COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 6, 1-7 February 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 9 October 2014 Latest update: 5 February 2015

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

For week 5/2015, 30 countries reported increasing influenza activity and the proportion of influenza virus-positive sentinel specimens reached 49%, the same level as in the previous week.

Botulism in people who inject drugs - Norway and the UK - 2015

Opening date: 5 January 2015 Latest update: 5 February 2015

Since December 2014, 13 cases of botulism have been reported in Norway (6) and Scotland (7) affecting people who inject drugs. These cases raise the possibility that a batch of contaminated heroin is in circulation.

→Update of the week

On 2 February 2015, Norway reported two new suspected cases of clinical wound botulism in people who inject drugs in the Oslo area.

Non EU Threats

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 5 February 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, mainly affecting Guinea, Liberia and Sierra Leone. The situation in the affected countries remains serious. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC).

→Update of the week

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On 5 February, according to WHO, there have been 22 523 cases of Ebola virus disease (EVD) related to the outbreak in West Africa, including 8 994 deaths.

On 4 February, WHO reported that the Guinean prefecture of Tougué, which borders Mali, has reported its first two confirmed cases. Both cases are thought to have originated in the western prefecture of Dubreka. In light of the recent increase in cases in northern Guinea, cross-border meetings between Guinea, Mali and Senegal are planned to strengthen coordination of surveillance. A WHO rapid-response team has also arrived in the border area between Lola and Côte d'Ivoire to assess risk and strengthen surveillance.

According to WHO, weekly case incidence has increased in all three countries for the first time this year. There were 124 new confirmed cases reported in the week to 1 February: 39 in Guinea, 5 in Liberia, and 80 in Sierra Leone.

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

Opening date: 24 September 2012 Latest update: 5 February 2015

Since April 2012, 992 cases of MERS-CoV have been reported by local health authorities worldwide, including 401 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, Saudi Arabia has reported eight new cases of MERS-CoV infection from Riyad (3), Hafoof (3) and Alkharj (2). On 2 February 2015 Qatar reported the first case in 2015.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 5 February 2015

Dengue fever is one of the most prevalent vector-borne diseases, affecting an estimated 50 to 100 million people each year, mainly in the tropical regions of the world. The identification of sporadic autochthonous cases in non-endemic areas in recent years has already highlighted the risk of locally-acquired cases occurring in EU countries where the competent vectors are present. The dengue outbreak in the Autonomous Region of Madeira, Portugal, in October 2012 and the autochthonous dengue cases in the south of France in 2014 further underline the importance of surveillance and vector control in other European countries.

➔Update of the week

There are ongoing outbreaks of dengue fever globally.

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 5 February 2015

An outbreak of chikungunya virus infection has been ongoing in the Caribbean since December 2013 and spread to North, Central and South America. There is a simultaneous outbreak of chikungunya in French Polynesia. In Europe, France reported autochthonous cases of chikungunya virus infection in 2014. This was the first time that locally-acquired transmission of chikungunya had been detected in France since 2010.

➔Update of the week

Since the last update on 9 January 2015, WHO Pan-American Health Organization (WHO PAHO) has reported more than 61 000 new cases of chikungunya virus infection in the Pan-American region. Since the beginning of the outbreak in December 2013, there have been 176 deaths.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 5 February 2015

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. On 14 November, the Temporary Recommendations in relation to PHEIC were extended for a further three months.

➔Update of the week

During the past week, three new wild poliovirus type 1 (WPV1) cases were reported in Pakistan, all with onset of paralysis in 2015.

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II. Detailed reports

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

Opening date: 9 October 2014 Latest update: 5 February 2015

Epidemiological summary

Excess all-cause mortality among the elderly (aged ≥65 years), concomitant with increased influenza activity and A(H3N2) viruses predominating, has been observed during recent weeks in Belgium, France, Portugal, Spain, Switzerland and the United Kingdom (England, Scotland and Wales) (see the European project for monitoring excess mortality for public health action - EuroMOMO http://www.euromomo.eu/). Although the majority of A(H3N2) viruses characterised so far belong to genetic groups that exhibit antigenic differences to the virus included in the 2014–2015 northern hemisphere influenza vaccine, vaccination of the elderly and other risk groups is still recommended, since the A(H3N2) component is expected to induce some cross-reactive immunity that can reduce the likelihood of severe outcomes related to influenza virus infection. The circulation of respiratory syncytial virus (RSV) seems to have decreased across Europe, with activity having peaked during the first two weeks of 2015.

Web sources: Flu News Europe | ECDC Influenza |

ECDC assessment

The influenza season is well under way, particularly in western and central European countries.

Actions

ECDC and WHO produce the Flu News Europe bulletin weekly.

Botulism in people who inject drugs - Norway and the UK - 2015

Opening date: 5 January 2015 Latest update: 5 February 2015

Epidemiological summary

On 29 December 2014, the Norwegian Institute of Public Health (NIPH) was notified of one case of wound botulism in a heroin-injecting drug user residing in the Oslo area. The patient developed symptoms on 26 December. As of 2 February 2015, the NIPH has notified six cases in the Oslo area since December 2014.

As of 26 January 2015, NHS Greater Glasgow and Clyde, NHS Lanarkshire, Police Scotland and Health Protection Scotland notified seven confirmed, probable and possible cases of botulism among people who inject drugs (PWID). Of these cases, four are currently hospitalised in Glasgow. The source of these infections is contaminated heroin.

Web sources: NHS | Folkhelseinstitutet

ECDC assessment

Botulism in people who inject drugs has been reported in recent years in several European countries and the USA. Cases occurring in two EU Member States during a short time period indicate that a batch of heroin may have been contaminated with spores of the anaerobic bacterium *Clostridium botulinum*.

Given the complex international distribution chain of heroin, the exposure of people who inject drugs in other EU Member States cannot be excluded. Member States should consider increasing awareness in healthcare settings to support prompt diagnosis and treatment as well as reporting to appropriate public health authorities. In addition, heroin users, their social networks, drug treatment and harm reduction services should be alerted about signs and symptoms of wound botulism infection and the importance of seeking medical treatment immediately.

Actions

ECDC published a rapid risk assessment during the previous outbreak of botulism in Norway in October 2013 with conclusions and recommendations that remain valid for this event.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 5 February 2015

Epidemiological summary

Distribution of cases as of 1 February:

Countries with intense transmission:

- Guinea: 2 975 cases and 1 944 deaths (as of 2 February 2015)
- Liberia: 8 745 cases and 3 746 deaths (as of 1 February 2015)
- Sierra Leone: 10 740 cases and 3 276 deaths (as of 2 February 2015)

Countries with an initial case or cases, or with localised transmission:

- United Kingdom: one confirmed case on 29 December 2014.
- Mali, Nigeria, Senegal, Spain and the United States have been declared free of EVD after having cases related to the current epidemic in West Africa.

Situation in specific West African countries
According to WHO, weekly case incidence has increased in all three countries for the first time this year. There were 124 new confirmed cases reported in the week to 1 February: 39 in Guinea, 5 in Liberia, and 80 in Sierra Leone.
According to WHO in Guinea, in the week to 25 January, 14 of 26 (54%) new confirmed and probable cases arose among registered contacts; in Liberia in the 9 days to 31 January, all seven (100%) new confirmed cases arose among registered contacts; and in Sierra Leone in the week to 18 January, 26 of 121 (21%) confirmed cases arose among registered contacts.

Situation among healthcare workers
Among healthcare workers, 822 confirmed cases including 488 deaths have been reported in the three transmission-intense countries.
Distribution of cases: 164 HCWs in Guinea including 88 deaths, 371 HCWs in Liberia including 179 deaths, 287 HCWs in Sierra Leone including 221 deaths, two HCWs in Mali infected, 11 HCWs infected in Nigeria, one HCW infected in Spain while treating an EVD-positive patient, one HCW in the UK who became infected in Sierra Leone, and three HCWs in the USA (one HCW infected in Guinea, and two HCWs infected during the care of a patient in Texas).

Medical evacuations and repatriations from EVD-affected countries
Thirty-four individuals have been evacuated or repatriated worldwide from the EVD-affected countries. As of 5 February, there have been 12 medical evacuations of confirmed EVD-infected patients to Europe (three to Germany, two to Spain, two to France, one to the UK, one to Norway, one to Italy, one to the Netherlands and one to Switzerland). Thirteen persons exposed to Ebola who then tested negative have been repatriated to Europe (four to UK, three to Sweden, two to the Netherlands, one to Denmark, one to Germany, one to Spain and one to Switzerland).
Since the last report, UK notified through EWRS that two additional medical evacuations following needle stick injuries took place, both from Sierra Leone.

Figures

First epi-curve: distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Nigeria, Mali and Senegal, weeks 48/2013 to 06/2015 **

* In week 45/2014, WHO carried out retrospective correction in the data, resulting in 299 fewer cases being reported, which resulted in a negative value for new cases in week 45 which is not plotted.

** According to WHO, the marked increase in the cumulative total number of cases in week 43 is due to a more comprehensive assessment of patient databases, leading to 3 792 additional reported cases. However, these cases have occurred throughout the epidemic period.

Second epi-curve: Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 06* 2015.

* The marked increase in the number of cases reported in Sierra Leone (week 44) and Liberia (week 43) resulted from a more comprehensive assessment of patient databases. The additional 3 792 cases have occurred throughout the epidemic period.

** In week 45/2014, WHO reported -476 cases in Sierra Leone due to retrospective corrections.

§ In week 44/2014, WHO reported zero cases for Liberia.

Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO Ebola Factsheet | CDC | WHO Roadmap|

ECDC assessment

This is the largest ever documented epidemic of EVD in terms of numbers and geographical spread. The evolving epidemic of EVD 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 risk of EVD being imported into the EU or the risk of transmission occurring within the EU remains low or very low due to the range of risk reduction measures that have been put in place by the Member States and the affected countries. However, continued vigilance is essential in order to ensure that re-entry standards do not lapse.
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 significant drop of EVD cases in West Africa can only continue if control efforts are maintained. The situation in the three most affected countries varies considerably and a resurgence of cases and the epidemic remains a possibility. All public health measures should be continued or enhanced in order to mitigate the remaining risk of exposure.
The risk of EVD spreading between affected countries and into the countries sharing borders with Guinea, Liberia and Sierra Leone is still present due to the frequent movement of people and insufficient Ebola surveillance in the border areas.

Actions

As of 5 February 2015, ECDC has deployed 30 experts within and outside the EU in response to the Ebola outbreak. This includes an ECDC mobilised contingent of experts to Guinea. Furthermore, 14 additional experts are confirmed for deployment to Guinea over the next 4 months while additional deployments are envisaged but still pending confirmation.

ECDC is looking for additional French speaking experts with field epidemiology experience from EU member States to join the ECDC-coordinated contingent in response to the Ebola outbreak in Guinea. ECDC's role is to organise the technical support for contact tracing and epidemiological surveillance in the Guinèe forestière region under the GOARN mechanism. Individual experts are invited to contribute by deploying on 6-weeks missions with departure from March to June. The ECDC teams in Guinèe forestière are currently based in N'zerekoré town. For further information, please contact Niklas Danielsson, Response group leader at: niklas.danielsson@ecdc.europa.eu with cc to support@ecdc.europa.eu

An epidemiological update is published weekly on the EVD ECDC page
On 4 February 2015, ECDC published an updated rapid risk assessment
On 22 January 2014, ECDC published Infection prevention and control measures for Ebola virus disease. Management of healthcare workers returning from Ebola-affected areas
On 4 December 2014, EFSA-ECDC published a Scientific report assessing Risk related to household pets in contact with Ebola cases in humans
On 29 October 2014, ECDC published a training tool on the safe use of PPE and options for preparing for gatherings in the EU
On 23 October 2014, ECDC published Public health management of persons having had contact with Ebola virus disease cases in the EU
On 22 October 2014, ECDC published Assessing and planning medical evacuation flights to Europe for patients with Ebola virus disease and people exposed to Ebola virus
On 13 October 2014, ECDC published Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures
On 6 October 2014, ECDC published risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU
On 22 September 2014, ECDC published assessment and planning for medical evacuation by air to the EU of patients with Ebola virus disease and people exposed to Ebola virus
On 10 September 2014, ECDC published an EU case definition

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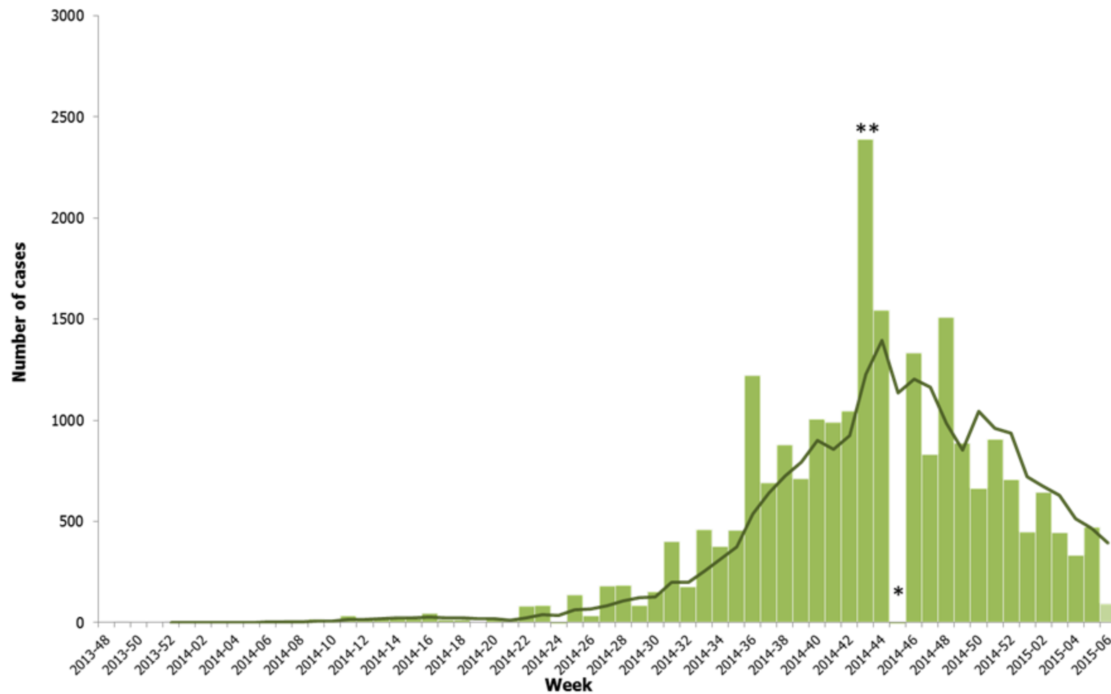
Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Mali, Nigeria and Senegal, weeks 48/2013 to 06*/2015

Source: Adapted from WHO figures; *data for week 06/2015 are incomplete



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Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 06* 2015. Source: Adapted from WHO figures; *data for week 06/2015 are incomplete

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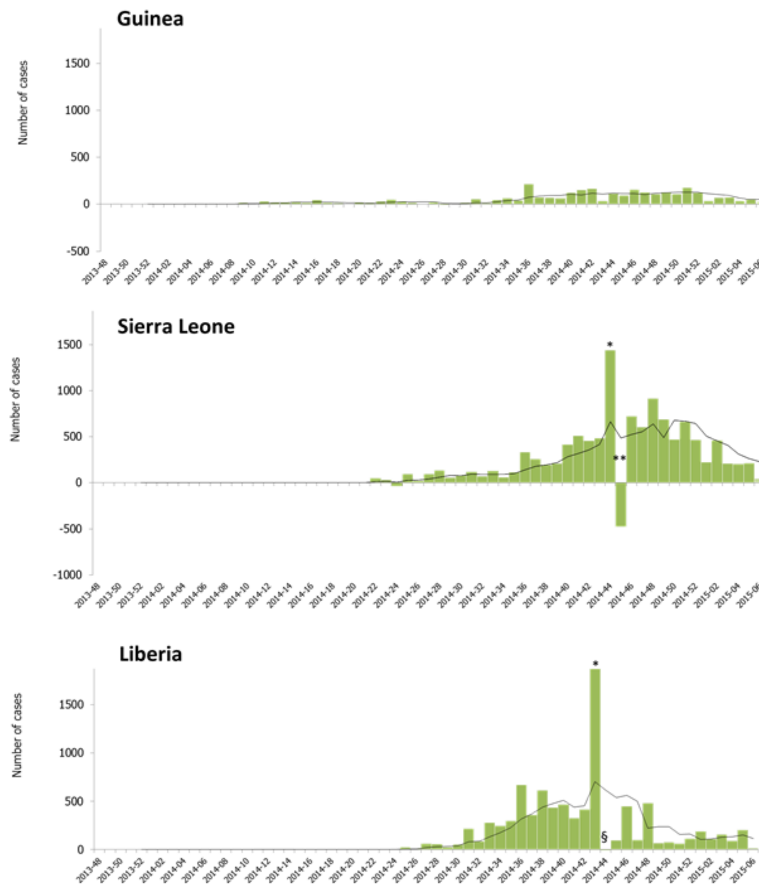

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Distribution of cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 05/2015)

Source: Adapted from national situation reports

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

Opening date: 24 September 2012 Latest update: 5 February 2015

Epidemiological summary

Since April 2012 and as of 05 February 2015, 992 cases of MERS-CoV have been reported by local health authorities worldwide, including 401 deaths. The distribution is as follows:

Confirmed cases and deaths by region:
Middle East
Saudi Arabia: 851 cases/365 deaths
United Arab Emirates: 73 cases/9 deaths
Qatar: 10 cases/4 deaths
Jordan: 19 cases/6 deaths
Oman: 5 cases/3 deaths
Kuwait: 3 cases/1 death

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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. There is therefore a continued risk of cases presenting in Europe following exposure in the Middle East and international surveillance for MERS-CoV cases remains essential.

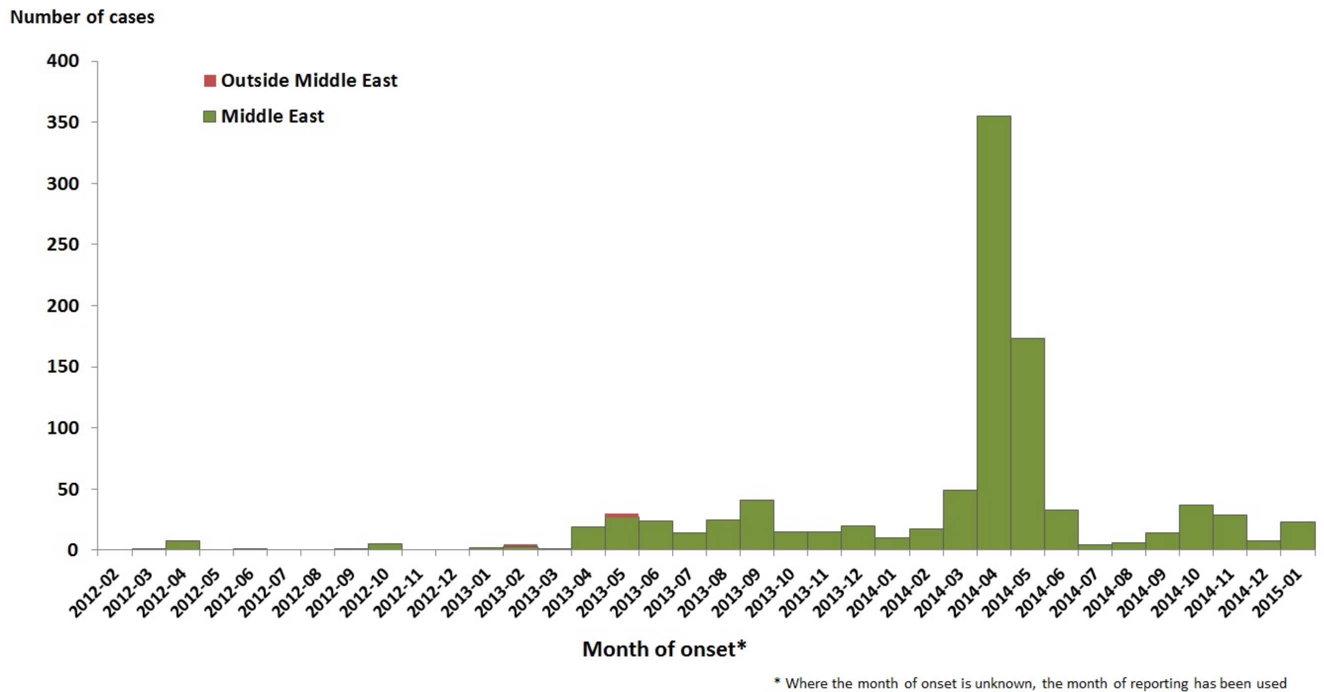
The risk of secondary transmission in the EU remains low and can be reduced further by screening for exposure among patients presenting with respiratory symptoms (and their contacts), and strict implementation of infection prevention and control measures for patients under investigation.

Actions

ECDC published an epidemiological update on 6 November 2014.
The last rapid risk assessment was updated on 21 January 2015.
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 31 January 2015 (n=985)

Source: ECDC



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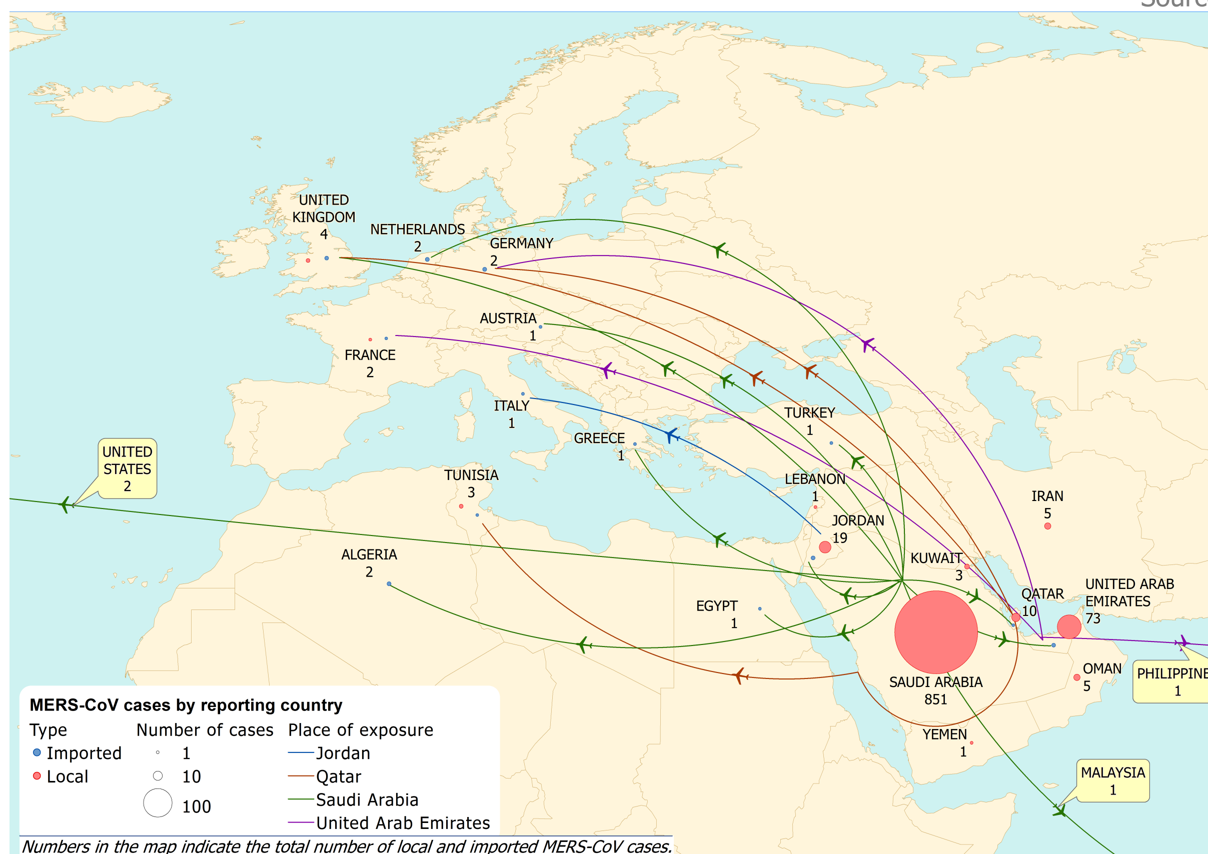
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 5 February 2015 (n=992)

Source:ECDC



Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 5 February 2015

Epidemiological summary

Europe: No new autochthonous dengue cases detected so far in 2015.

Asia: Malaysia is experiencing a recent spike in dengue cases nationally with more than 3 000 cases recorded in the past week alone. Of these cases, more than 1 000 were reported in Selangor, according to media quoting the Ministry of Health. **Sri Lanka** has reported the highest number of dengue cases in the month of January over the past five years with 5 034 cases reported up to 31 January 2015, according to the latest update from the Ministry of Health.

Caribbean: Dominican Republic reported nearly 6 000 dengue cases and 58 deaths nationally in 2014, according to the Ministry of Health. During the first week of January 2015, 32 new cases have been reported.

Americas: In Central America, **El Salvador** recorded 147 new dengue cases and two dengue haemorrhagic fever (DHF) cases

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during the first two weeks of January 2015. In South America, **Brazil** reports increased dengue activity across seven states, particularly in Ceará and São Paulo. As of 14 January 2015, **Ecuador** has recorded 163 cases nationally since the start of the year.

Pacific islands and Australia: A dengue outbreak has been declared by the Ministry of Health in **Tonga** with 33 confirmed cases reported to date, according to media. Fiji has recorded 72 laboratory confirmed dengue cases in the Northern division as of 25 January. The outbreak is primarily localised in the Macuata sub-division, specifically in rural areas. In **French Polynesia**, a DENV-1 outbreak is ongoing with eight confirmed cases reported for the week ending 25 January 2015. Overall, the weekly number of cases is decreasing, according to the Pacific Public Health Surveillance Network (PACNET).
A dengue outbreak in Cairns, **Australia**, is still increasing with 11 cases reported since 11 December 2015, according to Queensland Health.

Web sources: ECDC Dengue | Healthmap Dengue | MedISys | ProMed Americas, Asia, Pacific | WPRO |

ECDC assessment

The autochthonous transmission of dengue fever in the south of France in 2014 highlights the risk of locally-acquired cases occurring in countries where the competent vectors are present. This underlines the importance of surveillance and vector control in other European countries.

Actions

ECDC published a technical report on the climatic suitability for dengue transmission in continental Europe and guidance for the surveillance of invasive mosquitoes.

ECDC monitors the dengue situation worldwide on a monthly basis.

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 5 February 2015

Epidemiological summary

Nearly 1.2 million suspected and confirmed cases of chikungunya virus infection have been reported in the Caribbean and the Americas since the beginning of the outbreak in December 2013. In the Pacific, there are ongoing outbreaks in American Samoa, Cook Islands, French Polynesia, New Caledonia, Samoa and Tokelau. In French Polynesia, as of 25 January 2015, the estimated number of reported chikungunya cases is more than 69 000 since 10 October 2014. The cumulative attack rate is 25%. However, the recent trend has been decreasing, according to the Health Surveillance Bureau for French Polynesia.
Several EU/EFTA countries have reported imported cases of chikungunya infection in patients with a travel history to the affected areas.

Web sources: PAHO update| ECDC Chikungunya | WHO Factsheet | Medisys page |

ECDC assessment

Epidemiological data indicate that the outbreaks are still expanding both in the Caribbean, the Americas and the Pacific. The vector is endemic in both regions, where it also transmits dengue virus. Further spread of the outbreaks is to be expected. Continued vigilance is needed to detect imported cases of chikungunya in tourists returning to the EU from these regions. This requires awareness among clinicians, travel clinics and blood safety authorities.

Actions

ECDC published an updated Rapid Risk Assessment on 27 June 2014.

ECDC monitors the global chikungunya situation on a monthly basis.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 5 February 2015

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Epidemiological summary

Worldwide in 2015, six WPV1 cases had been reported to WHO, compared with eight for the same period in 2014.
In 2014, nine countries reported cases: Pakistan (303 cases), Afghanistan (28 cases), Nigeria (6 cases), Equatorial Guinea (5 cases), Somalia (5 cases), Cameroon (5 cases), Iraq (2 cases), Syria (1 case), and Ethiopia (1 case).
Circulating vaccine-derived poliovirus (cVDPV) cases will now be included in the CDTR in the context of the global preparations for the upcoming planned switch from trivalent OPV to bivalent OPV. One new cVDPV2 case was reported in the past week for 2014 in Nigeria bringing the number of cVDPV2 cases for 2014 to 30 in the country. Worldwide, 53 cases of cVDPV have been reported in 2014.
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 most recent 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 | WHO statement on the third meeting of the International Health Regulations Emergency Committee regarding the international spread of wild poliovirus, 14 November 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.
In 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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