Introduction

viral hepatitis represents an expanding public health problem throughout the world affecting several hundreds of millions of people***(Zuckerman, 1990).*** Despite widespread diagnosis and knowledge of infection routes, it remains one of the leading viral diseases requiring hospitalization. So, it is a heavy financial burden on the health services owing to high hospital costs. Also, it is proved to be the cause of considerable morbidity and mortality in human population both from acute infection and chronic sequelae ***(Bayoumi, 1992; Imam,1994).*** Viral hepatitis encompasses an extending alphabetical types from A to G The most dangerous types are those characterized by their ability to produce chronicity of infection; namely types B, C and D (***Morris et al., 1992).***

Infection with hepatitis B and C viruses (HBV and HCV) results in a broad spectrum of liver disease, ranging from subclinical infection to acute, self-limited hepatitis and fatal, fulminant hepatitis. Exposure to HBV or HCV, particularly when it occurs early in life , may also result in an asymptomatic carrier state that can progress to chronic active hepatitis, liver cirrhosis and eventually hepatocellular carcinoma. The viral and host factors determine this variable clinical outcome ***(Moradpour and Wands, 1995).***

It is estimated that there are 400 to 500 million HBV carriers in the world today. In the United States between 50,000 and 100,000 people

acquire HBV infection each year-even though a highly effective vaccine is available- one quarter become ill with jaundice, more than 10.000 patients require hospitalization and an average of 250 die of fulminant disease each year. Approximately 5 to 10 percent of infected patients become long- term carriers of the virus, 25% of carriers develop chronic active hepatitis which often progress to cirrhosis ***(Vitiello et al., 1995).***

On the other hand, hepatitis C virus (HCV) is now believed to be the major cause of post-transfusion and "Community acquired" (or sporadic) non-A non -B hepatitis (NANBH) world-wide ***(Farci, et al., 1991)*** with approximately 80% of patients having antibodies (Anti-HCV) against the virus. Estimates of the background prevalence of HCV, based mainly on the rates of anti- HCV positivety in blood donors, vary from 0.18-1.2% in northern Europe and the USA to 17% in other areas ***(Sirchia et al., 1989; Brind, et al., 1990; Choo et al., 1990; Mets et al., 1993).*** This may be due to differences in selection of cases for study and also because some early tests for anti-HCV were prone to false positivity ***(Aceti et al., 1990; MCFarlane et al., 1990).*** Comparatively, little is known about the epidemiological factors influencing HCV infection among these populations. Furthermore, most of these previous studies have concentrated on the prevalence of HCV in Europe, the USA and Japan and there is still relatively little information available from Africa ***(Delaporte et al.,1993; Saleh et al., 1994).***

In Egypt HBV and HCV have been shown to be endemic. Several investigators reported that, the prevalence of HBV carrier state is variable, depending on population group tested with an average of 5.5% ***(Georgy,1994).*** However, the prevalence of anti-HCV in Egypt ranges between 12-25% ***(AL-Ads, 1994).***