

## WEEKLY BULLETIN

# Communicable Disease Threats Report

Week 17, 21–27 April 2024

## This week's topics

1. Overview of respiratory virus epidemiology in the EU/EEA – weekly monitoring
2. An early human West Nile virus infection case in March in Andalusia, Spain
3. SARS-CoV-2 variant classification
4. Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

## Executive summary

### Overview of respiratory virus epidemiology in the EU/EEA - weekly monitoring

- Syndromic surveillance in primary and secondary care indicates that respiratory virus activity continues to decrease and has returned to baseline levels in most EU/EEA countries.
- Seasonal influenza activity at the EU/EEA level continues to decrease.
- For five consecutive weeks, the primary care pooled test positivity at the EU/EEA level has remained below 10%, with only one country reporting test positivity above the epidemic threshold. Similarly, the pooled test positivity in secondary care was below 10% and continued to decrease.
- Most countries now report baseline or low levels of influenza intensity and baseline rates of influenza-like illness (ILI). Countries continue to report a mix of geographical spread, indicating continued heterogeneity of influenza activity at country level.
- During week 16, influenza type B accounted for 83% of the influenza virus detections in the EU/EEA. For four consecutive weeks, more Influenza B than Influenza A was detected, although the detections remain low and continue to decrease, with only one country reporting elevated activity driven by Influenza B.
- RSV activity remained at low levels in the EU/EEA and in most reporting countries.
- SARS-CoV-2 activity remained low in all EU/EEA countries.

### An early human West Nile virus infection case in March in Andalusia, Spain

- An autochthonous human case of West Nile virus (WNV) infection with date of onset of symptoms in the beginning of March 2024 was reported by Spain.

- The case was likely infected in Seville province, Andalusia.

### SARS-CoV-2 variant classification

Since the last update on 12 April 2024, and as of 26 April, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

### Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

- According to media, on 26 April, the Mayotte Regional Health Agency reported the first three autochthonous cases of cholera. Since 18 March, and as of 26 April 2024, 13 cholera cases and no deaths have been reported.
- Given the identification of the first three autochthonous cases in Mayotte, the ongoing outbreak in Comoros, and the frequent movement of people from Comoros to Mayotte, the likelihood of further community transmission and therefore the overall risk of cholera for the population in Mayotte remains high.
- In the Comoros, since the last available update on 18 April, and as of 24 April, 620 new cholera cases and 16 new deaths have been reported. As of 24 April 2024, 2 584 confirmed cholera cases and 61 deaths have been reported in the country.

## 1. Overview of respiratory virus epidemiology in the EU/EEA – weekly monitoring

### Overview:

#### Respiratory virus activity

- ILI and acute respiratory infection (ARI) consultation rates are continuing to decrease or remaining stable at low levels (19 reporting countries). Moving Epidemic Method (MEM) thresholds were available for 18 countries, two of which observed consultation rates above baseline levels. Short-term forecasts of ILI and ARI rates in EU/EEA countries are published on ECDC's [RespiCast](#).
- In primary care sentinel settings, the median test positivity at the EU/EEA level was highest for influenza, at 3% (pooled country data: 5%; interquartile range (IQR) of country values: 1–4%), with most countries reporting a decrease in test positivity. In week 16, one of 13 countries reported a test positivity above 10%. Qualitative assessments of seasonal influenza activity from 21 countries indicate decreasing intensity in recent weeks (10 baseline, eight low, three medium). Of 20 countries reporting geographical spread of seasonal influenza, 11 reported sporadic spread, five regional, and four widespread.
- Among the 66 sentinel primary care detections of seasonal influenza, 55 (83%) were typed as influenza virus type B and 11 (17%) were typed as influenza virus type A. Of the influenza type B detections, 25 were further defined as B/Victoria lineage, while the remaining 30 were of unknown lineage. Of the influenza type A detections that were further subtyped, two were A(H1)pdm09 and four were A(H3). The remaining five influenza type A detections were of unknown subtype. It is worth noting that one country continues to account for most of the total number of reported influenza B detections (75% in week 16).
- The median sentinel primary care RSV positivity was 0% (pooled: 1%; IQR: 0–1%). Decreasing or stable trends were observed at the country level in both sentinel positivity and non-sentinel detections.
- The median sentinel primary care positivity for SARS-CoV-2 remained low at 1% (pooled: 1%; IQR: 0–1%). Decreasing or stable trends were observed at the country level in both sentinel positivity and non-sentinel detections.

#### Severe disease

- Rates of severe acute respiratory infection (SARI) from sentinel secondary sites were stable or decreasing and at levels comparable to the same time last year in all five countries reporting data up to week 16.

- The median SARI test positivity for seasonal influenza was 1% (pooled: 1%; IQR: 0–2%), with decreasing or stable trends observed in most countries reporting this indicator. All countries reporting non-sentinel hospital or ICU data observed decreasing or stable trends.
- The median SARI test positivity for RSV was 1% (pooled: 2%; IQR: 0–1%), with decreasing or stable trends observed in all countries reporting this indicator.
- The median SARI test positivity for SARS-CoV-2 was 0.6% (pooled: 3%; IQR: 1–4%). Both SARI positivity and non-sentinel indicators of severity remained at low levels in all countries.
- EuroMOMO pooled estimates of weekly excess all-cause mortality for the participating European countries were within expected levels.

## Virus characterisation

### Influenza

- WHO [recommendations](#) for the composition of trivalent vaccines for use during the 2024–2025 influenza season in the northern hemisphere are as follows (egg-based and cell culture or recombinant-based vaccines respectively): an A/Victoria/4897/2022 or A/Wisconsin/67/2022 (H1N1)pdm09-like virus (subclade 5a.2a.1); an A/Thailand/8/2022 or A/Massachusetts/18/2022 (H3N2)-like virus (subclade 2a.3a.1); and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus (subclade V1A.3a.2).
- From week 40, 2023 to week 16, 2024, 2 981 A(H1)pdm09, 1 149 A(H3) and 177 B/Victoria viruses from sentinel and non-sentinel sources were genetically characterised. Of the A(H1)pdm09 viruses that have been assigned to a clade, 1 982 were reported as clade 5a.2a and 992 were subclade 5a.2a.1. Of the A(H3) viruses that have been assigned to a clade, 10 were reported as clade 2a.3a, 1 105 were subclade 2a.3a.1, one was subclade 2a.3b, and 30 were subclade 2a. All B/Victoria viruses were reported as subclade V1A.3a.2.
- Antigenic characterisation data presented in WHO [2024-2025 northern hemisphere vaccine composition](#) report indicate current northern hemisphere vaccine components are well matched to circulating 5a.2a and 5a.2a.1 A(H1N1)pdm09 subclades and V1A.3a.2 B/Victoria subclades. While components also appear well matched for 2a.3a A(H3) clade viruses, 2a.3a.1 clade viruses are less well matched. Based on human post-vaccination serology studies, haemagglutination inhibition and virus neutralisation against some recent 2a.3a.1 viruses were significantly reduced for some serum panels.
- ECDC has [published](#) interim influenza vaccine effectiveness (VE) estimates for the 2023–2024 season. Analysis of data submitted from multi-country primary care and hospital study sites between September 2023 and January 2024 indicated that up to 53% and 44% of vaccinated individuals in primary care or hospital settings, respectively, were protected against mild and severe influenza.

### SARS-CoV-2 variants for weeks 14–15 (1 April to 14 April 2024)

- The estimated distribution (median and IQR of proportions from two countries) of variants of concern (VOCs) or variants of interest (VOIs) was 94% (87–100%) for BA.2.86 (which includes JN.1 isolates) and 0% for XBB.1.5-like (which now includes XBB.1.5+F456L). These estimates should be interpreted with caution as they are based on data from only four countries, a result of the very low number of sequences deposited in recent weeks during a period of low SARS-CoV-2 transmission.

### Period overview (week 25, 2023 to week 16, 2024)

- Following relatively low respiratory illness transmission over the summer period, consultation rates increased in primary care settings from September 2023. Consultation rates were highest at different timepoints in each country during the winter period, with peak rates reached between week 50, 2023 and week 7, 2024. As of week 16, 2024, consultation rates continued to decrease and have returned to baseline levels in most EU/EEA countries. Transmission of SARS-CoV-2 began increasing in late summer, with clear increases observed at the EU/EEA level up to week 49 and decreases in activity thereafter. Activity is currently low in most EU/EEA countries. Similarly, a steady decrease in severe disease has been observed since week 50. COVID-19 has predominantly affected individuals aged 65 years and above. Week 50 marked the start of the seasonal influenza epidemic. A decreasing trend in influenza activity has been observed since week 4, 2024, with a mixed picture at the country level. Compared to trends observed in previous influenza epidemics, seasonal influenza activity decreased earlier this season. Severe disease due to influenza has affected all age groups. Since week 6, 2024, a decrease in the severe disease indicators for seasonal influenza has been observed in most EU/EEA countries. Both influenza type A and type B viruses have been detected, with a dominance of A(H1)pdm09 viruses during the first part of the season. As of week 13, B/Victoria lineage was the most detected virus, although the number of detections was low. RSV activity

began increasing around week 41, reaching a peak in week 50, followed by a decreasing trend. RSV has had the greatest impact among children aged 0–4 years.

### **ECDC assessment:**

After marking the start of the seasonal influenza epidemic in the EU/EEA in week 50, 2023, seasonal influenza continued to circulate at higher levels than SARS-CoV-2 and RSV in primary care sentinel systems during week 16, 2024. Influenza activity at the EU/EEA level continues to decrease, and pooled positivity in primary care has been below the 10% positivity threshold for five consecutive weeks. Even if the respiratory virus circulation is decreasing, it is still essential to continue closely monitoring the impact of influenza and other respiratory viruses on hospital and ICU admissions.

### **Actions:**

ECDC monitors rates of respiratory illness presentation and respiratory virus activity in the EU/EEA, presenting findings in the European Respiratory Virus Surveillance Summary ([ERVISS.org](http://ERVISS.org)). Updated weekly, ERVISS describes the epidemiological and virological situation for respiratory virus infections across the EU/EEA and follows the principles of integrated respiratory virus surveillance outlined in '[Operational considerations for respiratory virus surveillance in Europe](#)'.

**Sources:** [ERVISS](#)

**Last time this event was included in the Weekly CDTR:** 19 April 2024

## **2. An early human West Nile virus infection case in March in Andalusia, Spain**

### **Overview:**

A confirmed autochthonous human case of West Nile virus (WNV) infection with onset of symptoms in the beginning of March 2024 that was likely infected in Seville province, Andalusia, was reported by Spain.

Spain's public health authorities informed that entomological investigations are being carried out, with preliminary results showing higher densities of *Culex pipiens* mosquitoes compared to the same month in previous years, with no detection of WNV in female mosquitos. Active case finding was performed with no additional cases detected.

### **ECDC assessment:**

The detection of a human confirmed case of the WNV infection in March is unusual but not unexpected, considering the extraordinarily mild weather in late winter and increased vector activity. The lack of further cases may suggest that the identified case was an isolated incident and might not signal the onset of an active transmission season, which usually starts in early summer.

### **Actions:**

ECDC is monitoring the situation.

## **3. SARS-CoV-2 variant classification**

### **Overview:**

#### **Weekly update on SARS-CoV-2 variants:**

Since the last update on 12 April 2024, and as of 26 April, **no changes** have been made to ECDC's variant classifications for variants of concern (VOCs), variants of interest (VOIs), variants under monitoring (VUMs), and de-escalated variants.

For the latest update on SARS-CoV-2 variant classifications, please see [ECDC's webpage on variants](#).

Variant surveillance data, including the distribution of VOC and VOI variant proportions in the EU/EEA and detailed country-specific COVID-19 updates, are available as part of the [European Respiratory Virus Surveillance Summary \(ERVISS\)](#).

### Actions:

For the latest update on SARS-CoV-2 variant classifications, please see [ECDC's webpage on variants](#). Variant surveillance data, including the distribution of VOC and VOI variant proportions in the EU/EEA and detailed country-specific COVID-19 updates, are available as part of the [European Respiratory Virus Surveillance Summary \(ERVISS\)](#).

**Last time this event was included in the Weekly CDTR:** 12 April 2024

## 4. Cholera – Comoros and Mayotte – 2024 – Weekly monitoring

### Overview:

#### Update

On 26 April 2024, [media](#) quoting Mayotte health authorities reported on the first three autochthonous cholera cases in the commune of Koungou. According to media, these cases lived in different households.

In addition, [media](#) report that ARS Mayotte will set up a screening centre and conduct a vaccination campaign in the area of Koungou. Public health surveillance will be reinforced to identify suspected cases.

Since the first case was detected on 18 March, and as of 26 April, 13 cholera cases and no deaths have been reported. According to the [bulletin](#) published on 22 April, a total of 68 contacts of the cases have received antibiotic chemoprophylaxis and 449 contacts have been vaccinated.

Further information on the case definition and close contacts is available on the website of the [Prefect of Mayotte](#).

Since the last available update on 18 April, and as of 24 April, [Comoros health authorities](#) have reported 620 new cholera cases and 16 new deaths. Since the outbreak was declared on 2 February in the Union of the Comoros\*, a total of 2 584 cases and 61 deaths have been reported on the three islands. In all, 2 322 cases have recovered.

*\* Note that the report from other sources is irregular and data on the date of symptom onset are not available.*

### Summary

On 31 January 2024, a boat from Tanzania carrying 25 people [arrived in Moroni](#), the capital of the Comoros archipelago. One person on board died of suspected cholera and several others were symptomatic. The Comoros Ministry of Health [declared](#) a cholera outbreak on 2 February. The first locally transmitted cases in Comoros were reported on 5 February in Moroni. Cholera cases were also detected in Mohéli and Anjouan by the end of February and the first week of March.

Following the increase in cholera cases in Comoros during February, the Mayotte Regional Health Agency (ARS Mayotte) [announced](#) that health surveillance capacities would be strengthened on the island, including risk communication for health professionals and passengers. The first [imported cholera](#) case was detected in Mayotte on 18 March.

### Background

There is frequent undocumented population movement between the Comoros archipelago and the French territory of Mayotte. No cholera cases had been reported in Mayotte since 2000.

Cholera is a bacterial disease caused by the bacterium *Vibrio cholerae*. The main risk factors are associated with poor water, sanitation and hygiene practices. Several countries in eastern and southern Africa are currently responding to cholera outbreaks. Response efforts are constrained by global shortages of cholera vaccines.

**ECDC assessment:**

Considering the detection of the first autochthonous cases of cholera in Mayotte, ECDC assesses the likelihood of further community transmission of cholera in Mayotte as high. The impact of the cholera outbreak in Mayotte is considered to be high. The overall risk of cholera for the population in Mayotte is therefore assessed to be high.

Early detection and response activities are essential and have been reinforced in the French territory of Mayotte, as well as increasing awareness among healthcare workers and at points of entry.

**Actions:**

ECDC is in contact with French authorities and relevant partners and is monitoring the situation through its epidemic intelligence activities.

**Last time this event was included in the Weekly CDTR:** 19 April 2024