Hepatitis E virus seroprevalence in pregnant women in Pakistan: maternal and fetal outcomes

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Abstract: The objective of this study was to estimate the seroprevalence of Hepatitis E virus (HEV) in pregnant women and to evaluate the maternal and fetal outcomes among HEV-positive women. A cross-sectional study was conducted in 2015 among 135 pregnant women at the tertiary care hospitals in Pakistan. The seropositivity for HEV was 2.9% (4/135). The pregnant women who were seropositive for HEV had a higher risk of developing acute liver disease (14.2%) compared to those who were seronegative (0.19%). There was a higher proportion of pregnant women who died (14.2%) and stillbirths (17%) among HEV-positive women compared to HEV-negative women (3% and 7%, respectively).
ABSTRACT Hepatitis E virus (HEV) is endemic in Pakistan. Although otherwise asymptomatic, HEV infection becomes fatal in pregnancy, with considerable maternal and fetal morbidity and mortality. We conducted a descriptive study from April to October 2015 in 10 tertiary care hospitals throughout Pakistan to determine maternal and fetal morbidity and mortality in HEV-positive pregnant women with acute jaundice or raised liver function tests. Twenty-one of 135 women were HEV positive and in 3rd trimester except for 1 in 1st trimester. Overall prevalence of HEV in pregnancy was 0.19%. Ten women were artificially induced, 3 had premature labour, 4 delivered spontaneously (full term), 3 died and there was 1 intrauterine death. One woman had a home abortion before coming to hospital. There were 7 perinatal infant deaths: 4 intrauterine, 3 stillbirths and 1 abortion. Maternal mortality was significantly associated with delivery, as 17 mothers who lived went into labour spontaneously or were artificially induced, whereas 3 women who continued their pregnancy and did not deliver, died. Case fatality rate of HEV infection in pregnancy was 14.2%.

Séroprévalence de l'infection par le virus de l'hépatite E chez des femmes enceintes au Pakistan : conséquences sur la santé maternelle et fœtale

RÉSUMÉ Le virus de l'hépatite E (VHE) est endémique au Pakistan. Bien qu’asymptomatique dans la plupart des cas, le virus de l’hépatite E devient mortel lors d’une grossesse, contribuant de façon considérable à la morbidité et la mortalité maternelles et fœtales. Une étude descriptive a été conduite entre avril et octobre 2015 dans 10 hôpitaux de soins tertiaires dans l’ensemble du Pakistan afin de déterminer la morbidité et la mortalité chez les femmes enceintes positives au virus de l’hépatite E avec ictère aigu ou présentant une élévation des tests hépatiques. Sur 135 femmes, 21 étaient positives au virus de l’hépatite E et se trouvaient au troisième trimestre de grossesse, exception faite de l’une d’entre elles qui en était au premier trimestre. La prévalence globale du virus de l’hépatite E durant la grossesse s’élevait à 0,19 %. Dix femmes avaient subi un accouchement déclenché, trois avaient eu un travail prématuré, quatre avaient accouché naturellement (à terme), trois femmes étaient décédées et on dénombrait un décès intra-utérin. Une femme avait avorté à domicile avant de se rendre à l’hôpital. Il y a eu sept cas de décès perinataux, dont quatre cas intra-utérins, trois mortinaiassances et un avortement. La mortalité maternelle était significativement associée à l’accouchement puisque les 17 mères qui ont survécu avaient accouché naturellement ou avaient subi un accouchement déclenché, tandis que trois femmes avaient poursuivi leur grossesse sans accoucher, et étaient décédées. Le taux de létalité de l’infection par le virus de l’hépatite E durant la grossesse était de 14,2 %.

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Introduction

Hepatitis E virus (HEV) is a small, nonenveloped virus with a single-stranded RNA genome. The virus has four genotypes, but only one serotype. Genotypes 1 and 2 exclusively infect humans, whereas genotypes 3 and 4 also infect pigs and several other mammalian species.

Like hepatitis A virus, HEV also spreads via the faecal–oral route, and in nonpregnant women and men, the disease is usually self-limiting and has a low case fatality rate.

In Pakistan, epidemics of acute viral hepatitis were first reported in the 1950s and 1960s. In 1972, an outbreak of ~250 cases was observed in an army battalion on field exercises, and all infected persons had drunk untreated river water (2). Many similar outbreaks of hepatitis E had been wrongly attributed to HAV. However, it subsequently became clear that all the outbreaks were caused by HEV (2, 3). In Pakistan, HEV remains highly endemic and mainly affects the adult population (4). Several mini-epidemics have recently been reported in Pakistan and all of these appear to have been due to faecal contamination of the water supply. Although Islamabad has a supply of potable water and a good drainage system, it had a massive outbreak of acute hepatitis caused by HEV between December 1993 and March 1994 that created a lot of concern in the general population (5). The Pakistan Viral Hepatitis Surveillance System reported that during June 2010–March 2011, 712 cases of viral hepatitis were seen at 5 sentinel sites and prevalence of acute hepatitis E was 12.2% (6).

The prevalence of HEV is higher in pregnancy, which has mostly been reported in developing regions and countries like North Africa, India, Pakistan, Ghana and Egypt. It remains inconclusive whether the severe outcome in pregnancy in these countries reflects viral
virulence, viral variants or host factors, especially malnutrition, or failure of timely and proper
treatment (7). For unknown reasons, the mortality rate is higher among pregnant women,
especially during the 3rd trimester (8). Fulminant hepatic failure secondary to hepatitis E
infection is common in pregnancy and associated with a mortality rate of up to 20–25% (9). In
India, Islamic Republic of Iran, Africa and the Middle East, the incidence of fulminant hepatitis
was higher in pregnancy. The mortality rate in HEV-infected mothers was 100% and
mother-to-child transmission of HEV was established in 50% of cases (10).

Screening pregnant women for HEV is thus important for improving knowledge about the
epidemiology of the virus and planning for its prevention and control. A few studies have been
conducted in Pakistan to document the prevalence of HEV in pregnant women. The results of
the present study will help to determine the prevalence of HEV infection in pregnant women and
its outcomes at the national level. We also investigated fetal outcomes and rate of vertical
transmission. Analysis of our results will help to plan future strategies to prevent the high
mortality associated with this infection.

Methods

The objective of this study was to determine the maternal and fetal morbidity and mortality in
pregnant women positive for HEV IgM who presented with jaundice or abnormal liver function
tests, in comparison with HEV-negative cases. None of the women had jaundice of pregnancy
or hepatocellular carcinoma. We conducted an observational study from 1 April to 30 October
2015 in 10 hospitals in Pakistan: Pakistan Institute of Medical Sciences, Islamabad; Dow
University of Health Sciences, Karachi; Jinnah Postgraduate Centre, Karachi, Sindh; Shaikh
Zayed Hospital, Lahore; Allied Hospital, Faisalabad, Punjab; Bolan Medical College, Quetta,
Balochistan; Lady Reading Hospital and Hayatabad Medical Complex, Peshawar, Khyber
Pakhtoonkhwa; and Holy Family Hospital and Benazir Bhutto Hospital, Rawalpindi.

After receiving ethical clearance and consent from participating hospitals, data collectors were
trained to maintain the uniformity of data coding, delivery of questions, data gathering, decoding
and data entry. Data collectors were trained researchers. The questionnaire consisted of
close-ended questions and information was collected under 5 headings: participating hospital,
patient demography, details about hospital admission, details of laboratory findings, and
outcome of pregnancy (both maternal and fetal). Any pregnant woman with acute jaundice
presenting for the first time anywhere within the hospital, either in the obstetric outpatient
department, labour room or emergency department, was immediately reported to the research
team. After obtaining informed consent from the patients, demographic information was
recorded through face-to-face interview with the patient. However, if the patient was too ill, the
attending physician gave the information. Data regarding gestational age, laboratory findings
[hepatitis B surface antigen, hepatitis C virus (HCV) antibody, liver function tests, coagulation
tests (e.g., activated partial thromboplastin time)] and complications associated with pregnancy
were retrieved from patients' files. All enrolled patients were followed through medical records or telephone contact after discharge for pregnancy outcomes (mother and fetus) and data were recorded.

In addition to laboratory information collected from the patients' files, pregnant women were screened for HEV IgM by taking 3-ml blood. Samples were transported to the designated research centre for that city where they were analysed for HEV-specific IgM antibodies using indirect antibody capture, quantitative ELISA. Sample testing used one negative and two positive controls. The ELISA kit had sensitivity and specificity of 97.9 and 100%, respectively. Data on patient demography, hospital admission, laboratory findings and outcomes were analysed using Epi Info version 7.2. Descriptive analysis is presented as frequencies and percentages. A P value

**Results**

**Patient characteristics**

One hundred and forty-two pregnant women were enrolled, however, 7 did not give consent for the study and were excluded. Among the remaining 135 patients, 21 were HEV positive and 114 were HEV negative.

Mean age of the HEV-positive women was 29.2 (standard deviation; SD, 7.7) years and mean age of the HEV-negative women was 28.6 (4.9) years. The women were divided into 2 age groups: 20–30 and 31–40 years. All HEV-positive women were in the 31–40 years group, whereas 23 HEV-negative women were in the 20–30 years and 91 were in 31–40 years group. Mean gestational age was 33.46 (4.45) weeks for HEV-positive women and 35 (2.2) weeks for HEV-negative women. Twenty-one pregnant women had acute hepatitis E. Overall prevalence of HEV among pregnant women was 0.19% (21 out of expected pregnant population of 10 956). One hundred and fifteen (85%) women were multigravida and 20 (15%) primigravida. One hundred and sixteen (86%) women presented in the 3rd trimester, 17 (13%) in 2nd trimester and 2 (1.4%) in 1st trimester, and 116 presented with jaundice. All HEV-positive cases were in the 3rd trimester.

Regarding educational status, 29 were illiterate; 31 were educated to primary level, 34 to intermediate level and 23 to matric level; 11 were graduates and 7 had a masters degree.

**Clinical presentation**

Ten (7.4%) of the 135 women had a history of jaundice and all those were multigravida. Jaundice was the most common symptom experienced by 116 (86%) patients followed by nausea/vomiting in 55 (41%), pruritus in 47 (35%) and bleeding from the gums or nose in 19
(14%). All 21 HEV-positive pregnant women had jaundice, and jaundice to encephalopathy interval was 1–3 days. Three (14.2%) HEV-positive patients developed encephalopathy and all died and 5 (4.4%) of 114 HEV-negative women developed this complication and 4 died. All pregnant women with jaundice (116, 86%) were treated symptomatically.

### Laboratory investigations

Among the 135 patients, 7 were infected with hepatitis B virus (HBV) (3 HEV positive and 4 HEV negative), 7 with HCV (1 HEV positive and 6 HEV negative) and 3 were co-infected with HBV and HCV (1 HEV positive and 2 HEV negative). LFTs, haemoglobin level, total leukocyte count, platelet count and random blood sugar were abnormal in HEV-positive and HEV-negative patients (Table 1).

### Maternal and fetal outcomes

Among HEV-positive cases, 3 women died from hepatic encephalopathy and there was 1 intrauterine death (IUD) (Table 2). All babies that were born alive survived. Among HEV-negative cases, 4 women died (2 from hepatic encephalopathy and 1 each from disseminated intravascular coagulation and renal failure) as well as 6 newborns (3 stillbirths and 3 intrauterine deaths). Overall there were 7 perinatal infant deaths: 4 IUDs, 3 stillbirths and 1 abortion. Regarding maternal deaths, 6 died from hepatic encephalopathy and 1 from renal failure/disseminated intravascular coagulation. No significant difference was found in the laboratory findings between the fatal and surviving cases. Maternal mortality was significantly associated with delivery (P ≤ 0.012), as 17 of 21 mothers who survived delivered naturally or were induced, while 3 who continued their pregnancy died.

### Discussion

Our study showed that jaundice was more common in multigravida as compared to primigravida women. Among 20 primigravida and 115 multigravida women, 116 (86%) presented in 3rd trimester, including all HEV-positive cases. This means severity of HEV infection increases with repeated exposure to virus, and during pregnancy, severity increases with each trimester, becoming lethal in the last trimester. An Indian study showed that 63% of HEV infection was in the 3rd trimester of pregnancy when presented with jaundice (11), and fulminant hepatic failure and death were more common in the HEV-positive group (relative risk of fulminant hepatic failure, 2.7; relative risk of death, 6.0). The current study had similar findings; out of 21 HEV-positive women, 3 developed fulminant hepatic failure and all died. However, the difference in maternal mortality between the HEV-positive and -negative groups was not significant, which may have been due to the small study group.

Abraham found that among HEV-positive pregnant women, mean gestational age was 31
weeks (12), whereas in the current study mean gestational age was 35 weeks. In another Indian study of acute liver failure (1989–1996), 49 of 83 women of childbearing age were pregnant (33 in 3rd trimester) and all except 2 had HEV infection (13). Our results are consistent with these findings in that 86% (116/135) were in 3rd trimester at presentation and all HEV-positive patients except 1 were in 3rd trimester.

Regarding maternal mortality in HEV-positive women, Zhu et al. (14) reported high mortality (up to 30%), mainly from fulminant hepatic failure. However, in our study, 3 of 21 HEV-positive patients died (14%) and this may have been due to the small study population. In Ghana, HEV seropositivity in pregnancy is high at up to 29% (15), whereas our study only showed an HEV prevalence of 0.19% among pregnant women.

Regarding fetal outcomes, Khuroo and colleagues have reported that HEV infection in neonates born to HEV-positive mothers is mostly benign as neonates usually survive with no prolonged illness (16). We found a similar result and only reported 1 perinatal death from miscarriage among 21 HEV-infected mothers. A study from the United Arab Emirates showed that only a few babies of HEV-infected mothers were either preterm, had hepatitis or died within a few hours after birth (17). However, in our study there were only 2 neonatal deaths among HEV-infected mothers; 1 from IUD and another from miscarriage (10%), which was higher than those born to uninfected mothers (5%). In Sudan, among 39 pregnant women with HEV infection during an outbreak, there were 14 IUDs and 9 premature deliveries (18), and neonatal mortality was high compared to that in our study. A similarly high neonatal mortality has been reported in India, where 15–50% of live-born infants of HEV-infected mothers died within 1 week of birth (19). In contrast, all babies born alive from HEV-infected mothers in our study survived. Other studies have also shown that fetal morbidity in HEV-infected mothers varies from case to case and geographically, and includes miscarriage, stillbirth, preterm labour, or perinatal or neonatal death (20, 21).

Bhatia and colleagues have revealed that HEV-positive pregnant women had a jaundice to encephalopathy interval of 5.2 (4.4) days, serum bilirubin level of 14.4 (5.8) mg/dl and serum aspartate aminotransferase/alanine aminotransferase (AST/ALT) ratio of thousands (22). However, the current study had different findings. The jaundice to encephalopathy period was 1–3 days and other laboratory values were not high.

In our study, most of the women affected were in the 31–40 years. However, an Indian study reported that most patients (82.7%) were aged 21–30 years (23).
A recent study from Pakistan documented that there was no history of jaundice in all 34 cases (24). Pruritus was the most common symptom experienced by 28 (82%) patients, followed by jaundice in 27 (79%), nausea/vomiting in 25 (74%), encephalopathy in 18 (53%) and bleeding from gums or nose in only 2 cases. Fulminant hepatic failure was diagnosed in 11 cases and all died. Similarly, in the current study only 10 patients had a history of jaundice and all 3 HEV-positive women who died eventually developed fulminant hepatic failure.

Our study had some limitations. This was a hospital-based study involving only the public sector but 70% of our population goes to the private sector, so the results cannot be generalized. In addition, discontinuation of treatment in some hospitals by patients further reduced the data.

This is believed to be the first study from Pakistan comparing clinical and laboratory profiles between HEV-positive and -negative pregnant women with jaundice. We described maternal and fetal outcomes in pregnant women who developed hepatitis E. We showed that incidence of infection increases with duration of gestation, which suggests that pregnant women should be periodically screened for clinical features of acute hepatitis during antenatal visits and should be investigated for hepatitis E. Pregnant women with HEV should be closely monitored for fetal and maternal well-being and signs of fetal distress, to prevent disease-associated morbidity and mortality.

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