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We compared the epidemiology of hepatitis A and hepatitis E cases in China from 1990–2014 to better inform policy and prevention efforts. The incidence of hepatitis A cases declined dramatically, while hepatitis E incidence increased. During 2004–2014, hepatitis E mortality rates surpassed those of hepatitis A.

Hepatitis A virus (HAV) and hepatitis E virus (HEV) cause acute hepatitis in humans and are transmitted mainly through the fecal–oral route. Hepatitis A and hepatitis E became notifiable in China in 1990 and 1996, respectively. Since the introduction of the hepatitis A vaccine and the start of mass vaccination in several countries in the 1980s, hepatitis A incidence declined substantially, not only among vaccinated children but in the population as whole (1,2). China first licensed its live attenuated hepatitis A vaccine in 1992 and later the inactivated hepatitis A vaccine in 2002 (3). The hepatitis A vaccine was initially introduced into the private market, although some provinces provided subsidies through the World Health Organization Expanded Programme on Immunization (http://www.wpro.who.int/china/areas/immunization/en/). Starting in May 2008, hepatitis A vaccinations were incorporated into the routine national childhood immunization program for children >18 months of age (3).

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HEV is a substantial cause of illness and death worldwide, particularly among pregnant women (4). Until the introduction of the first hepatitis E vaccine to private markets in China in 2011, there were no specific pharmaceutical interventions for HEV (5). Given the similarity in diseases caused by HAV and HEV and the recent decline in hepatitis A incidence, we compared the epidemiology of human cases infected with the 2 pathogens in China.

The Study
We obtained data on cases of hepatitis A reported during 1990–2014 and hepatitis E for 1997–2014 from China’s National Notifiable Disease Report System and collated demographic information from the China National Bureau of Statistics. We defined confirmed cases on the basis of dates of disease onset and updated diagnostic criteria issued by the Chinese Ministry of Health in 2008; these criteria are based on epidemiologic history, clinical signs, and laboratory test results (online Technical Appendix Table, https://wwwnc.cdc.gov/EID/article/23/2/16-1095-Techapp1.pdf).

We used R version 3.0.1 (R Foundation for Statistical Computing, Vienna, Austria) and SAS version 9.2 (SAS Institute Inc., Cary, NC, USA) to estimate annual incidence and mortality rates for hepatitis A and hepatitis E according to patient age and sex. Notified cases were geocoded into provinces and mapped by ArcGIS 10 (Esri Inc., Redlands, CA, USA). To examine seasonality, we created heat maps by using monthly incidence normalized to the maximum incidence each year. We used a similar approach to examine seasonality across latitudes. We assessed potential associations between incidence and demographic and economic factors by using Poisson regression.

Hepatitis A incidence dropped from 55.7 cases/100,000 person-years in 1991 to 1.9 cases/100,000 person-years in 2014, a decrease of 96.6% (Figure 1). In contrast, hepatitis E incidence increased significantly over this period, from 0.21 cases/100,000 person-years in 1997 to 1.99 cases/100,000 person-years in 2014, an 8-fold increase (p<0.0001 by Poisson regression) (Figure 1). The mortality and incidence rates for hepatitis E overtook those for hepatitis A in 2004 and 2011, respectively (Figure 1). Hepatitis E cases across the country were most frequently reported in March (online Technical Appendix Figures 4, 5). This change may result from increased temperature and rainfall in the spring, which could increase the likelihood of acquiring

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HEV infection from exposure to contaminated water, such as water sourced from a stream near a free-range pig farm (6–8). In contrast, the seasonal pattern of HAV infections varied by latitude; cases were reported most frequently in the spring in southern provinces and in the autumn in most northern provinces (online Technical Appendix Figure 5). The decline in the incidence of hepatitis A cases in winter and summer varies by province, and reasons for the differential latitudinal pattern are unclear (7–9).

Hepatitis A incidence was highest among children and young adults (Figure 2). In contrast, hepatitis E incidence was highest among older adults and low among children and young adults (Figure 2). For both diseases, incidence and mortality rates were higher among male patients, and mortality rates tended to increase with age (Figure 2). The percentage of infections resulting in death were generally similar among men and women within each age group for most years (online Technical Appendix Figure 2).

We found considerable changes in the epidemiology of hepatitis A and E over time in mainland China. The major decline in hepatitis A incidence during 1992–2014 cannot be explained solely by the introduction of the vaccine because implementation of vaccinations in the general population had been relatively low until the inactivated hepatitis A vaccine was included in the national Expanded Program on Immunization in May 2008 (3). Other key reasons could be heightened public awareness, improved social hygiene, and upgrades in sewage treatment and water quality (9–11). Decreasing incidence was also accompanied by a change in the age distribution of reported hepatitis A case-patients; the average age increased over time (Figure 2), possibly a consequence of inclusion of the vaccine in the national Expanded Program on Immunization, which targets children >18 months of age. The incidence of hepatitis A is now highest in northwestern China, which is a comparatively less developed region of the country (online Technical Appendix Figure 1).

Our findings in China are similar to those documented in other countries, where HEV infection is now more common than HAV infection (12,13). The increase in hepatitis E incidence could result from either a true increase in the number of cases or from improved case diagnosis. Hepatitis E case-patients are mostly adults, particularly older adults (Figure 2). Although we did not have data on HEV genotypes for this study, it is possible that the change in age distribution of hepatitis E patients may result from the shift of the prevalent HEV genotype in China from genotype 1 to genotype 4 (and, to a lesser extent, genotype 3). Genotype 3 and genotype 4 are known to infect older men (14,15). The increase in the number of HEV infections in eastern China (online Technical Appendix Figure 1) could also be caused by this genotype shift and improved surveillance in these more developed provinces (15), rather than by true geographic heterogeneity in risk factors.

There are some limitations to our study (online Technical Appendix). Our findings are inferred from case notification data, and the data quality could vary because of changes in case definitions. Other limitations include
variable availability of laboratory diagnostics and lack of hepatitis E genotype data.

**Conclusions**

Reports of hepatitis A in China have declined substantially, while reports of hepatitis E cases have continued to rise. The mortality rate for hepatitis E surpassed that for hepatitis A in 2004. Decreasing trends of hepatitis A incidence after implementation of a vaccination program targeting children >18 months of age indicate a similar strategy for hepatitis E could be considered as a means to curtail incidence. In addition, variations in demographic, geographic and seasonal distributions of hepatitis A and E may inform future prevention strategies in China.

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Technical Appendix

Regional Hepatitis Incidence

Provinces along the Yangtze River and some northeastern provinces had relatively higher hepatitis A incidence in the 1990s, while a higher incidence has been observed in western China since 2000 (Technical Appendix Figure 1). In contrast, hepatitis E incidence has remained highest in eastern China (Technical Appendix Figure 1). In the Poisson regression models, both GDP and GDP per capita (Technical Appendix Figure 3) showed a strong association with the incidence of hepatitis A (p < 0.0001) and the incidence of hepatitis E (p < 0.0001). GDP and GDP per capita were inversely correlated with incidence of hepatitis A but positively associated with the incidence of hepatitis E.

Study Limitations

There are some potential limitations to our work. First, the data quality may be influenced by changes in the national notifiable disease reporting system including changes in case definitions, reporting methods, availability of health facilities and laboratory diagnostics, underreporting, and completeness and accuracy of data over the years. Diagnosis and notification of cases may vary across the country, affecting our geographic comparisons of incidence. Second, we inferred the relative disease burden of hepatitis A and E on the basis of case notification data, but underestimation of hepatitis A or E cases may have biased our comparison since many cases may not have been diagnosed and reported. Information on hepatitis E genotypes was not available in the case reports, and therefore we could not explore the potential effect of changing patterns in the genotypes on HEV infections. In addition, the increase in hepatitis E could be due to increased awareness of the disease and use of diagnostic testing. We cannot be certain if there has been a true increase in incidence as data on the total number of cases tested for HEV...
over the study period are not available. Finally, we did not have information on the total number of laboratory tests performed over time, and increase in laboratory capacity may have led to gradual increases in the incidence of notified cases of hepatitis A and E over time.
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<td>Chinese Standard Number</td>
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<tr>
<td>3.3 has serum bilirubin (BIL) &gt; 17.1 µmol/L and positive urinary bilirubin tests</td>
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<tr>
<td>3.4 has serum bilirubin (BIL) increased, especially the direct bilirubin, with alkalinephosphatase(ALP), glutaminpeptideenzyme(GGT) and cholesterol increased, and serum alanine moderately increased</td>
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<td>3.5 has abnormal liver function, serum bilirubin increased to over 171 µmol/L within a few days or increased by more than 17.1 µmol/L per day, and prothrombin activity less than 40%</td>
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<tr>
<td>3.6 has abnormal liver function, transaminase level decreased but the serum bilirubin continued to be elevated, Albumin globulin ratio(A/G)&lt;1, cholesterol decreased and prothrombin activity less than 40%</td>
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**Diagnosis and Classification**

4.1 Acute anicteric hepatitis

- **Probable case:** 4.1.1+3.1
- **Confirmed case:** 4.1.1+3.2

4.2 Acute icteric hepatitis

- **Probable case:** 2.1+2.2+3.1+3.3
- **Confirmed case:** 4.2.1+3.2

4.3 Cholestasis hepatitis

- **Probable case:** 2.1+2.2+2.3+3.4
- **Confirmed case:** 4.3.1+3.2 or 2.7+3.2

4.4 Acute severe hepatitis

- **Probable case:** 2.4+2.5+3.5
- **Confirmed case:** 4.4.1+3.2 or 2.5+2.7

4.5 Sub-acute severe hepatitis

- **Probable case:** 2.6+3.6
- **Confirmed case:** 4.5.1+3.2 or 2.7+3.2

4.6 Acute severe hepatitis

- **Probable case:** 2.4+2.5+3.5
- **Confirmed case:** 4.4.1+3.2 or 2.5+2.7

4.7 Sub-acute severe hepatitis

- **Probable case:** 2.6+3.6
- **Confirmed case:** 4.5.1+3.2 or 2.7+3.2

**4.1 Hepatitis A**

- **Probable case:** 1.1+2.1+2.2+3.1 or 1.1+2.1+2.2+3.1+3.2
- **Confirmed case:** 4.1.1+3.2

**4.2 Acute anicteric hepatitis A**

- **Probable case:** 1.1+2.1+3.1 or 2.1+3.1
- **Confirmed case:** 4.2.1+3.2

**4.3 Acute icteric hepatitis A**

- **Probable case:** 1.1+2.1+2.2+3.1+3.2
- **Confirmed case:** 4.3.1+3.2

**4.4 Acute severe hepatitis A**

- **Probable case:** 2.4+2.5+3.1+3.2+3.3+3.5
- **Confirmed case:** 4.4.1+3.2 or 2.5+2.7

**4.5 Sub-acute severe hepatitis A**

- **Probable case:** 2.6+3.6
- **Confirmed case:** 4.5.1+3.2 or 2.7+3.2

**4.6 Acute severe hepatitis A**

- **Probable case:** 2.4+2.5+3.5
- **Confirmed case:** 4.4.1+3.2 or 2.5+2.7

**4.7 Sub-acute severe hepatitis A**

- **Probable case:** 2.6+3.6
- **Confirmed case:** 4.5.1+3.2 or 2.7+3.2

**4.1 Acute anicteric hepatitis E**

- **Probable case:** 2.1+3.1+3.2
- **Confirmed case:** 4.1.1+3.4

**4.2 Acute icteric hepatitis E**

- **Probable case:** 2.1+2.2+3.1+3.2+3.3
- **Confirmed case:** 4.2.1+3.2

**4.3 Acute severe hepatitis E**

- **Probable case:** 2.1+2.2+3.1+3.2+3.3+3.5
- **Confirmed case:** 4.3.1+3.1

**4.4 Sub-acute severe hepatitis E**

- **Probable case:** 2.1+2.2+3.1+3.2+3.3+3.7
- **Confirmed case:** 4.4.1+3.2 or 2.4+3.6

**4.5 Hepatitis E with acute liver failure**

- **Probable case:** 1.1+2.1+2.2+3.1+3.2+3.5+2.3a+3.4a
- **Confirmed case:** 4.5.1+3.1

**4.6 Hepatitis E with sub-acute liver failure**

- **Probable case:** 1.1+2.1+2.2+3.1+3.2+3.3+3.5+2.3a+3.4b
- **Confirmed case:** 4.6.1+3.1

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*The revised diagnostic criteria in 2008 provided a simplified disease categorization for hepatitis A and clarified laboratory confirmation for IgG and IgM antibody using ELISA and HAV RNA using RT-PCR. The hepatitis E laboratory testing guidelines were changed in 2008 to include quantification of IgG and IgM antibody using suggested assays.*
Technical Appendix Figure 1. Averaged annual incidence of notifications of hepatitis A (left column) and hepatitis E (right column) in each province of China in 1990–1999, 2000–2009 and 2010–2014. Data were not available on hepatitis A and E cases in Hong Kong SAR, Macau SAR, and Taiwan. Chongqing municipality has been administratively separated from Sichuan province since 1997, and therefore estimates of incidence and mortality rates of hepatitis A in Sichuan province before 1997 were calculated by using data that included Chongqing.
Technical Appendix Figure 2. Point estimates (dots) and 95% confidence intervals (vertical gray lines) of the case fatality ratio (defined as notified deaths divided by all notifications) of hepatitis A and E by age group among males (blue) and females (red) in 1990–1999, 2000–2009 and 2010–2014.
Technical Appendix Figure 4. Seasonal patterns in incidence of notified hepatitis A (upper panel) and hepatitis E (lower panel) cases by year in China from 1990 through 2014. The monthly incidence was calculated for each year and then divided by the maximum monthly incidence in each year.
**Technical Appendix Figure 5.** Seasonal patterns in incidence of notified hepatitis A (upper panel) and hepatitis E (lower panel) cases by province from 1990 through 2014. The monthly incidence was calculated for each province and then divided by the maximum monthly incidence in each province. The provinces are sorted by latitude from north to south.