COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 21, 18-24 May 2014

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Influenza - Multistate (Europe) - Monitoring 2013-2014 season

Opening date: 4 October 2013 Latest update: 22 May 2014

Following the 2009 pandemic, influenza transmission in Europe has returned to its seasonal epidemic pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes the results on its website in the Weekly Influenza Surveillance Overview.

➔Update of the week

With influenza activity continuing to decline in all reporting countries after five months of active transmission, the 2013–2014 influenza season is coming to an end.

This is the last weekly report for the 2013-2014 influenza season. The next report will be issued for data covering weeks 21-30/2014.

Non EU Threats

Middle East respiratory syndrome- coronavirus (MERS CoV) - Multistate

Opening date: 24 September 2012 Latest update: 22 May 2014

Since April 2012, 658 laboratory-confirmed cases, including 204 deaths, of acute respiratory disease caused by Middle East respiratory syndrome coronavirus (MERS-CoV) have been reported by national health authorities. To date, all cases have either occurred in the Middle East, have direct links to a primary case infected in the Middle East, or have returned from this area. The source of the virus remains unknown but the pattern of transmission points towards an animal reservoir in the Middle East from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission to close contacts and in hospital settings has occurred, but there is no evidence of sustained transmission among humans. MERS-CoV is genetically distinct from the coronavirus that caused the SARS outbreak.

➔Update of the week

Since the previous CDTR, 37 new cases have been reported. Thirty cases were reported by Saudi Arabia. Seven cases, which occurred in 2012 in Jordan, have been included to the case count following a publication. The USA has reported a third case with positive serology, however this does not meet the current case definition for a confirmed case, but meets the case definition of a probable case.

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Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 22 May 2014

Polio, a crippling and potentially fatal vaccine-preventable disease that mainly affects children, is close to being eradicated as a result of global public health efforts. Polio transmission currently occurs in 10 countries in the world.

➔Update of the week

During the past week five new infections with Wild poliovirus 1 (WPV1) were reported in Pakistan.

Polio was declared a public health emergency of international concern (PHEIC) on 5 May 2014 by the World Health Organization (WHO) Director-General. As a result of the PHEIC, WHO issued temporary recommendations for controlling the spread of polioviruses from polio transmitting countries.

Outbreak of Ebola Virus Disease - West Africa - 2014

Opening date: 22 March 2014 Latest update: 22 May 2014

An ongoing outbreak of Ebola virus disease (EVD) in West Africa is affecting Guinea and Liberia, with onset in early February 2014.

➔Update of the week

Since the last update of 12 May 2014, there have been six new confirmed cases and five new deaths. Media is reporting a suspected family cluster in Télimélé in Guinea, which has not yet been confirmed by WHO.

Chikungunya outbreak - The Caribbean, 2013-2014

Opening date: 9 December 2013 Latest update: 23 May 2014

On 6 December 2013, France reported two laboratory-confirmed autochthonous cases of chikungunya in the French part of the Caribbean island of Saint Martin. Since then, local transmission has been confirmed in the Dutch part of Saint Martin, on Martinique, Saint Barthélemy, Guadeloupe, British Virgin Islands, Dominica, Anguilla, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, the Dominican Republic, Haiti, Antigua and Barbuda and French Guiana. Aruba only reported imported cases. This is the first documented outbreak of chikungunya with autochthonous transmission in the Americas. As of 25 April 2014, there have been more than 60 000 probable and confirmed cases in the region. At least 13 fatalities have been reported so far.

➔Update of the week

During the past week, new cases have been reported in most of the affected areas. In the French Antilles, the number of new cases is generally decreasing or constant. In French Guiana, the number of autochthonous cases is increasing and the virus circulation is intensifying, with new emerging clusters identified particularly around Cayenne. Increased transmission is reported by the Dominican Republic with almost all provinces affected (ProMed-mail). Media quoting the Department of Health reports a substantial increase of cases in Haiti in particular around the capital Port-au-Prince (LINK). This report is substantiated by the increase of reported confirmed cases by WHO. Antigua and Barbuda, British Virgin islands and Saint Lucia have reported additional cases (WHO, ProMed-mail). The Florida Department of Health has reported the first three cases of chikungunya imported in the USA from the Caribbean (Link). The US CDC also published a report on two imported cases of chikungunya in mainland France from the Caribbean, but the date of importation is not quoted (Link).
To date, islands with confirmed cases are Saint Martin/Sint Maarten, Martinique, Saint Barthélemy, Guadeloupe, British Virgin Islands, Anguilla, Dominica, Aruba, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Dominican Republic, Haiti, Antigua and Barbuda, and French Guiana in mainland South America (WHO). In most of the territories of the French Antilles, given the caseload, the health authorities decided not to seek laboratory confirmation for all suspected cases.

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II. Detailed reports

Influenza - Multistate (Europe) - Monitoring 2013-2014 season

Opening date: 4 October 2013 Latest update: 22 May 2014

Epidemiological summary

For week 20/2014:

- Low-intensity influenza activity was reported by 24 reporting countries;
- Of 68 sentinel specimens tested across 15 countries, six (9%) were positive for influenza virus;
- No hospitalised, laboratory-confirmed influenza cases were reported.

With influenza activity continuing to decline in all reporting countries after five months of active transmission, the 2013–2014 influenza season is coming to an end. In this season, A(H1N1)pdm09 and A(H3N2) viruses co-circulated in almost equal proportions. The intensity of the season was low in many countries throughout the season and reached high intensity in three countries only.

This is the last weekly report for the 2013-2014 influenza season. The next report will be issued for data covering weeks 21-30/2014.

Web sources: WISO | ECDC Influenza |

ECDC assessment

The influenza season started in EU/EEA countries in week 2/2014.

Actions

This is the last weekly report for the 2013-2014 influenza season. The next report will be issued for data covering weeks 21-30/2014.

Middle East respiratory syndrome- coronavirus (MERS CoV) - Multistate

Opening date: 24 September 2012 Latest update: 22 May 2014

Epidemiological summary

Summary: Since April 2012 and as of 22 May 2014, 658 laboratory-confirmed cases of MERS-CoV have been reported by local health authorities worldwide, including 204 deaths.

Confirmed cases and deaths by region:

Middle East:
Saudi Arabia: 541 cases/160 deaths
United Arab Emirates: 67 cases/9 deaths
Qatar: 7 cases/4 deaths
Jordan: 16 cases/4 deaths
Oman: 2 cases/2 deaths
Kuwait: 3 cases/1 death
Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths

Europe:
UK: 4 cases/3 deaths
Germany: 2 cases/1 death
France: 2 cases/1 death

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Italy: 1 case/0 deaths
Greece: 1 case/0 deaths
Netherlands: 2 cases/0 deaths

Africa:
Tunisia: 3 cases/1 death

Asia:
Malaysia: 1 case/1 death
Philippines: 1 case/0 deaths

Americas:
United States of America: 2 cases/0 deaths
Third case with positive serology in the US does not meet the current case definition for a confirmed case, but meets the case definition of a probable case.

Nineteen cases have been reported from outside the Middle East: the UK (4), France (2), Tunisia (3), Germany (2), USA (2), Italy (1), Malaysia (1), Philippines (1), Greece (1) and Netherlands (2). In France, Tunisia and the UK, there has been local transmission among patients who had not been to the Middle East, but had been in close contact with laboratory-confirmed or probable cases. Person-to-person transmission has occurred both among close contacts and in healthcare facilities.

ECDC notes the decision of Margaret Chan, the Director General of WHO, on 14 May 2014 not to call the MERS-CoV outbreak a Public Health Emergency of International Concern (PHEIC) as the conditions have not yet been met. This decision was based on the advice of the WHO Emergency Committee under the international health regulations on MERS-CoV. However the committee indicated that, based on current information, "the seriousness of the situation had increased in terms of public health impact, but that there is no evidence of sustained human-to-human transmission."

Web sources: ECDC's latest rapid risk assessment| ECDC novel coronavirus webpage | WHO | WHO MERS updates | WHO travel health update | WHO Euro MERS updates | CDC MERS | Saudi Arabia MoH | Eurosurveillance article 26 September |

ECDC assessment

The source of MERS-CoV infection and the mode of transmission have not been identified, but the continued detection of cases in the Middle East indicates that there is a persistent source of infection in the region. Dromedary camels are likely an important host species for the virus, and many of the primary cases in clusters have reported direct or indirect camel exposures. Almost all of the recently reported secondary cases, many of whom are asymptomatic or have only mild symptoms, have been acquired in healthcare settings. There is therefore a continued risk of cases presenting in Europe following exposure in the Middle East, and international surveillance for MERS-CoV cases is essential. An international case-control study has been designed and proposed by WHO. Results of this or similar epidemiological studies in order to determine the initial exposures and risk behaviours among the primary cases are urgently needed.

The risk of secondary transmission in the EU remains low and can be reduced further through screening for exposure among patients presenting with respiratory symptoms (and their contacts) and strict implementation of infection prevention and control measures for patients under investigation.

Actions

ECDC published an epidemiological update on 16 May 2014.

The last update of the rapid risk assessment was published on 25 April 2014.

The first 133 cases are described in Eurosurveillance, published on 26 September 2013.

ECDC is closely monitoring the situation in collaboration with WHO and EU Member States.

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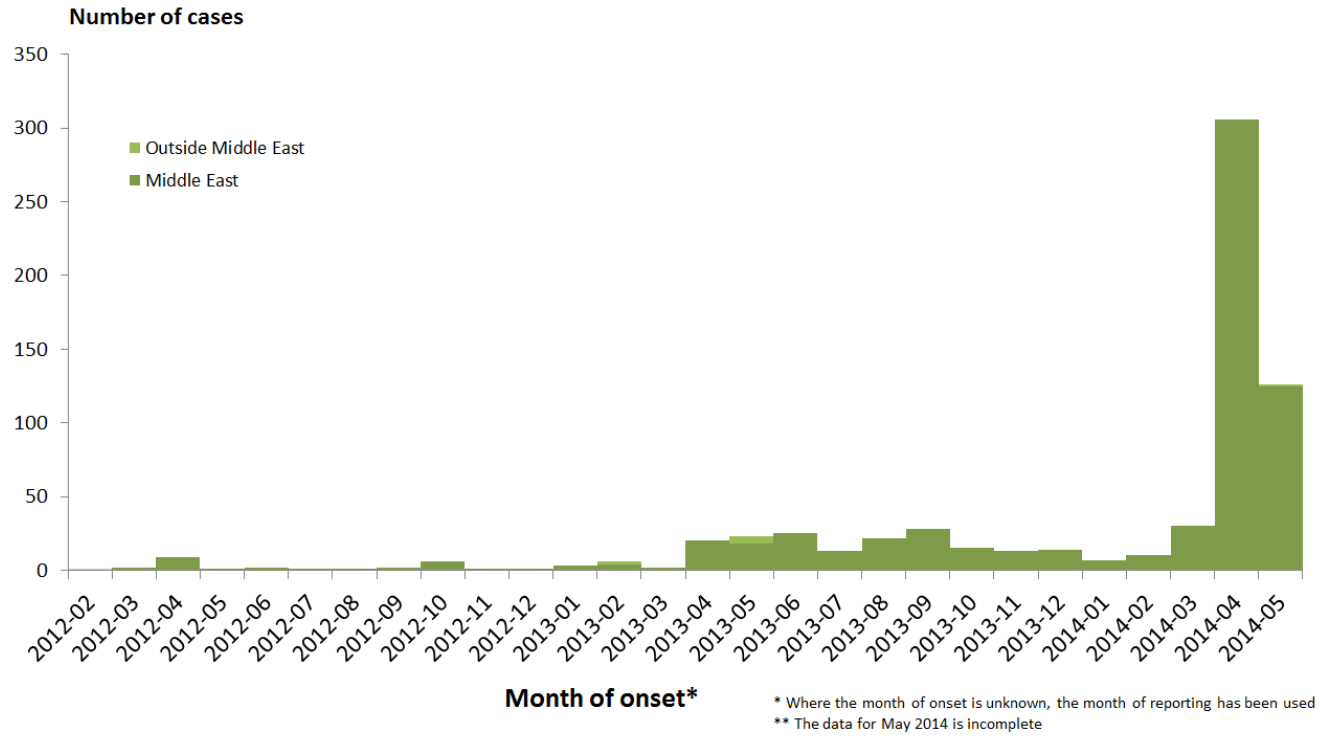
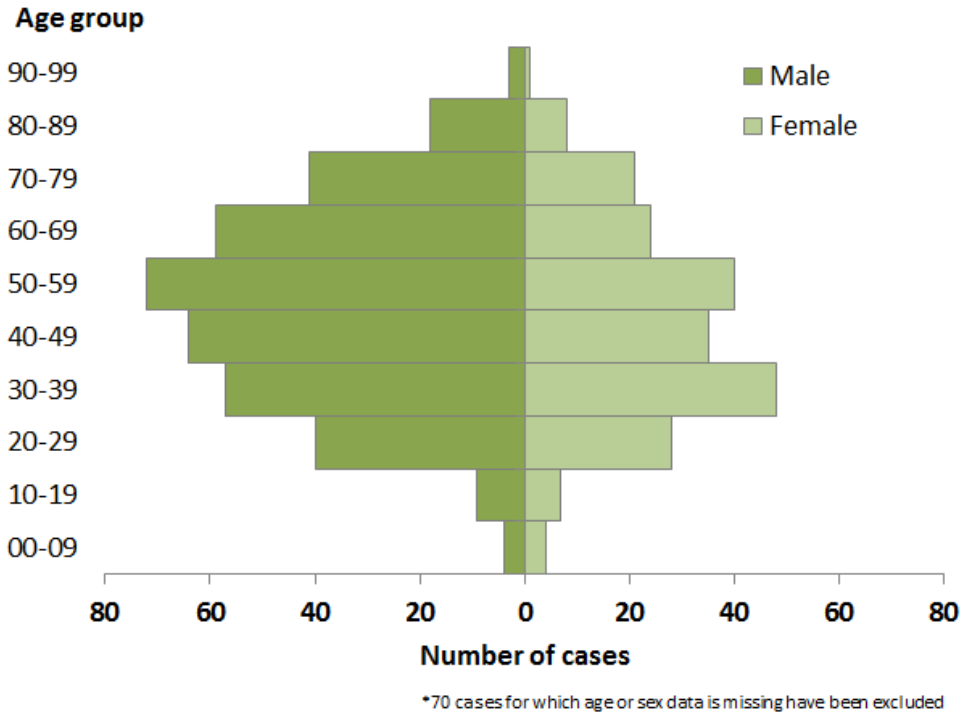
Distribution of confirmed cases of MERS-CoV by month of onset and place of probable infection, March 2012 - 22 May 2014 (n=658*)



Distribution of confirmed cases of MERS-CoV by gender and age group, March 2012 - 22 May 2014 (n=588*)



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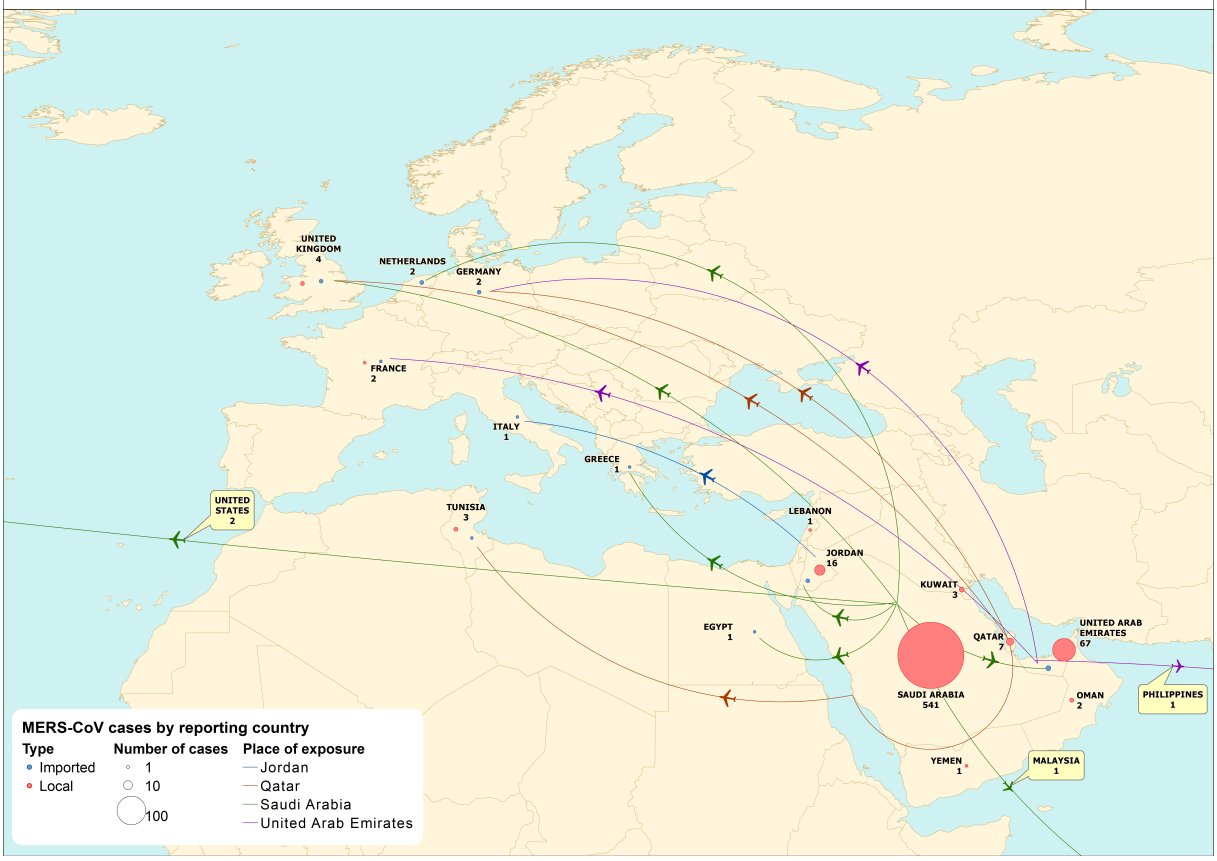
Distribution of confirmed cases of MERS-CoV by reporting country and place of probable infection, March 2012 - 22 May 2014 (n=658)



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 22 May 2014

Epidemiological summary

Worldwide, 82 cases have been reported to WHO in 2014, compared with 34 for the same time period in 2013. The most affected country is Pakistan (66 cases this year).

The Government of Pakistan announced that it had initiated implementation of the recently issued WHO *Temporary Recommendations* to reduce the international spread of wild poliovirus. Health facilities across Pakistan are now vaccinating prospective travellers and issuing the required vaccination certificates.

Web sources: Polio Eradication: weekly update | MedISys Poliomyelitis | ECDC Poliomyelitis factsheet

ECDC assessment

Europe is polio-free. The last polio cases within the current EU borders were reported from Bulgaria in 2001. This was an imported outbreak, and it was demonstrated that the WPV originated from India. An outbreak in the Netherlands, in a religious community opposed to vaccination, caused two deaths and 71 cases of paralysis in 1992.

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The last indigenous WPV case in the WHO European Region was in Turkey in 1998. The latest outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460 cases.
There is an ongoing polio outbreak in Syria with onset in 2013, and until 15 May 2014, 35 confirmed cases of Acute Flaccid Paralysis (AFP) caused by WPV-1 have been reported from across the country. WPV-1 originating from Pakistan has been circulating in Israel since early 2013 without causing any cases of AFP. The circulation was detected through routine environmental surveillance of sewage for polioviruses. Israel has responded with vaccination campaigns, first with IVP later followed by OPV, and has reintroduced a single dose of OPV in addition to IPV into the routine vaccination schedule for children.

There are indications that the transmission of WPV is increasing in Pakistan, and the number of new AFP cases during the first four months of 2014 increased ten-fold compared to the same period in 2013.

On 5 May 2014, the Director-General of WHO, Dr Margaret Chan, acted on the recommendation of the International Health Regulations Emergency Committee and declared that the spread of wild-type poliovirus in 2014 constitutes a Public Health Emergency of International Concern (PHEIC) in accordance with the International Health Regulations (IHR). WHO has issued Temporary Recommendations for controlling the international spread of polioviruses out of the remaining ten polio-infected countries in the world. Three of the countries, Cameroon, Pakistan and Syria, are required to ensure that all people leaving these countries after staying for more than four weeks must have received a dose of polio vaccine within 12 months to four weeks prior to departure.

References: Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA | Wild-type poliovirus 1 transmission in Israel - what is the risk to the EU/EEA? | WHO statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus, 5 May 2014 | WHO position paper on polio vaccines, January 2014

Actions

ECDC follows reports of polio cases worldwide through epidemic intelligence in order to highlight polio eradication efforts and identify events that increase the risk of re-introduction of wild poliovirus into the EU.

Following the declaration of polio as a PHEIC, ECDC is updating its risk assessment. ECDC has also prepared a background document of travel recommendations for the EU.

Outbreak of Ebola Virus Disease - West Africa - 2014

Opening date: 22 March 2014 Latest update: 22 May 2014

Epidemiological summary

Guinea
As of 18 May 2014, the Ministry of Health (MOH) of Guinea has reported a cumulative total of 253 clinical cases of Ebola virus disease (EVD), including 176 deaths. The number of confirmed cases is 144, including 97 deaths.

The geographical distribution of the clinical cases of EVD since the beginning of the outbreak is as follows: Conakry (50 cases, including 25 deaths), Guéckédou (168/123), Macenta (22/17), Kissidougou (8/6), Dabola (4/4), and Djinguiraye (1/1). The cumulative total of laboratory-confirmed cases and deaths since the beginning of the outbreak is: Conakry (40 cases, including 20 deaths), Guéckédou (89/65), Macenta (12/10), Kissidougou (2/1) and Dabola (1/1). Guéckédou remains the only area where community transmission and deaths are still being reported.

Two incubation periods (42 days) have passed since the isolation of the last reported cases in Djinguiraye, Dabola and Kissidougou. In Macenta, there have been no new cases since 9 April and Conakry since 26 April. In Guéckédou, the date of isolation of the most recent cases is 15 May 2014.

The number of cases remains subject to change due to reclassification, retrospective investigation, consolidation of cases and laboratory data, enhanced surveillance activities, and contact tracing activities.

Liberia and Sierra Leone
In Liberia and Sierra Leone, the situation is stable. In Liberia, the date of isolation of the most recent case is 9 April 2014. It is therefore projected that EVD outbreak could be declared soon. Harmonisation of data has brought the number of EVD cases to 12, including 9 deaths. Surveillance activities have been enhanced in districts bordering Guinea.

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WHO and international organisations are supporting the Ministries of Health of Guinea and Liberia in their EVD prevention, contract tracing, healthcare and control-related activities.

No cases have been detected in returning travellers to Europe.

Web sources: WHO/AFRO outbreak news | WHO Ebola Factsheet | ECDC Ebola health topic page | ECDC Ebola and Marburg fact sheet |Risk assessment guidelines for diseases transmitted on aircraft | NEJM 16 April article

ECDC assessment

This is the first time an EVD outbreak has been reported in Guinea. The origin of this outbreak is currently unknown. The outbreak seems to be slowing down. The risk of infection for travellers is considered very low since most human infections result from direct contact with the bodily fluids or secretions of infected patients, particularly in hospitals (nosocomial transmission), and as a result of unsafe procedures, use of contaminated medical devices (including needles and syringes) and unprotected exposure to contaminated bodily fluids.

Actions

ECDC published an updated rapid risk assessment and provided guidance to Member States for the safe handling of bush meat, as well as for travellers EU travellers to and from the affected countries.

ECDC has published an epidemiological update on its website.

ECDC is closely monitoring this event.

Chikungunya outbreak - The Caribbean, 2013-2014

Opening date: 9 December 2013 Latest update: 23 May 2014

Epidemiological summary

Cases reported as of 18 May 2014:

- Anguilla, 33 confirmed cases;
- Antigua and Barbuda, 4 cases;
- Aruba, 1 imported case originating from Sint Maarten;
- Dominica, 1 578 suspected cases and 121 confirmed cases;
- Dominican Republic, 8 017 suspected and 17 confirmed cases;
- French Guiana, 176 confirmed or probable cases 70% of which autochthonous;
- Guadeloupe, 18 000 suspected and 1 328 confirmed or probable cases, one death;
- Haiti, 632 confirmed cases;
- Martinique, 26 670 suspected and 1 515 confirmed or probable cases, 9 deaths;
- Saint Barthélemy, 510 suspected and 135 confirmed or probable cases;
- Saint Lucia, 5 confirmed cases;
- Saint Martin (FR), 3 280 suspected and 793 confirmed or probable cases, 3 deaths;
- Saint Vincent and the Grenadines, 24 suspected cases and 3 confirmed cases;
- Sint Maarten (NL), 325 suspected and 301 confirmed cases;
- St. Kitts and Nevis, one confirmed case;
- Virgin Islands (UK), 20 confirmed cases.

Web sources: ECDC Chikungunya | CDC Factsheet | Medisys page |

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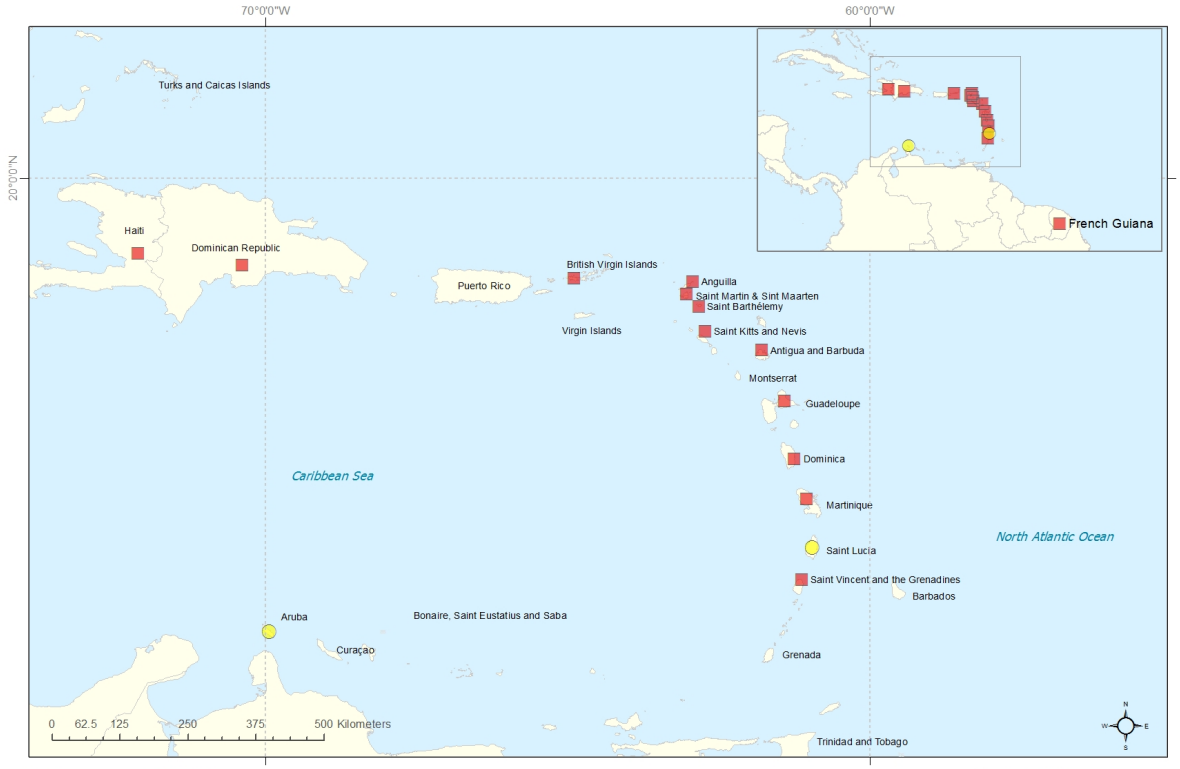
ECDC assessment

Epidemiological data indicate that the outbreak, which started in Saint Martin (FR), is expanding. An increasing number of cases have been observed from most of the affected areas. The vector is endemic in the region, where it also transmits dengue virus. Vigilance is recommended for the occurrence of imported cases of chikungunya in tourists returning to the EU from the Caribbean, including awareness among clinicians, travel clinics and blood safety authorities. The autochthonous cases in French Guiana are the first autochthonous chikungunya cases in mainland South America.

Actions

ECDC published a rapid risk assessment on 12 December 2013 and epidemiological updates on 10 January and 7 February 2014.

Chikungunya outbreak as of 18 May 2014



Chikungunya in Caribbean.

Period Dec 2013 to 23 May 2014.

Sources: CARPHA, PAHO, ECDC, RIVM, PHE and INVS.

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