

Editorial

Volume 1 Issue 3 – October 2016
DOI: 10.19080/JOJIV.2016.01.555562

JOJ Immuno Virology

Copyright © All rights are reserved by Abdulghani Mohamed Alsamara

Viral Hepatitis Infections: Endemicity Indicated a Continuous Health Problem in Iraq

Abdulghani Mohamed Alsamara*

Tikrit University College of Medicine, Iraq

Submission: November 11, 2015; **Published:** November 14, 2015

***Corresponding author:** Abdulghani Mohamed Alsamara, Tikrit University College of Medicine, Tikrit, Iraq,
Email: galsamarrai@yahoo.com; momoghsa@gmail.com

Editorial

Viral hepatitis infection is still a global health problem. The infection caused by a group of viruses, which include hepatitis A virus (HAV), hepatitis B virus (HBV), hepatitis C virus (HCV), hepatitis D virus (HDV), hepatitis E virus (HEV), hepatitis F virus (HFV), hepatitis G virus (HGV), and torque teno virus (TTV) [1-4]. The burden of infection on society is mainly attributed to the induction of chronic infection, liver cirrhosis and development of hepatocellular carcinoma (HCC). The chronic infection is caused by HBV, HCV, HDV, and TTV are the major causes of severe illness and death and are characterized by induction of chronic infections and carrier state that may lead to HCC [2-6]. Primary HCC in 78% of cases are attributed to HBV and HCV, while 57% of liver cirrhosis are due to HBV and HCV [4,6-7].

Disease high endemicity trend was associated with low socioeconomic levels which may influence the availability of resources [8] UN, 2012. Although, WHO is interested in performing research and control and prevention programs, still the incidence of viral hepatitis not declined with time. In addition, the health system situation in developing countries indicating that inequitable access to health [2] and lack of the documentation of the chronic viral hepatitis and development of national guidelines. Effective national programs for prevention and control of HBV and HCV infection must be established [9], especially in developing countries with infrastructure destruction due to conflict.

In the Mediterranean region HBV Seroprevalence ranged from intermediate ($\geq 2\%$) to high prevalence ($\geq 7\%$) [10]. In Iraq, a recently one national wide community based study was performed [11] and indicated that national prevalence of HBsAg was 1.6% and correlated positively with age, while the prevalence of anti-HBs and anti-HBc antibodies was 17% and 9.7% respectively. However, in a retrospective study (published in this issue of the journal), which included 16165 individuals; we found that Seroprevalence of HBsAg was 3.2% in Samara city,

Iraq [12]. These two studies indicated a regional variation in prevalence of HBsAg and this reflect a regional variation of HBV infections in Iraqi population. Our study illustrated a trend on prevalence increase with time as it was 1.6% for 2011, 3.55% for 2012 and 4.73% for 2013. HCV infection shows the same pattern of prevalence increase with time. Both HBV and HCV prevalence was significantly increased with time, which in contrast with expectation and this illustrate a pocket gap in the Endemicity and epidemicity of the disease. The prevalence of 3.2% of HBsAg is too much higher than goal prevalence ($< 1\%$).

In Iraqi community, the proposed pattern of chronic hepatitis B infection is a combination of the first and third global patterns, where the infection transmission occurs vertically and horizontally. This pattern illustrates difficulty in performing control and prevention programs because it must cover a wide range of community. However, implementation of effective antenatal screening, infant vaccination program, blood screening and safe injection will contribute to reduction in HBV and HCV infection and chronicity. The overall prevalence of HCV is on decline, but the isolated pockets of very high prevalence in different districts within the same country (for e.g. Iraq) pose a serious health care problem. In addition, the most widely screening test for HCV is detection of antibody and thus early infection and those non-seroconvert individuals show a negative result. These hidden cases are responsible for HCV spread in Iraqi population and warranted use of test that detect HCV antigen such as PCR.

The reported studies in Iraq indicated that HCV Seroprevalence decreased with time, however, our recent study shows an increase in anti-HCV in 2013 as compared to 2012 and 2011. This suggest increased pockets in Iraq, which represent a serious health problem and thus a regional and national well designed survey is warranted. The impact of HCV on health and medical care in Iraq is a major problem for the

community and infectious disease physicians and evolving of new epidemiological characteristics is expected.

There are insufficient data about HCV prevalence in most of the Iraqi governorates and information about the prevalence of HCV infections is generally been limited to laboratory data and personal interest of research projects in certain education institution. Majority of regional health authorities and hospital director's poor collaboration with educational institutes strengthen the complexity of the problem. Health care setting need to implement and address primary prevention programs and a grass root programs and support is an essential in control and prevention of HCV infections in health setting. Good collaboration between educational institutes and regional health authority is vital to achieve good outcome for hepatitis research programs.

References

1. Olivera KB (2015) Torque teno virus: a ubiquitous virus. *Rev Bras Hematol Hemoter* 37(6): 357-358.
2. WHO (2016) Hepatitis B. World health organization , Geneva, Switzerland.
3. WHO (2016) Hepatitis C. World health organization, Geneva, Switzerland.
4. WHO (2013) Hepatitis B. World health organization, Geneva, Switzerland.
5. American Cancer Society (2011) Global cancer facts and figures. (2nd edn), American Cancer Society, USA, p. 23.
6. De Martel C, Maucort-Boulch D, Plummer M, Franceschi S (2015) World-wide relative contribution of hepatitis B and C viruses in hepatocellular carcinoma. *Hepatology* 62(4): 1190-1200.
7. WHO (2012) Prevention and control of viral hepatitis infection: framework for global action. World health organization, Geneva, Switzerland.
8. <http://hdr.undp.org/en/data>
9. Easterbrook P, Sands A, Harmanchi (2012) Challenges and priorities in the management of HIV/HBV and HV/HCV co-infection in resource limited settings. *Semin Liver Dis* 32(2): 147-157.
10. Colvin HM, Mitchell AE (2010) Institute of Medicine. Hepatitis and liver cancer: a national strategy for prevention and control of hepatitis B and C. National Academic Press, Washington DC, USA.
11. Tarky AAM, Akram W, Al-Naaimi AS, Omer AR (2013) Epidemiology of hepatitis B and C in Iraq: a national survey 2005-2006. *Zanco J Med Sci* 17(1): 370-380.
12. Alsamarai AGM, Abdulrazaq G, Fatah A, Alobaidi AHA (2016) Seroprevalence of hepatitis B virus in Iraqi population. *J Vaccines Immunol* 102: 1-11.

**Your next submission with JuniperPublishers
will reach you the below assets**

- Quality Editorial service
- Swift Peer Review
- Reprints availability
- E-prints Service
- Manuscript Podcast for convenient understanding
- Global attainment for your research
- Manuscript accessibility in different formats
(Pdf, E-pub, Full Text, Audio)
- Unceasing customer service

Track the below URL for one-step submission

<http://juniperpublishers.com/online-submission.php>