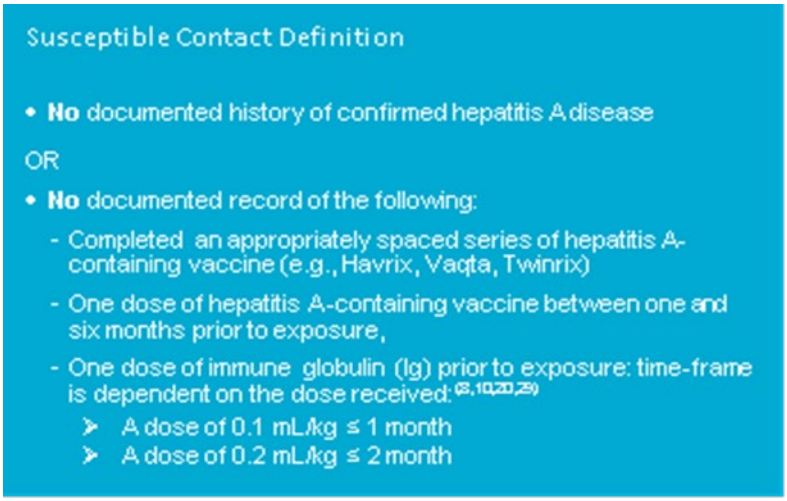
The MOH may consider excluding a contact from food or drink handling duties until it is demonstrated that the contact has received hepatitis A vaccine and/or Ig, or the contact has demonstrable anti-HAV Total and no anti-HAV IgM. The decision to exclude individuals who do not have evidence of immunity, or who are unable to receive the vaccine and/or Ig within **14 days** of last exposure, should be determined on a case-by-case basis. The MOH may take into consideration the health and hygiene status of the contact. This can include whether the contact is asymptomatic, has received and is following proper hygiene advice, is only handling food that requires cooking, and has received information about the symptoms associated with infection, the incubation period, and what to do if he/she experiences symptoms.

Also refer to Section 5.3 Exclusion of cases.

6.4 Post-exposure prophylaxis (PEP) for contacts

If susceptible, Hepatitis A vaccine and/or intramuscular (IM) Ig should be given as soon as possible after a known exposure to a confirmed case, preferably within 14 days of last exposure. HA vaccine should still be considered if more than 14 days have elapsed since last exposure as there are no data on the outer limit of efficacy. *Note: Grifols, manufacturer of Immunoglobulin, will be discontinuing production of intramuscular (IM) Ig GamaSTAN in March 2024 with the last produced lot expiring in August 2025. In the absence of intramuscular (IM) Ig, YCDC will provide updated guidance for passive immunization as it develops.*

Figure 6-2 Susceptible Contact Definition



Alberta Public Health Disease Management Guidelines, 2021

Hepatitis A vaccine is preferred for post exposure prophylaxis of susceptible contacts. Immunoglobulin (Ig) is the recommended in the following situations:

- For infants less than six months of age
- For persons with a history of anaphylaxis after previous administration of the HA vaccine and those with proven or immediate or anaphylactic hypersensitivity to any component of the HA vaccine or its container
- Immunocompromised persons and people with chronic liver disease should receive Ig in addition to HA vaccine because of increased risk of severe disease and risk of suboptimal response to HA vaccine
- If HA vaccine is unavailable

*Adults 60 years of age and older may receive Ig in addition to HA vaccine because of the risk of suboptimal response to HA vaccine at the discretion of YCDC, MOH, and most responsible health care provider.

If there is documentation of a full hepatitis A series or documentation of lab-confirmed immunity related to prior HAV infection, no further PEP is indicated. Do not delay the administration of PEP to wait for pending lab results which confirm immunity.

Table 7-1. PEP for susceptible contacts

Immunoprophylactic Agent	Post-Exposure Indication	Notes
Hepatitis A vaccine	• Preferred immunoprophylaxis agent	• PEP with one dose of hepatitis A vaccine alone is recommended for susceptible contacts of a case of hepatitis A • If a contact has received only one dose of hepatitis A vaccine more than 6 months previously, provide a second dose
Immune Globulin (Ig) **and** Hepatitis A vaccine	• Susceptible individuals with chronic liver disease* • Immunocompromised persons who may not fully respond to vaccine**	• NACI notes Ig can be considered in addition to hepatitis A vaccine for susceptible persons aged ≥ 60 years who are household or close contacts of a case of hepatitis A, though does not routinely recommend it
Immune globulin (Ig)	• Infants < 6 months of age • When vaccine is contraindicated	

* Refer to the Yukon Immunization Program manual for further information.

Ig can only be accessed for PEP with the authorization of the MOH/YCDC. Whitehorse General Hospital Laboratory is the sole location storing Ig for the territory.

Whitehorse

Monday-Friday 0830-1630, if Ig is indicated, YCDC will notify the WGH Laboratory (867-393-8739) and arrange for administration to occur in the WGH ER.

After hours and weekends: The MOH will call the WGH Laboratory.

Communities
Monday–Friday 0830-1630, if Ig is indicated, YCDC will notify the WGH Laboratory (867-393-8739) and arrange for the product to be shipped to the requesting community health centre or community hospital. See above for after hours.

6.5 Accessing Human Immune Globulin Intramuscular (Ig) (GamaSTAN)

Ig can only be accessed for PEP with the authorization of the MOH/YCDC. Whitehorse General Hospital Laboratory is the sole location storing Ig for the territory.

Whitehorse
Monday-Friday 0830-1630, if Ig is indicated, YCDC will notify the WGH Laboratory (867-393-8739) and arrange for administration to occur in the WGH ER.

After hours and weekends: The MOH will call the WGH Laboratory.

Communities
Monday–Friday 0830-1630, if Ig is indicated, YCDC will notify the WGH Laboratory (867-393-8739) and arrange for the product to be shipped to the requesting community health centre or community hospital. See above for after hours.

6.6 Administering Intramuscular (IM) Ig (GamaSTAN)

Offer hepatitis A PEP (0.1ml/kg) intramuscular (IM) to all susceptible contacts as outlined in Table 7- 1. Refer to BCCDC Part 4: Biological Products (Vaccines & Immune Globulins)
http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/immunization/biological-products

7.0 OUTBREAK, DAYCARE, and INSTITUTIONAL SETTING MANAGEMENT

An outbreak of hepatitis A occurs when two or more epidemiologically linked cases occur within two incubation periods (i.e., 100 days) within a community or closed setting. The following sections below are specific to the management of hepatitis A outbreak scenarios.

7.1 Daycare Centres

Practitioner Alert!

Although administration of vaccine and/or intramuscular (IM) Ig to daycare staff and children is routine in an outbreak scenario, an exception may be considered in a facility where risk is completely contained in one section and no other cases have occurred in any other area of the facility. This decision will be made at the discretion of the MOH.

Daycare centres that accept diapered children

Provide hepatitis A vaccine and/or Ig to:

- All child attendees and staff when one case occurs in an attendee or staff member **OR** when cases are identified in at least two of the households of the child attendees
- Consider the use of hepatitis A vaccine and/or Ig for household contacts of diapered daycare centre attendees when cases have occurred in three or more households of child attendees or when the outbreak is recognized more than 3 weeks after the onset of the index case
- Newly hired staff or children newly admitted to the centre during the six week time period following identification of that last case
- Supervised hand washing should be implemented for the children

Daycare centres not caring for diapered children

If a case occurs in a staff member or child attendee, provide hepatitis A vaccine and/or Ig for previously unimmunized staff members in contact with the index case and for unimmunized children in the same room as the index case. In daycare facilities, careful hand washing is important, particularly after changing diapers and before preparing or serving food. Supervised hand washing should be implemented for the children.

7.2 Institutional settings

Provide hepatitis A vaccine and/or Ig to residents and staff in facilities for developmentally challenged individuals and inmates and staff in correctional facilities when an outbreak occurs.

For confirmed hepatitis A cases, routine precautions and a point of care risk assessment are recommended during the first 2 weeks of illness and no more than 1 week after onset of jaundice. Consider prolonged routine precautions and point of care risk assessments for an outbreak in the neonatal intensive care setting.

7.3 Prevention education

Emphasize the importance of personal hygiene (e.g., handwashing after using the bathroom, before preparing meals and before eating). Advise travelers going to countries of high or intermediate endemicity (refer to https://www.who.int/images/default-source/maps/global_hepa_ithriskmap.png?sfvrsn=a54529dd_0) about careful selection of food and drink to avoid potentially contaminated sources of infection. Refer to the Health Files for travelers:

- https://www.healthlinkbc.ca/healthlinkbc-files/travel-immunizations-adults
- https://www.healthlinkbc.ca/healthlinkbc-files/hepatitis-vaccine

Refer to the Yukon Immunization Program manual under Hepatitis A Vaccine for a list of groups for whom hepatitis A vaccine is recommended.

8.0 PUBLIC HEALTH REPORTING

Practitioner Alert!

Report hepatitis A outbreaks to YCDC by fastest means possible.

Review the necessity of any public announcement with YCDC and the MOH.

To speak with a nurse about hepatitis A, call YCDC at 867-667-8323. After hours, contact the MOH on call.

9.0 CONTACT INFORMATION

Yukon Communicable Disease Control
Hours: Monday- Friday (08:30 to 16:30)
#4 Hospital Road, Whitehorse, YT Y1A 3H8
Telephone: Local (867) 667-8323
Within Yukon 1-800-661-0408, ext. 8323
Fax: (867) 667-8349

Medical Officer of Health On-Call
PO Box 2703 (H-2)
Whitehorse, YT
Cell: (867) 332-6922

Whitehorse General Hospital
(Ambulatory Care)
#5 Hospital Road, Whitehorse, YT Y1A 3H7
Telephone: (867) 393-8700
Fax: (867) 393-8707
WGH Laboratory telephone: (867) 393-8739

APPENDIX A: YCDC Hepatitis A Follow-Up Form

Date Case Contacted (YYYY/MM/DD):	Form Completed By:	Email Address:
Attending Physician:	Phone # attending:	Discussed with attending: □ yes □ no If yes, date:
□ Lab results (HAV IgM) as attached or (specify): Date Collected (YYYY/MM/DD):		
This case is: □ Confirmed □ Clinical		

A. Demographic Information

Case Last Name: **First Name:** **Initial:**		
YHIS:	Birth date (YYYY/MM/DD):	Age:
Gender: □ Male □ Female	Ethnicity:	
Parent/Guardian name (If Applicable):		
Address:	Phone # (Include Area Code):	
	Cell #:	
	email:	

Type of residence:
□ Private home □ Institution □ Other

Occupation:
□ Food/drinking water handler □ Daycare worker □ Care facility or prison □ Hospital worker

Place of work/address/phone #

Family Physician □ attending (details as above)
Or if different from above:

Surname: **First Name:** **Initial:**

City: Phone # (Include Area Code):

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B. Case Details

Check (√) if applicable: If not (√) then = not present:

Symptoms:	Onset Date	Resolution Date
□ Jaundice		
□ Fever		
□ Abdominal Pain		
□ Vomiting		
□ Nausea		
□ Diarrhea		
□ Other:		

History of prior hepatitis A infection □ yes □ no If yes, Date (YYYY/MM/DD):

Prior immunization for hepatitis A □ yes □ no If yes, Date (YYYY/MM/DD):

**** Calculate Infectious Period ****

14 days prior to first symptom onset, to 7 days after jaundice onset or 14 days after first symptom, whichever is longer

From (YYYY/MM/DD): To (YYYY/MM/DD):

C. Exposure Information/Risk Factors

Exposure (incubation) Period: *(max 50 days to min 15 days prior to first symptom)*

From (YYYY/MM/DD): To (YYYY/MM/DD):

Check box if applicable. Indicate DNA, "did not ask", beside box if applicable

□ **Known contact of hepatitis A case**

Name of case: Telephone #:

Place of contact: Contact's physician name/telephone:

□ **Post exposure prophylaxis given** If yes, Date (YYYY/MM/DD):

Name and Lot # (if known): Vaccine: IgG:

□ **Travel/Immigration:**

□ Domestic □ International Dates/place/details of travel:

□ **Occupational Exposure:**	Details:
□ **Raw or Cooked Shellfish:**	Details:
□ **Child Daycare Attendee:**	Specify:
□ **Suspect Food:**	Specify:
□ **Suspect Water Supply:**	Specify:
□ **Institutional Care:**	Details:

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The following questions are of a sensitive nature and should be asked if no alternative exposure is identified:	
□ **High risk sexual activity (oral-anal sex)**	Specify:
□ **Injection drug use**	Specify drug & if "rig"/needle shared:
□ **Other street drug use/indicate if shared**	Specify:

Complete section below if no clear exposure identified

Restaurants visited in past 2 months:

Name:	Date (YYYY/MM/DD):	Items eaten:

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D. Contact Information

Estimated Infectious Period (see **Calculate Infectious Period** page 2)

From (YYYY/MM/DD): To (YYYY/MM/DD):

Name of Contact	Relationship	Age	Sex	Telephone #	Date of Contact (YYYY/MM/DD)	Symptoms?	Date Vaccine Given	Lot#
Household								
Place of Work								
Contacts for whom case has prepared food								

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Name of Contact	Relationship	Age	Sex	Telephone #	Date of Contact (YYYY/MM/DD)	Symptoms?	Date Vaccine Given	Lot#
Child Day Care contacts								
Additional/ Other Contacts *(sexual partners, share drugs/cigarettes, etc)*								

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