

I. Executive summary

EU Threats

New! Autochthonous cases of chikungunya virus disease - France - 2014

Opening date: 22 October 2014

Latest update: 23 October 2014

On 21 October 2014, WHO was notified by the National IHR Focal Point for France of four cases of chikungunya locally-acquired infection in Montpellier, France. The cases were confirmed by tests conducted by the French National Reference Laboratory for arboviruses on 20 October 2014. This is the first time that locally-acquired transmission of chikungunya has been detected in France since 2010. On 23 October, one additional autochthonous case was reported in the same neighbourhood of the four cases.

Influenza – Multistate (Europe) – Monitoring 2014–2015 season

Opening date: 9 October 2014

Latest update: 24 October 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 Flu News Europe.

[→Update of the week](#)

In the third week of the season, influenza activity across the European Union remains low.

West Nile virus - Multistate (Europe) - Monitoring season 2014

Opening date: 3 June 2014

Latest update: 23 October 2014

West Nile fever (WNF) is a mosquito-borne disease which causes severe neurological symptoms in a small proportion of infected people. During the June to November transmission season, ECDC monitors the situation in EU Member States and neighbouring countries in order to inform blood safety authorities of WNF-affected areas and identify significant changes in the epidemiology of the disease.

[→Update of the week](#)

During the past week, Romania reported one new confirmed case in the previously affected Ilt district. In neighbouring countries, no new cases were reported.

Non EU Threats

Ebola Virus Disease Outbreak - the Democratic Republic of Congo - 2014

Opening date: 26 August 2014

Latest update: 24 October 2014

On 24 August 2014, an outbreak of Ebola virus disease (EVD) was declared in the Boende health zone of Equateur province in the Democratic Republic of Congo. This outbreak is the seventh outbreak of EVD in the country.

→Update of the week

No new case has been reported during the past week. Ebola has not been confirmed in two previously suspected cases, decreasing the number of cases to 66. All suspected cases have now been laboratory confirmed or discarded. Of 1 121 contacts, 1 116 have now completed 21-day follow-up and five remain under monitoring.

Ebola Virus Disease Epidemic - West Africa - 2014

Opening date: 22 March 2014

Latest update: 24 October 2014

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, affecting Guinea, Liberia and Sierra Leone. The situation in the affected countries remains critical. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC). In recent weeks, cases of transmission to healthcare workers involved in caring for patients were reported by Spain (1) and the USA (2).

→Update of the week

Since the publication of the last CDTR on 17 October 2014, the affected countries have reported 939 additional cases and 384 additional fatalities. Senegal and Nigeria were declared Ebola free after completing 42 days without transmission.

On 23 October 2014, [CDC](#) confirmed that a medical aid worker who volunteered in Guinea and recently returned to the United States has tested positive for Ebola in New York City. In addition, the [Ministry of Health](#) in Mali has reported that a two-year-old girl who recently arrived from Guinea has tested positive for Ebola. This is the first confirmed case of Ebola virus infection in Mali.

Outbreak of Enterovirus D68 - USA and Canada

Opening date: 10 September 2014

Latest update: 24 October 2014

Since mid-August 2014, local health authorities in more than 45 states in the USA have been notifying the Centers for Disease Control and Prevention (CDC) of laboratory-confirmed enterovirus 68 (EV-D68) infections. Canada has also experienced an increase in severe respiratory illness associated with EV-D68 infections during the same time period. All patients presented with respiratory symptoms. Several others, particularly those with pre-existing asthma, were admitted to paediatric intensive care units. Health authorities are also investigating reports of paralysis or muscle weakness and other polio-like symptoms in a small number of children, some of whom tested positive for EV-D68 in both the USA and Canada. It is not yet clear whether EV-D68 is associated with paralysis in these children.

→Update of the week

Since the last CDTR on 16 October 2014, the [US CDC](#) has reported that from mid-August to 23 October 2014, CDC or state public health laboratories have confirmed 973 cases in 47 states and the District of Columbia, with respiratory illness caused by EV-D68.

In Canada as of 16 October 2014, the [British Columbia \(BC\) provincial laboratory](#) has confirmed 36 cases of enterovirus D68.

Outbreak of Marburg fever – Uganda

Opening date: 6 October 2014

Latest update: 9 October 2014

On 5 October, the Ministry of Health in Uganda reported a laboratory-confirmed outbreak of Marburg fever. The index case was a healthcare worker who died on 30 September at Mengo hospital in Kampala.

→Update of the week

No new confirmed cases of Marburg haemorrhagic fever have been reported since the detection of the index case in early October.

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

Opening date: 24 September 2012

Latest update: 24 October 2014

Since April 2012, 908 cases of MERS-CoV have been reported by local health authorities worldwide, including 362 deaths. 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 and virological studies points towards dromedary camels in the Middle East being a reservoir from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission is amplified among household contacts and in healthcare settings.

→Update of the week

Since the last CDTR of 16 October, 11 cases have been reported from the following countries: Saudi Arabia (9), Turkey (1) and Qatar (1).

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 24 October 2014

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission stops and the world is polio-free.

Polio was declared a public health emergency of international concern (PHEIC) on 5 May 2014 due to concerns regarding the increased circulation and the international spread of wild poliovirus during 2014.

→Update of the week

During the past week, four new wild poliovirus type 1 (WPV1) cases have been reported in Afghanistan.

II. Detailed reports

New! Autochthonous cases of chikungunya virus disease - France - 2014

Opening date: 22 October 2014

Latest update: 23 October 2014

Epidemiological summary

On 20 October 2014, the French National Reference Laboratory for arboviruses confirmed a cluster of four autochthonous cases of chikungunya infection in Montpellier (Hérault district, Languedoc-Roussillon region, France). The four cases of chikungunya infection occurred within the same family, with the onset of symptoms onset between 20 September and 12 October. The cases live in Montpellier in the vicinity of a chikungunya case imported from Cameroon. The cases have no history of travel out of their district of residence in the 15 days prior to the onset of symptoms. On 23 October 2014, the Regional Health Agency (ARS) of Languedoc-Roussillon reported one additional autochthonous case of chikungunya virus infection in the same district.

Vector control measures have been implemented in the affected areas and surveillance has been reinforced. The competent vector for chikungunya, *Aedes albopictus*, has been established in this district since 2011.

In French Polynesia, 194 confirmed cases of chikungunya fever have been reported as of 21 October 2014, with an additional 420 suspected cases currently under investigation. No severe cases have been recorded. Of the 194 confirmed cases, 175 cases have been notified in Tahiti.

Web sources: [ECDC Chikungunya](#) | [CDC Factsheet](#) | [ARS statement on 22 October 2014](#) | [ARS statement on 23 October 2014](#) | [WHO DON](#) | [French Polynesia government](#) |

ECDC assessment

The first documented cases of autochthonous chikungunya virus transmission in France since 2010 is not an unexpected event as the competent vector, *Aedes albopictus*, has been established in this district since 2011. In Polynesia, with the beginning of the rainy season and related favourable conditions for the mosquito vector, which is endemic in the region where it also transmits dengue virus, additional cases are expected. In addition, the co-circulation of other flaviviruses such as dengue and Zika virus in Polynesia since October 2013 could make the diagnosis of chikungunya more difficult.

Both events highlight the risk of locally-acquired cases occurring in countries where the competent vectors are present.

Actions

ECDC published an [epidemiological update](#) on 24 October 2014.
ECDC published an updated [Rapid Risk Assessment](#) on 27 June 2014.

Influenza – Multistate (Europe) – Monitoring 2014–2015 season

Opening date: 9 October 2014

Latest update: 24 October 2014

Epidemiological summary

Influenza activity in the European Union is low at this time of year and there is no indication that the influenza season has started in the region. Out of 429 sentinel specimens tested in 25 countries, four detections (1%) were reported by three countries. One was subtyped as influenza A(H3N2) and one as influenza A(H1N1). Influenza A was detected in one patient who was admitted to a hospital in Ireland, but who is not in intensive care. No indications of increased mortality due to influenza have been reported through the European monitoring of excess mortality for public health action ([EuroMOMO](#)).

Web sources: [Flu News Europe](#) | [ECDC Influenza](#) |

ECDC assessment

Influenza activity in the European region is low for the time of year.

Actions

ECDC, together with WHO, produces [Flu News Europe](#), which is updated weekly.

West Nile virus - Multistate (Europe) - Monitoring season 2014

Opening date: 3 June 2014

Latest update: 23 October 2014

Epidemiological summary

As of 23 October 2014, 74 human cases of West Nile fever have been reported in the EU, and 120 cases have been reported in neighbouring countries since the beginning of the 2014 transmission season.

EU Member States

Italy has reported 24 cases from the following provinces: Bologna (4), Parma (1), Cremona (3), Modena (2), Reggio nell'Emilia (1), Verona (1), Pavia (5), Mantova (2), Lodi (2), Piacenza (2) and Brescia (1). Romania has reported 23 cases in the districts of Mures (2), Olt (6), Constanta (1), Ialomita (1), Bucuresti (1), Dambovit (1), Dolj (3), Galati (1), Giurgiu (1), Teleorman (2), Sibiu (1), Braila (1), Iasi (1) and Valcea (1). Hungary has recorded 11 cases in the following areas: Budapest (4), Csongrad county (2), Pest County (1), Jasz-Nagykun-Szolnok county (1), Bekes county (1), Hajdu-Bihar county (1) and Bacs-Kiskun county (1). Austria reported one autochthonous case of West Nile fever in Vienna. In Greece, 15 human cases have been notified since the start of the 2014 transmission season in the following prefectures: Attiki (2), Ileia (6), Rodopi (4) and Xanthi (3).

Neighbouring countries

Thirteen cases have been reported by Bosnia and Herzegovina, in Republika Srpska, in the following municipalities: Banja Luka (4), Trebinje (1), Novi Grad (1), Kljuc (1), Krupa na Uni (1), Mrkonjic Grad (1), Gornji Ribnik (1), Teslic (1), Laktasi (1) and Prijedor (1). Serbia has reported 69 cases of West Nile fever in the following regions: City of Belgrade (33), Juzno-backi district (5), Nisavski (1), Kolubarski (4), Sremski (6), Juzno-banatski (15), Podunavski (3), Raski (1) and Sumadijski (1). Russia has reported 29 cases in the following oblasts: Saratovskaya (9), Samarskaya (6), Volgogradskaya (5), Astrakhanskaya (3), Belgorodskaya (1), Altayskiy Kray (1), Chelyabinskaya (1) and Voronezhskaya (3). Israel has recorded nine cases of West Nile fever in the following areas: Central district (1), Tel Aviv district (3), Haifa district (2), Jerusalem (1) and Northern district (2).

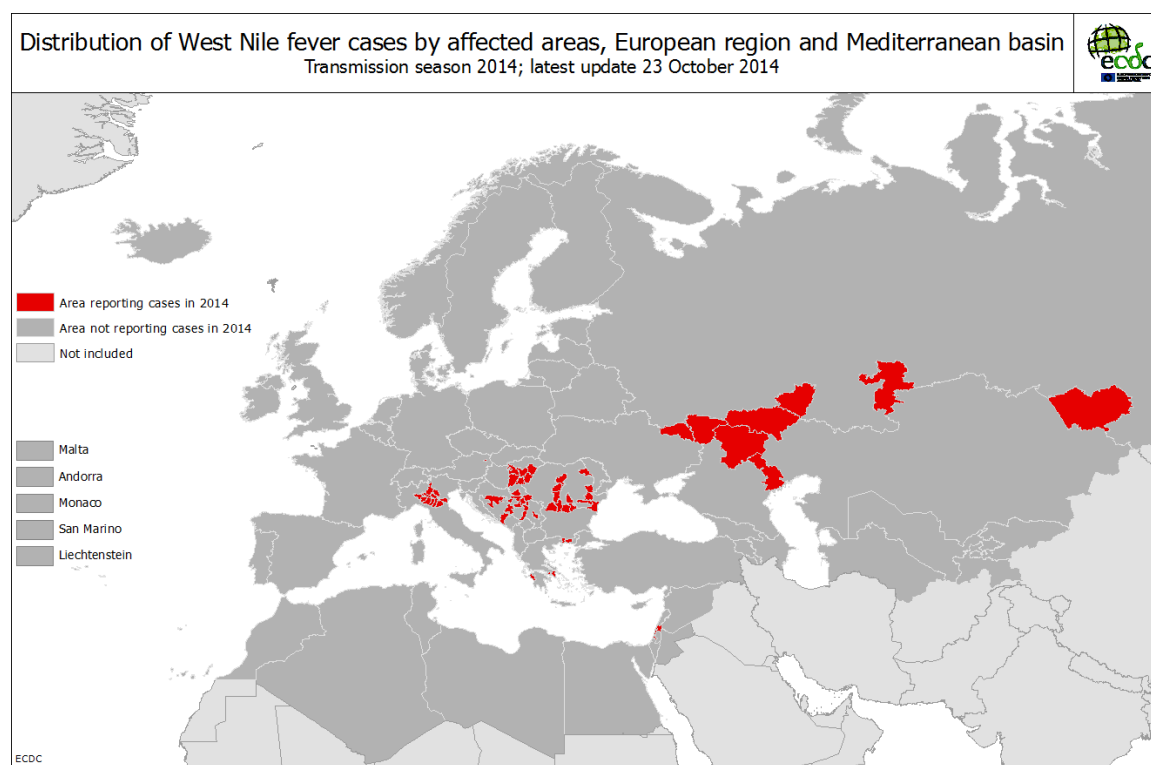
Web sources: [ECDC West Nile fever](#) | [ECDC West Nile fever risk assessment tool](#) | [West Nile fever maps](#) | [WHO fact sheet](#)

ECDC assessment

West Nile fever in humans is a notifiable disease in the EU. The implementation of control measures is considered important for ensuring blood safety by the national health authorities when human cases of West Nile fever occur. According to the [EU blood directive](#), efforts should be made to defer blood donations from affected areas with ongoing virus transmission.

Actions

Since week 23, ECDC has been producing weekly West Nile fever (WNF) risk maps during the transmission season to inform blood safety authorities regarding WNF affected areas.



Ebola Virus Disease Outbreak - the Democratic Republic of Congo - 2014

Opening date: 26 August 2014

Latest update: 24 October 2014

Epidemiological summary

As of 20 October 2014, there have been 66 cases (38 confirmed, 28 probable) of Ebola virus disease (EVD) reported in the Democratic Republic of the Congo, including 49 deaths. Eight of the deaths have been among healthcare workers. The index case was a pregnant woman exposed to bush meat who presented with symptoms of EVD and died in hospital on 11 August. The last confirmed case was reported on 4 October.

A team of national and international specialists has been deployed to work with the local response teams.

The species causing this outbreak is *Zaire ebolavirus*. The strain was found to be 99% homologous to Kikwit 1995 strain and therefore different from the *Zaire ebolavirus* strain circulating in West Africa.

Web Sources: [WHO AFRO](#) | [ECDC Ebola factsheet](#) | [OCHA](#) | [WHO situation report](#)

ECDC assessment

The outbreak in DRC is unrelated to the current epidemic in West Africa. It is possible that more cases will be identified in the coming weeks, as active case-finding and contact monitoring is ongoing and the incubation period can be up to three weeks. However, control measures implemented with the support of international partners is expected to prevent further spread of the disease.

Actions

ECDC is monitoring this event through epidemic intelligence and has published a [rapid risk assessment](#).

Ebola Virus Disease Epidemic - West Africa - 2014

Opening date: 22 March 2014

Latest update: 24 October 2014

Epidemiological summary

Since December 2013 and as of 19 October 2014, WHO reports 9 936 cases, including 4 877 deaths (the additional cases from the USA and Mali reported on 23 October have not been acknowledged by WHO and are not included in the overall figures).

The distribution of cases is as follows:

Countries having reported cases in the previous 42 days (affected countries according to WHO):

- **Guinea:** 1 540 cases and 904 deaths;
- **Liberia:** 4 665 cases and 2 705 deaths;
- **Sierra Leone:** 3 706 cases and 1 259 deaths;
- **United States:** four cases including one death, the last confirmed case occurred in New York City on 23 October 2014.
- **Spain:** one case, no deaths. The case is the result of secondary transmission in Spain to a nurse who cared for an EVD patient who had been evacuated from Liberia on 6 October 2014.
- **Mali:** one confirmed case in a two-year-old girl who recently travelled from Guinea. The case tested positive on 23 October 2014.

Countries having reported cases more than 42 days ago (Previously affected countries according to WHO):

- **Nigeria:** 20 cases and 8 deaths. Nigeria was declared Ebola free on 19 October 2014.
- **Senegal:** 1 confirmed imported case. Senegal was declared Ebola free on 17 October 2014.

The increasing number of healthcare workers that have been infected by the Ebola virus is a major cause for concern: as of 19 October 2014 and according to WHO, 433 healthcare workers are known to have been infected with EVD and among them, 244 have died.

United States: One new case was reported on 23 October in New York City. The case is medical aid worker who volunteered in Guinea and recently returned to the United States. On 20 October, Texas Health Department confirmed that 43 people in Texas who had contact with the state's first Ebola patient have been cleared from twice-daily monitoring after reaching the 21-day mark.

Spain: No new cases have been reported since 6 October when the nurse tested positive. On 21 October 2014, the nurse was declared free of Ebola infection. Eighty-three contacts remain under active follow-up, fifteen of them are in isolation.

As of 23 October ten medical evacuations and repatriations to Europe have taken place of confirmed EVD cases: three to Germany, two to Spain, two to the Netherlands, one to the UK, one to France and one to Norway. MSF Norway reported this week that the MSF employee evacuated to Oslo from Sierra Leone on 7 October has recovered.

Web sources: [ECDC Ebola page](#) | [ECDC Ebola and Marburg fact sheet](#) | [WHO Ebola Factsheet](#) | [Spanish MoH](#) | [CDC](#) | [WHO Roadmap](#) | [Media](#)

ECDC assessment

This is the largest ever documented epidemic of EVD in terms of numbers and geographical spread. The epidemic has not yet reached its peak and is currently in a phase of rapid spread.

The evolving epidemic of EVD over the last weeks increases the likelihood that EU residents and travellers to the EVD-affected countries will be exposed to infected or ill persons. The risk of infection for residents and visitors in the affected countries through exposure in the community is considered low if they adhere to the recommended precautions. Residents and visitors to the affected areas run a risk of exposure to EVD in healthcare facilities. The level of this risk is related to how well the infection control measures are being implemented in these settings and the nature of the care required.

As the epidemic is still evolving and more international staff are deployed to the affected countries to support the epidemic control, the risk of importation of EVD cases to the EU is increasing. The risk of Ebola virus spreading from an EVD patient who arrives in the EU as result of a planned medical evacuation is considered to be low when appropriate measures are strictly adhered to, but cannot be excluded in exceptional circumstances. The transmission of Ebola from a patient to a healthcare worker in Spain illustrates the connection between the epidemic in West Africa and the risk for the EU, and further stresses the need to control the epidemic in West Africa.

If a symptomatic case of EVD presents in an EU Member State, secondary transmission to caregivers in the family and in healthcare facilities cannot be excluded. The highest risk is at an early stage of the disease, before the risk of EVD has been recognised, and at the late stage of the disease when patients have very high viral loads and undergo invasive therapeutic procedures.

Actions

On 13 October, ECDC published an updated [rapid risk assessment](#).

On 10 September, ECDC published an EU [case definition](#).

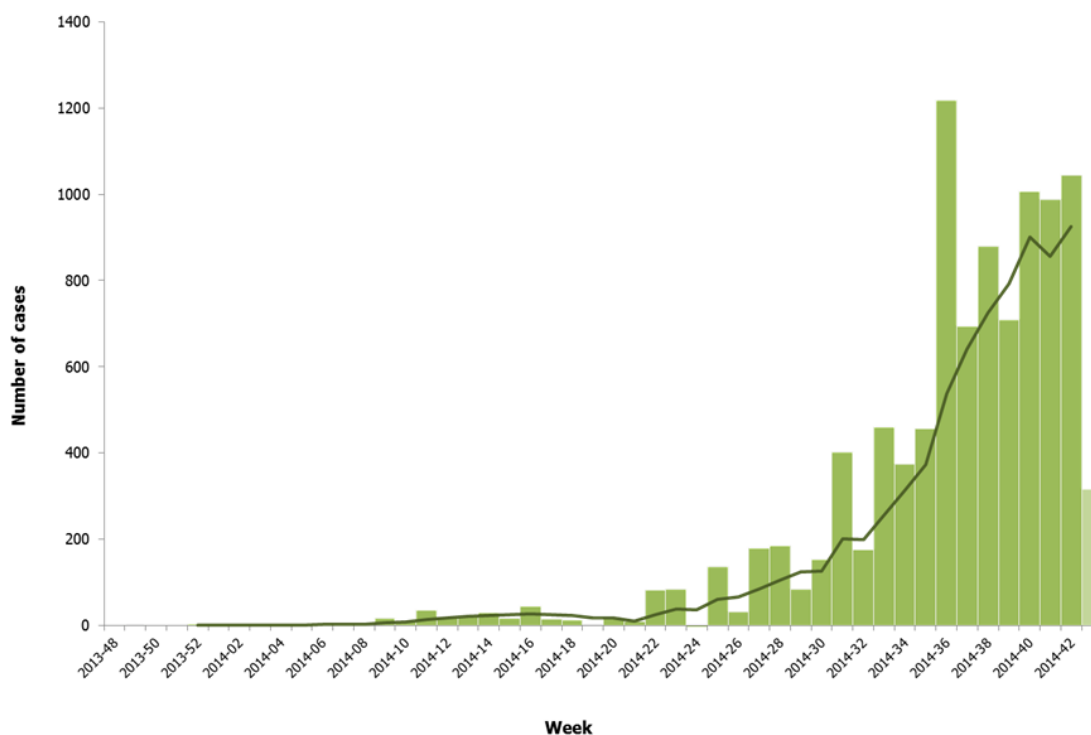
An epidemiological update is published weekly on the [EVD ECDC page](#).

On 13 October, ECDC published a document entitled "[Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures](#)".

Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Nigeria and Senegal, weeks 48/2013 to 43*/2014

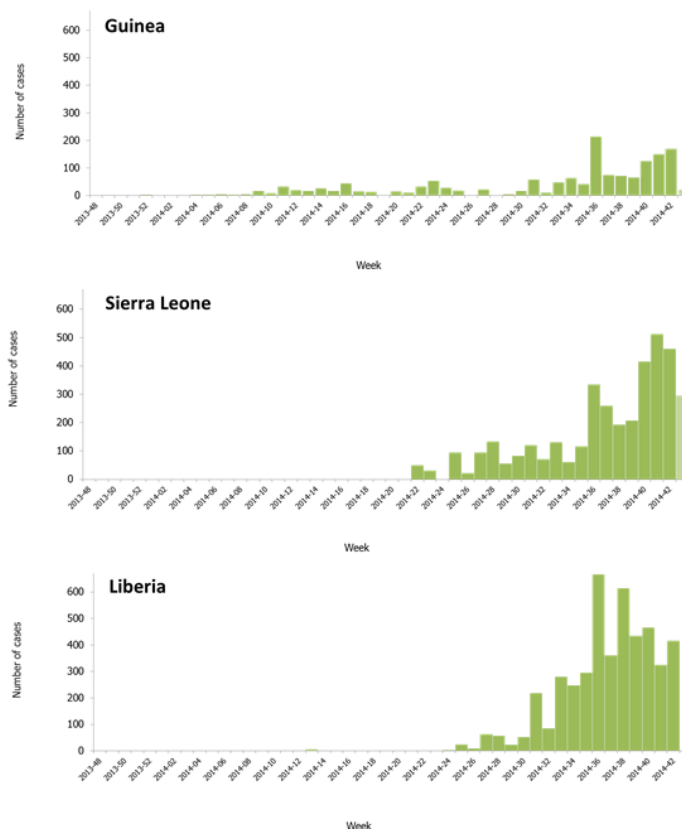
Source: Adapted from WHO; *Data for week 43 are incomplete

Weekly number of EVD cases published on 22/10/2014



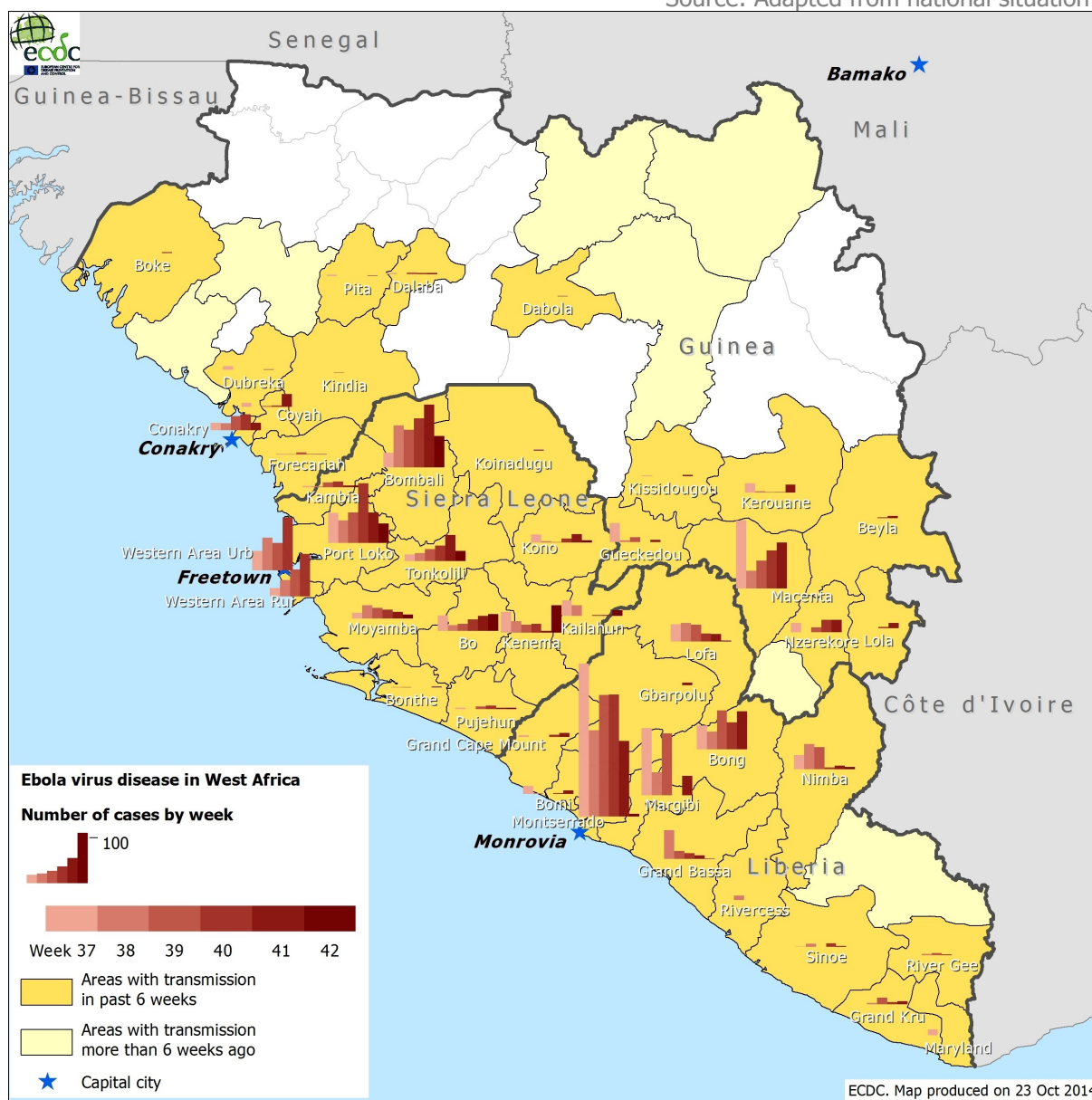
Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 43* 2014

Source: Adapted from WHO figures; *Data for week 43 are incomplete



Distribution of cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia and Nigeria (as of week 42/2014)

Source: Adapted from national situation reports



Outbreak of Enterovirus D68 - USA and Canada

Opening date: 10 September 2014

Latest update: 24 October 2014

Epidemiological summary

Since the last CDTR on 16 October 2014, the [US CDC](#) has reported that from mid-August to 23 October 2014, CDC or state public health laboratories have confirmed 973 cases in 47 states and the District of Columbia, with respiratory illness caused by EV-D68. This is an increase of 177 cases in the past week.

In Canada as of 16 October 2014, the [British Columbia \(BC\) provincial laboratory](#) has confirmed 36 cases of enterovirus D68, mostly in young children <10 years of age. Also a fatal case of a young adult male has occurred according to the same report.

In August 2014, hospitals in Missouri and Illinois were the first to document an increase of severe respiratory illness in children. Most of the cases were later found to be caused by EV-D68 infection. Almost all confirmed cases have been among children, and many of the children have a medical history of asthma and wheezing. According to [US CDC](#), EV-D68 has been detected in specimens from eight patients who died and had samples submitted for testing.

On 26 September 2014, the US CDC issued a [National Health Advisory](#) with a case definition to investigate the possible linkage of the clusters of acute neurologic disease to the EV-D68 outbreak. On 3 October 2014, [two reports](#) were published by the US CDC on clusters of neurologic illness, including acute flaccid paralysis (AFP) with possible association with EV-D68:

Between 8 August and 15 September 2014, a cluster of nine children at Children's Hospital Colorado, Denver, developed symptoms of neurological illness characterised by extremity weakness and/or cranial nerve dysfunction. All had a preceding febrile illness 3–16 days prior to onset of neurologic illness.

Between January 2012 and May 2014, 23 cases of AFP, mainly children, with anterior myelitis of unknown etiology were detected by active surveillance in California. EV-D68 was identified in upper respiratory tract specimens of two patients out of 23.

On 23 October 2014 the [US CDC](#) verified reports of 51 cases in 23 states that meet the case definition. A dozen additional reports are under investigation. It is not yet clear how many tested positive for EV-D68.

According to health authorities in [British Columbia](#) in Canada, there have been two cases of AFP, both with upper respiratory specimens positive for EV-D68. In both cases serious and prolonged duration of paralytic findings were observed. In [Alberta](#), four paralysis cases were investigated, two of which were positive for EV-D68 by upper respiratory specimen. In [Ontario](#), nine paralysis cases are under investigation to determine if there might be a connection to EV-D68.

Sporadic cases of EV-D68 were documented in several EU/EEA countries in recent years. In 2014, EV-D68 was detected in at least four EU/EEA countries, but no epidemic clusters of severe disease have been reported. To date, EU/EEA countries have not reported a growing number of acute respiratory infections or an increased number of hospital admissions.

On 23 October 2014 an article describing the EV D68 situation in the Netherlands was published in the [Eurosurveillance](#).

Web sources: [MMWR](#) | [CDC](#) | [Kansas Health institute](#) | [Illinois Department of Health](#) | [CDC Q&A](#) | [Public Health Canada](#) | [Alberta health services](#)

ECDC assessment

EV-D68 is a potential cause of respiratory tract infections, mainly among children. It can be found in respiratory secretions such as saliva, nasal mucus or sputum. The virus spreads from person to person when an infected person coughs, sneezes or touches contaminated surfaces. There are no available vaccines or specific treatments for EV-D68 and clinical care is symptomatic treatment.

EV-D68 has rarely been reported outside North America, and the number of cases are likely to be underestimated in the United States and Canada due to the absence of a mandatory surveillance system. This year, the magnitude of the outbreak in the United States exceeds previous years, and the transmission of the virus outside North America, including the EU/EEA, remains a possibility. However, the probability that EV-D68 cases will be laboratory-confirmed in EU/EEA countries is low because most EU Member States do not routinely screen for EV-D68, and the disease is not notifiable. EU/EEA countries need to remain vigilant and consider strengthening respiratory sample screening for enteroviruses and enterovirus typing. More systematic testing of severe respiratory illness cases for EV-D68 could be considered in EU/EEA countries to better document the circulation of this virus.

A connection between EV-D68 and the observed neurological illness in the USA and Canada has not yet been proven.

Actions

ECDC published a first update of the [rapid risk assessment](#) on 15 October 2014.

Outbreak of Marburg fever – Uganda

Opening date: 6 October 2014

Latest update: 9 October 2014

Epidemiological summary

On 8 October 2014, the Ministry of Health in Uganda reported the death on 30 September of a medical worker from Marburg fever. The 30-year-old male patient was recently recruited as a radiographer at Mengo hospital, Kampala with onset of disease on 11 September 2014. The case presented to Mpigi District Health Centre on 17 September 2014, and transferred to Mengo

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Hospital, Kampala, on 23 September 2014. On admission the case presented with symptoms including fever, headache, abdominal pain, vomiting and diarrhoea and died on 28 September 2014. The case reported no history of travel beyond Mpigi, and no contact with a person with similar illness. He had not eaten bush meat nor had he had contact with bats in the last 4 weeks.

According to the last situation report on 17 October, there have been no new confirmed Marburg cases in Uganda since the index case was reported.

Source : [CDC](#) | [MoH Uganda](#) | [WHO AFRO](#)

ECDC assessment

Marburg virus disease is a severe and highly fatal disease caused by a virus from the same family as the one that causes Ebola virus disease. Both viruses can cause large outbreaks such as the ongoing Ebola virus disease outbreak in West Africa. Marburg fever cases are not unexpected in Uganda as authorities have reported several outbreaks there since the virus was identified in 1967: in 2007 (4 cases), in 2008 (2 cases) and in 2012 (20 cases including nine deaths). The last outbreak in 2012 affected four districts in Uganda (Kabale, Ibanda, Mbarara, and Kampala).

Actions

The response to the current outbreak is led by the Ministry of Health, the US Centers for Disease Control and Prevention, Médecins Sans Frontières, and UNICEF.

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

Opening date: 24 September 2012

Latest update: 24 October 2014

Epidemiological summary

Since the last MERS-CoV update in the CDTR on 16 October 2014, nine additional cases of MERS-CoV infection have been reported in [Saudi Arabia](#), six cases from Taif and one each from Alkharj, Jawf and Madinah. Six of the nine cases were male. One case was a healthcare worker.

On 18 October 2014, the [Ministry of Health Turkey reported through ProMed](#) that a Turkish citizen working in Saudi Arabia died on 11 October 2014, 10 days after onset of a confirmed MERS-CoV infection. The case returned to Turkey on 10 October 2014. It is assumed that the case was symptomatic during the flight. The local health authorities are conducting contact tracing.

On 22 October, the [health authorities in Qatar](#) reported a case of MERS-CoV in a 43-year-old citizen. The case had fever for a week and is currently in isolation at an emergency unit of Hamad Hospital. This is the first local case reported by Qatar since November 2013.

Since April 2012 and as of 23 October 2014, 908 cases of MERS-CoV have been reported by local health authorities worldwide, including 362 deaths. The distribution is as follows:

Confirmed cases and deaths by region:

Middle East

Saudi Arabia: 772 cases/329 deaths
United Arab Emirates: 73 cases/9 deaths
Qatar: 8 cases/4 deaths
Jordan: 18 cases/5 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
Iran: 5 cases/2 deaths

Europe

Turkey: 1 case/1 death

UK: 4 cases/3 deaths
Germany: 2 cases/1 death
France: 2 cases/1 death
Italy: 1 case/0 deaths
Greece: 1 case/1 death
Netherlands: 2 cases/0 deaths
Austria: 1 case/0 deaths

Africa

Tunisia: 3 cases/1 death
Algeria: 2 cases/1 death

Asia

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

Americas

United States of America: 2 cases/0 deaths

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](#) | [ECDC factsheet for professionals](#)

ECDC assessment

The source of MERS-CoV infection and the mode of transmission have not been identified. Dromedary camels are a host species for the virus, and many of the primary cases in MERS-CoV clusters have reported direct or indirect camel exposure. 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. International surveillance for MERS-CoV cases is essential.

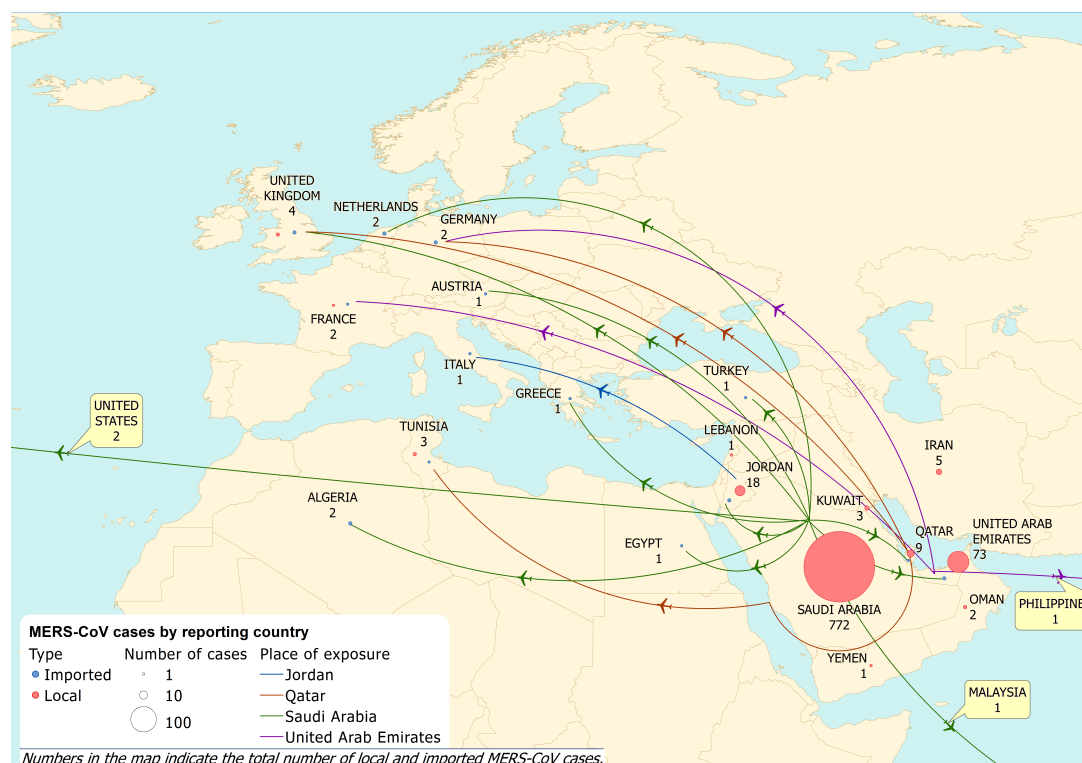
The risk of secondary transmission in the EU remains low and can be reduced further through screening for exposure among patients presenting with respiratory symptoms (and their contacts), and strict implementation of infection prevention and control measures for patients under investigation.

Actions

ECDC published an [epidemiological update](#) on 22 October 2014.
The last [rapid risk assessment](#) was updated on 16 October 2014.
ECDC is closely monitoring the situation in collaboration with WHO and EU Member States.
ECDC published a [factsheet for health professionals regarding MERS-CoV](#) on 20 August 2014.

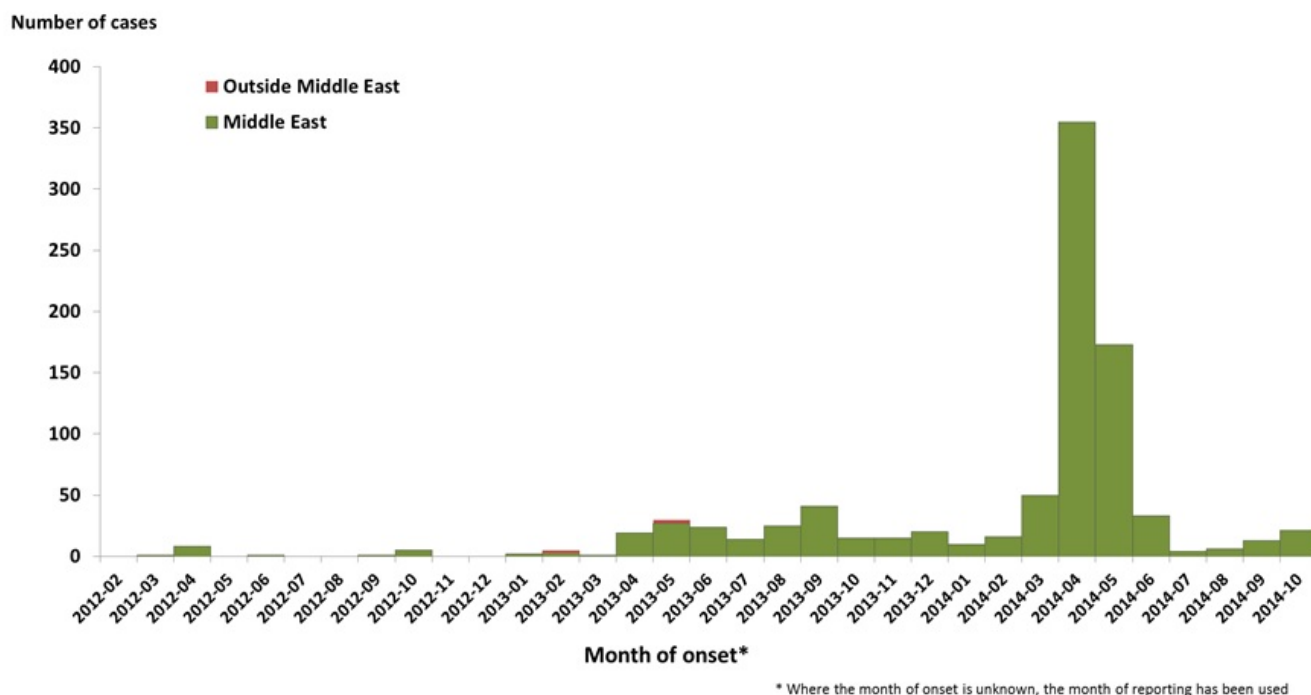
Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 23 October 2014 (n=908)

Source: ECDC



Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 –23 October 2014 (n=908)

Source: ECDC



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 24 October 2014

Epidemiological summary

During the past week, four new cases of WPV1 have been reported to WHO.

Worldwide, 247 cases have been reported to WHO so far in 2014, compared with 298 for the same time period in 2013. In 2014, nine countries have reported cases: Pakistan (210 cases), Afghanistan (12 cases), Nigeria (6 cases), Equatorial Guinea (5 cases), Somalia (5 cases), Cameroon (5 cases), Iraq (2 cases), Syria (1 case), and Ethiopia (1 case).

The number of cases of paralysis caused by wild poliovirus in 2014 is the highest number on record by October in Pakistan in any year since 2009.

More than 6 months have passed since a case of wild poliovirus was reported in Syria or Iraq.

After the declaration of a PHEIC, WHO issued a set of Temporary Recommendations that call for the vaccination of all residents in, and long-term visitors to, countries with polio transmission prior to international travel.

Web sources: [Polio Eradication: weekly update](#) | [MedISys Poliomyelitis](#) | [ECDC Poliomyelitis factsheet](#) | [Temporary Recommendations to Reduce International Spread of Poliovirus](#)

ECDC assessment

Europe is polio-free. The last polio cases within the current EU borders were reported from Bulgaria in 2001. The latest outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460 cases.

The confirmed circulation of WPV in several countries and the documented exportation of WPV to other countries support the fact that there is a potential risk for WPV being re-introduced to the EU/EEA. The highest risk of large poliomyelitis outbreaks occurs in areas with clusters of unvaccinated populations and in people living in poor sanitary conditions, or a combination of the two.

References: [ECDC latest RRA](#) | [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](#)

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 wild poliovirus being re-introduced to the EU.

Following the declaration of polio as a PHEIC, ECDC updated its [risk assessment](#). ECDC has also prepared a background document with travel recommendations for the EU.

On 4 September 2014, [ECDC](#) published a news item regarding the WHO IHR Emergency Committee decision to add Equatorial Guinea as a wild poliovirus-exporting country and the renewal of the WHO PHEIC recommendations.

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The Communicable Disease Threat Report may include unconfirmed information which may later prove to be unsubstantiated.