COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 47, 16-22 November 2014

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 3 June 2014 Latest update: 20 November 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, no new cases were reported in the EU or neighbouring countries.

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

Opening date: 9 October 2014 Latest update: 14 November 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 week 46/2014, influenza activity remained low across the WHO European Region.

Outbreak of Legionnaires' disease – Portugal - 2014

Opening date: 10 November 2014 Latest update: 20 November 2014

On 9 November, Portugal reported a large community-based outbreak of Legionnaires' disease in Vila Franca de Xira. As of 17 November 2014, 331 cases and eight deaths have been reported. An association was found between the bacteria in water samples from the cooling towers and in samples from patients. Further results are expected in relation to the source of the outbreak.

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Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 20 November 2014

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 has reported autochthonous cases of chikungunya virus infection. This is the first time that locally-acquired transmission of chikungunya has been detected in France since 2010.

➔Update of the week

Since the last update on 31 October and as of 14 November, WHO PAHO reported more than 100 000 new cases of chikungunya virus infection in the Pan-American region. Since the beginning of the outbreak in December 2013, there have been 154 deaths.

On 16 November, Mexican authorities reported the country's first authoctonous cases.

In Europe, eleven autochthonous cases from the Montpellier area have been reported in France this year.

The number of reported cases in the outbreak of chikungunya in French Polynesia has reached 1 023 cases including 957 in Tahiti, as of 9 November 2014.
According to media quoting health authorities, 2 deaths were reported in week 47 in French Polynesia.

Non EU Threats

New! Highly pathogenic avian influenza virus A(H5N8) - Multistate - 2014

Opening date: 17 November 2014

During November 2014, three EU countries have reported outbreaks of highly pathogenic avian influenza A(H5N8) in commercial poultry farms.

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

Opening date: 26 August 2014 Latest update: 20 November 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 confirmed cases have been reported during the past week. According to WHO, the 42 days time period without reported cases has ended on 21 November 2011, therfore the outbreak is over in DRC.

Ebola Virus Disease Epidemic - West Africa - 2014

Opening date: 22 March 2014 Latest update: 20 November 2014

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 critical. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC).

➔Update of the week

As of 19 November 2014, WHO reports 15 145 cases, including 5 420 deaths, confirmed, probable, and suspected cases of Ebola virus disease (EVD) in six affected countries (Guinea, Liberia, Mali, Sierra Leone, Spain and the United States of America) and two previously affected countries (Nigeria and Senegal). EVD transmission remains persistent and widespread in Guinea, Liberia, and Sierra Leone. No additional cases have been reported in Spain or the USA.

A total of six cases of EVD, including five deaths, have been so far reported in Mali. According to WHO, the most recent cases are in the Malian capital Bamako, and are not related to the country's first EVD case, who died in Kayes on 24 October.

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Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 20 November 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. 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, 12 new cases of wild poliovirus type 1 (WPV1) were reported: 10 in Pakistan and two in Afghanistan.

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

Opening date: 24 September 2012 Latest update: 20 November 2014

Since April 2012, 943 cases of MERS-CoV have been reported by local health authorities worldwide, including 379 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 14 November, five cases have been reported from Saudi Arabia, two from Sakaka, one from Riyadh and two from Alkharj.

Influenza A(H5N1) - Multistate (world) - Monitoring human cases

Opening date: 15 June 2005 Latest update: 20 November 2014

The influenza A(H5N1) virus, commonly known as bird flu, is fatal in about 60% of human infections. Sporadic cases continue to be reported, usually after contact with sick or dead poultry from certain Asian and African countries. No human cases have been reported from Europe.

➔Update of the week

Since the last monthly update on 2 October 2014, WHO has not acknowledged new human cases of avian influenza A (H5N1) worldwide.

During the month of November the Ministry of Health of Egypt has published information regarding three new human cases of A(H5N1) in Egypt.

Outbreak of Enterovirus D68 - Global - 2014

Opening date: 10 September 2014 Latest update: 20 November 2014

Since mid-August 2014, local health authorities in 47 states and the District of Columbia in the USA have been notifying the Centers for Disease Control and Prevention (CDC) of laboratory-confirmed enterovirus 68 (EV-D68) infections. Since mid-September Canada has also experienced an increase in severe respiratory illness associated with EV-D68 infections. 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 update on 13 November 2014, five new cases of respiratory illness caused by EV-D68 have been reported from the USA.

According to media, on 17 November 2014 two non-paralytic EV-D68 cases in children have been detected in Israel among 280 respiratory patients.

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II. Detailed reports

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

Opening date: 3 June 2014 Latest update: 20 November 2014

Epidemiological summary

As of 20 November 2014, 74 human cases of West Nile fever have been reported in the EU, and 136 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), Dambovita (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 76 cases of West Nile fever in the following regions: City of Belgrade (35), Juzno-backi district (5), Nisavski (1), Kolubarski (4), Sremski (6), Juzno-banatski (19), Podunavski (4), 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 17 cases of West Nile fever in the following areas: Central district (2), Tel Aviv district (4), Haifa district (3), Southern district (2) Jerusalem (1), Northern district (5). One confirmed case has been reported in Palestine* (Gaza Strip).

*This designation shall not be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue.

Web sources: ECDC West Nile fever | ECDC West Nile fever risk assessment tool | West Nile fever maps | WHO fact sheet

ECDC assessment

Since week 43, no new human cases of West Nile fever have been reported in EU Member States. ECDC will close its seasonal monitoring of West Nile virus transmission for 2014.

Actions

Today, November 21st, is the last weekly West Nile fever risk map for the 2014 transmission season. ECDC is preparing an epidemiological update.

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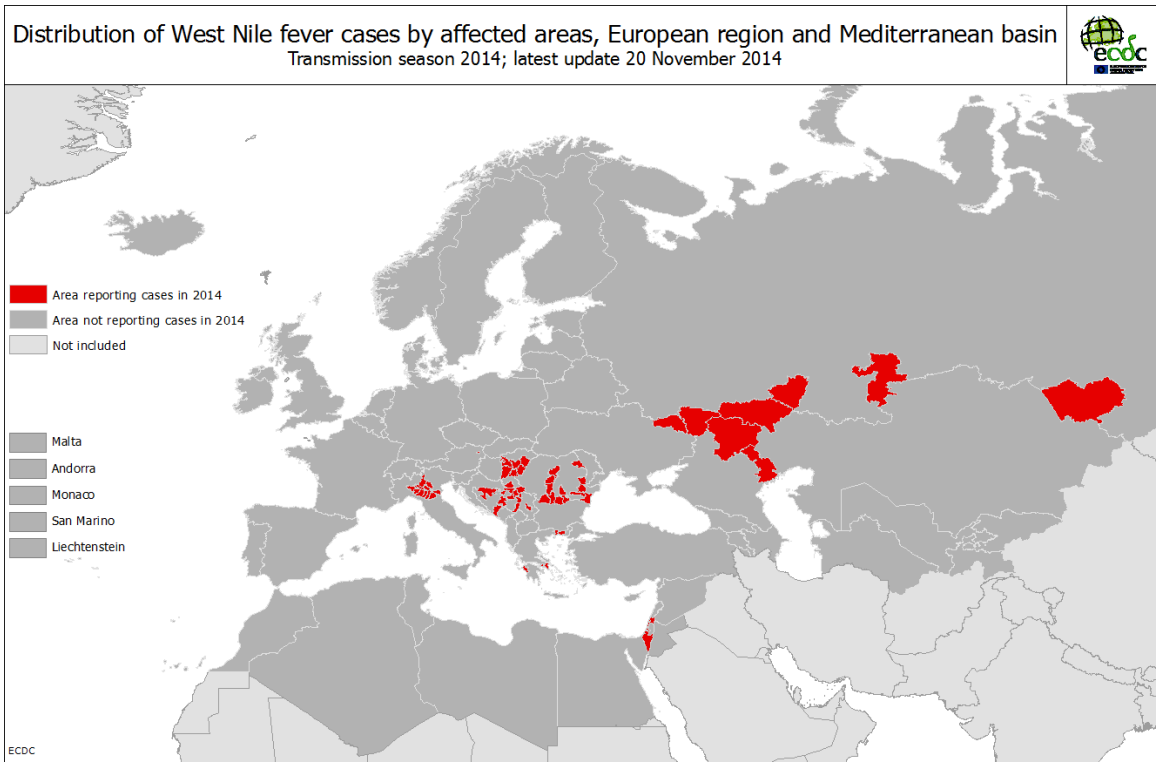

Influenza – Multistate (Europe) – Monitoring 2014–2015 season

Opening date: 9 October 2014 Latest update: 14 November 2014

Epidemiological summary

In week 46/2014, influenza activity remained low across the WHO European Region.
Fourteen countries reported sporadic influenza activity and eight countries reported increasing trends in influenza-like illness (ILI) and acute respiratory infection (ARI) consultation.
Of the 634 sentinel ILI and ARI specimens tested across 35 countries, only fourteen (2%) from eight countries tested positive for influenza. Currently circulating viruses include A(H1N1)pdm09, A(H3N2), and influenza B viruses.
Hospitalised cases remain low and stable, with one country reporting four hospitalised laboratory-confirmed influenza cases for week 46/2014. All were admitted to intensive care units.

Web sources: Flu News Europe | ECDC Influenza |

ECDC assessment

Although sporadic detections are being reported in an increasing number of countries there is no indication that the influenza season has started in the Region, which is normal for this time of year.
No indications of increased mortality due to influenza have been reported through the European monitoring of excess mortality for the public health action project

Actions

ECDC and WHO produce the Flu News Europe bulletin weekly.

Outbreak of Legionnaires' disease – Portugal - 2014

Opening date: 10 November 2014 Latest update: 20 November 2014

Epidemiological summary

On 6 November 2014, Portugal identified an outbreak of Legionnaires' disease in three parishes (Póvoa de Santa Iria, Forte da

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Casa and Vialonga) of Vila Franca de Xira, situated 30km north of Lisbon. Vila Franca de Xira is not considered a tourist area. Seventeen cases were initially identified on 7 November when epidemiological and environmental investigations started.

As of 17 November, the Portuguese Ministry of Health has reported 331 cases and eight deaths. The cases are from the Lisbon region (322), North region (3), Central region (5) and the region of Algarve (1).

Source: Portugese MoH |

ECDC assessment

This is the largest outbreak of Legionnaires' disease ever reported in Portugal and one of the largest in the European Union. Vila Franca de Xira is not considered a tourist destination. Despite the magnitude of the outbreak, this event can be considered a local event. All cases were infected in Vila Franca de Xira where the outbreak is occurring. Cooling towers of major industrial installations in the area of Vila Franca de Xira were closed. Provisional results demonstrate a strong association between bacteria in water samples obtained from the cooling towers and the bacteria isolated from samples taken from the patients. Further results are expected in relation to the source of the outbreak.

Actions

ECDC published a rapid risk assessment and deployed two experts to participate in the outbreak investigation.

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 20 November 2014

Epidemiological summary

As of 14 November 2014, 894 538 suspected and confirmed cases of chikungunya virus infection have been reported from the affected countries and territories in the Caribbean and the rest of the Americas, including 154 fatalities.

During the last week, Mexico reported the country's first autochthonous cases in Mexico City and in Chiapas State. As of 16 November, 14 autochthonous cases have been reported in Mexico.

In Europe, as of 14 November, French authorities have reported eleven autochthonous cases. The cases live in Montpellier in the vicinity of a chikungunya case imported from Cameroon. Several EU/EFTA countries (France, Greece, Italy, the Netherlands, Spain and Switzerland) have reported imported cases of chikungunya infection in patients with a travel history to the affected areas.

In French Polynesia, from the beginning of the year to 9 November, 1 023 cases including 957 in Tahiti were reported by authorities. The media reported two deaths among the chikungunya cases. In addition, two imported cases were reported in New Caledonia.

Web sources: PAHO update| ECDC Chikungunya | CDC Factsheet | Medisys page | Mexican MoH

ECDC assessment

Epidemiological data indicate that the outbreaks are still expanding both in the Caribbean, the Americas and in 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.

New! Highly pathogenic avian influenza virus A(H5N8) - Multistate - 2014

Opening date: 17 November 2014

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Epidemiological summary

On 6 November 2014, the German authorities reported an outbreak of highly pathogenic avian influenza (HPAI) virus A(H5N8) at a holding with 31 000 fattening turkeys in the north-east of Germany.

On 16 November 2014, the Dutch authorities reported an outbreak of HPAI virus due to A(H5N8) in a holding with 150 000 laying hens kept indoor located in Hekendorp (municipality Oudewater), north east of Rotterdam.

On 16 November 2014, the UK authorities reported another outbreak of HPAI virus due to A(H5N8) in an indoor holding with 6 000 breeding ducks in North Yorkshire, England.

Links: ECDC Avian Influenza | RKI | RIVM |PHE | FAO|

ECDC assessment

This virus has been detected among wild birds in Asia where it has caused several outbreaks on commercial poultry farms in South Korea, Japan and China. However, this is the first time it has been detected in Europe. It remains unclear how this virus was introduced into closed indoor holdings in Europe in regions far from each other and in different poultry production sectors at the same time. The ability of this highly pathogenic avian influenza virus to sub-clinically infect wild birds increases the risk of geographical spread and subsequent outbreaks, as observed in South Korea. The ongoing monitoring and testing of wild birds and domestic poultry in the EU therefore plays an important role in the possible detection of further virus occurrences.

To date, no human infections with this virus have ever been reported worldwide and the risk for zoonotic transmission to the general public in the EU/EEA countries is considered to be extremely low. However, given the evolutionary history of the virus, with HA gene evolved from the widely circulating H5N1 viruses, people in direct contact/handling diseased birds or poultry, or their carcasses (e.g. farmers, veterinarians and labourers involved in the culling and rendering) might be at risk for infection. Given this potential zoonotic risk, contingency plans for the control of avian influenza in poultry and birds should be developed in collaboration with public health and occupational health authorities to foresee that persons at risk are sufficiently protected from infection. Appropriate personal protective equipment, including respiratory protection should be made available and used.

Actions

On 20 November 2014, ECDC published an updated rapid risk assessment.

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

Opening date: 26 August 2014 Latest update: 20 November 2014

Epidemiological summary

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

As of 19 November 2014, there have been 66 cases (38 confirmed, 28 probable) of Ebola virus disease (EVD) reported in the Democratic Republic of Congo (DRC), 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 reported case tested negative for the second time on 10 October. The DRC will therefore be declared free of EVD 42 days after the date of the second negative test if no new cases are reported.

Web Sources: WHO AFRO | ECDC Ebola factsheet | OCHA | WHO situation report | WHO roadmap

ECDC assessment

The outbreak in DRC is unrelated to the current epidemic in West Africa. It appears at present that control measures implemented with the support of international partners have prevented further spread of the disease.

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Actions

ECDC has been monitoring this event through epidemic intelligence and published a rapid risk assessment.

Ebola Virus Disease Epidemic - West Africa - 2014

Opening date: 22 March 2014 Latest update: 20 November 2014

Epidemiological summary

Distribution of cases

Countries with widespread and intense transmission:
- Guinea: 1 971 cases and 1 192 deaths (as of 16 November 2014)
- Liberia: 7 069 cases and 2 964 deaths (as of 15 November 2014)
- Sierra Leone: 6 073 cases and 1 250 deaths (as of 16 November 2014).

Countries with an initial case or cases, or with localised transmission:
- United States: four cases including one death
- Spain: one case, no deaths
- Mali: six cases, five deaths
- Nigeria: 20 cases and eight deaths. Nigeria was declared Ebola free on 19 October 2014;
- Senegal: one confirmed imported case. Senegal was declared Ebola free on 17 October 2014.

Situation in specific West African countries

According to WHO, in the three countries with widespread and intense transmission, reported case incidence seems stable in Guinea and Liberia, but is still increasing in Sierra Leone. All administrative districts in Liberia and Sierra Leone have reported at least one confirmed or probable case of EVD since the start of the epidemic. Cases and deaths continue to be under-reported.

In Mali, there have been six cases, five confirmed and one probable case, including five deaths. The last five reported cases have occurred in the Malian capital Bamako, and are not related to the country's first EVD-positive patient, who died on 24 October. All identified contacts connected with this initial case have now completed 21-days follow-up. Among the cases in Bamako, two are healthcare workers (HCWs) who cared for an imported case from Guinea who was admitted in a Bamako clinic on 25 October.

Situation among Healthcare workers

As of 16 November WHO reported a total of 585 health-care workers infected with EVD, 335 of whom have died. According to WHO early indications a substantial proportion of infections among HCWs occurred outside the context of Ebola treatment and care centres

Situation outside of West Africa

USA

No new autochthonous EVD cases have been reported since 23 October. The latest autochthonous reported case concerns a medical aid worker who volunteered in Guinea and recently returned to the United States. He was hospitalised in New York City and was discharged healthy on 11 November 2014.

Spain

No new cases have been reported since 6 October when a healthcare worker was infected while caring for an Ebola-infected patient in Madrid. She recovered and tested negative for EVD on 19 October. A second negative test was obtained on 21 October. All 83 contacts of the HCW have completed a 21-day follow-up. Spain will be declared free of EVD 42 days after the date of the second negative test if no new cases are reported.

Medical evacuations and repatriations from EVD-affected countries

Nineteen individuals have been evacuated or repatriated from the EVD-affected countries. As of 20 November, there have been nine medical evacuations of confirmed EVD-infected patients to Europe (three to Germany, two to Spain, two to France, one to the UK and one to Norway). Two persons exposed to Ebola have been repatriated to the Netherlands and tested negative. One individual was evacuated to Switzerland and was not confirmed for EVD in September. On 20 November, a healthcare worker from Sierra Leone (Cuban citizen) was evacuated to Geneva (Switzerland).
According to media, the last case evacuated to USA (Nebraska) on the 15 November, a surgeon coming from Sierra Leone, died on 17 November as a result of the advanced symptoms of the disease.

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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 47*/2014
* In week 45/2014, WHO carried-out retrospective correction in the data resulting in reporting 299 fewer cases 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 47* 2014
* The marked increase in the number of cases reported in Sierra Leone (week 44) and Liberia (week 43) results 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 | Spanish MoH | CDC | WHO Roadmap | Media | MSF | Mali MoH | Media Medical Evacuation |

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 continues to spread. The evolving epidemic of EVD over recent 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

An epidemiological update is published weekly on the EVD ECDC page.
On 18 November, ECDC published an updated rapid risk assessment.

On 10 September, ECDC published an EU case definition.
On 22 September 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 6 October ECDC published risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU.
On 13 October, ECDC published a document entitled "Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures".
On 22 October ECDC published Assessing and planning medical evacuation flights to Europe for patients with Ebola virus disease and people exposed to Ebola virus.
On 23 October ECDC published Public health management of persons having had contact with Ebola virus disease cases in the EU.
On 29 October, ECDC published a training tool on the safe use of PPE and options for preparing for gatherings in the EU

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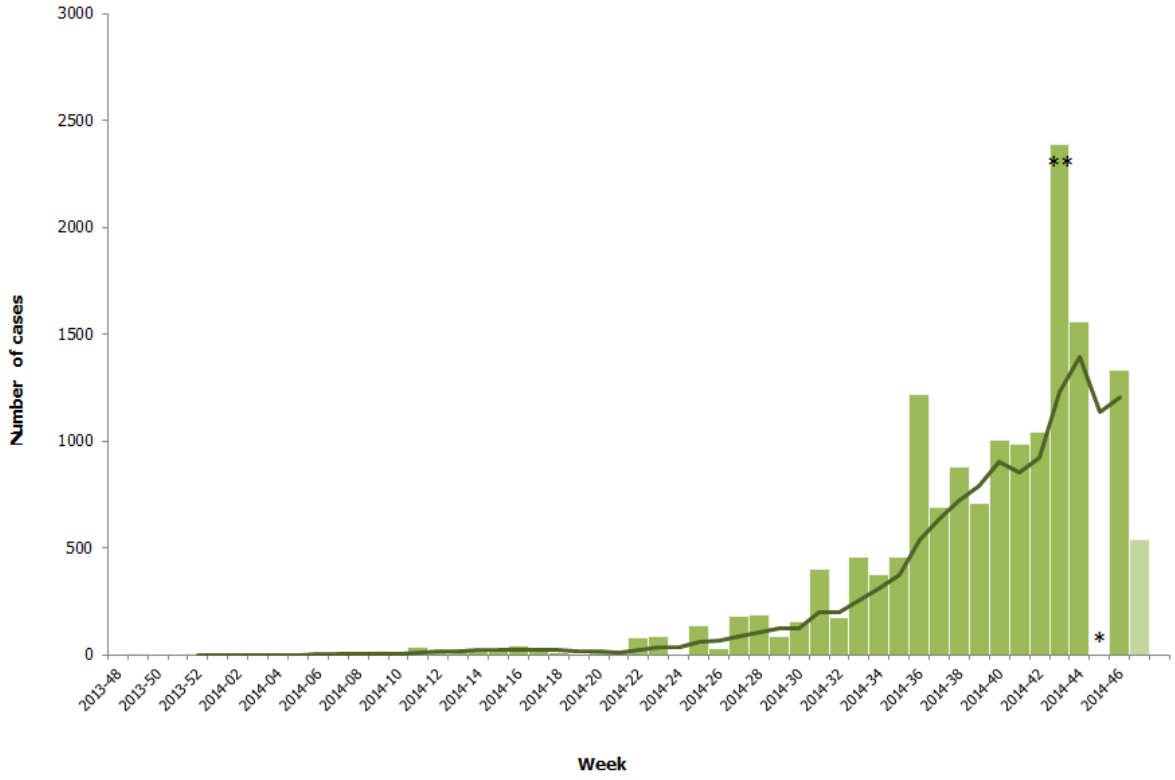
Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Nigeria and Senegal, weeks 48/2013 to 47*/2014

Source: Adapted from WHO; *Data for week 47 are incomplete



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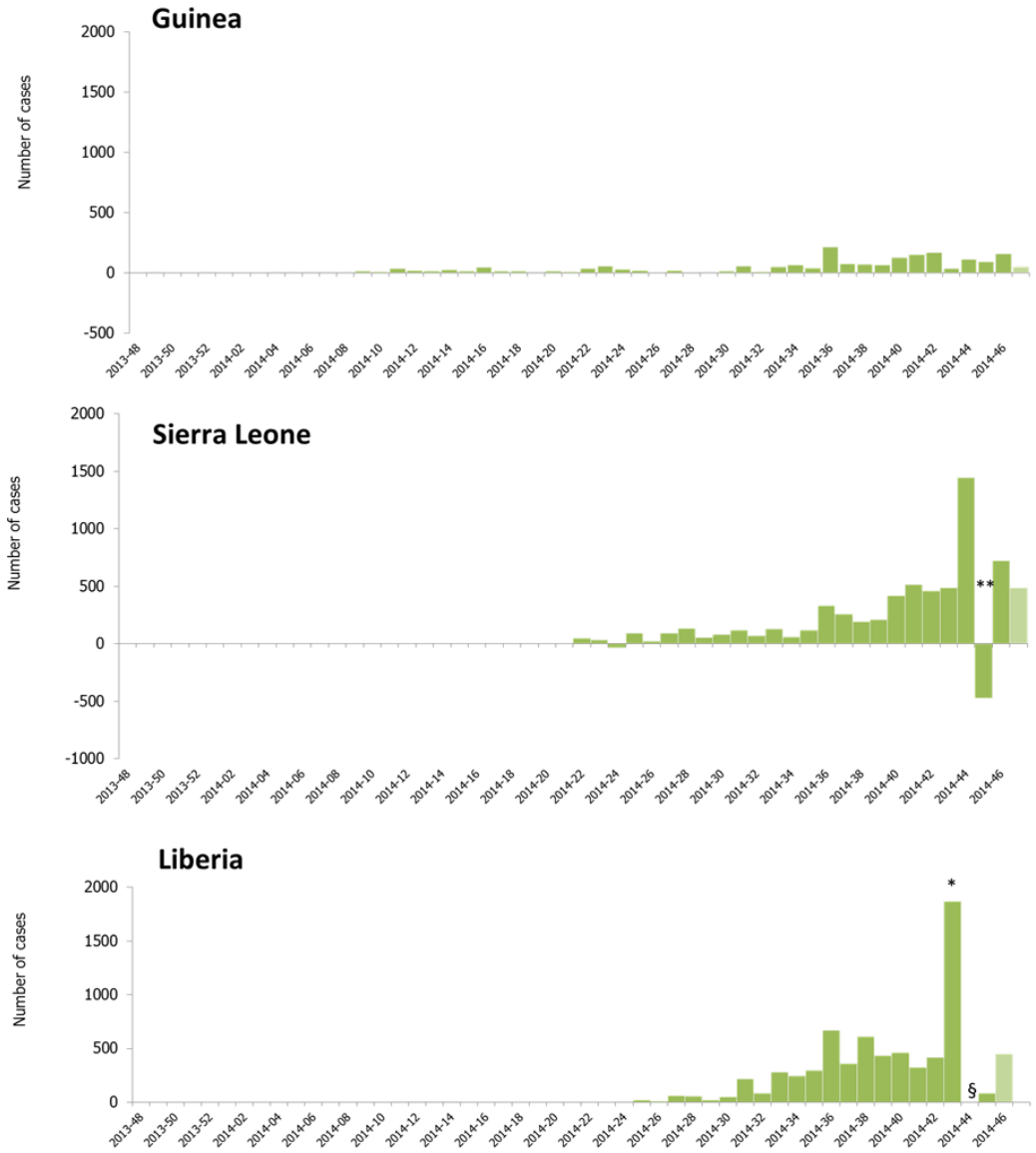
Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 47* 2014

Source: Adapted from WHO; *Data for week 47 are incomplete



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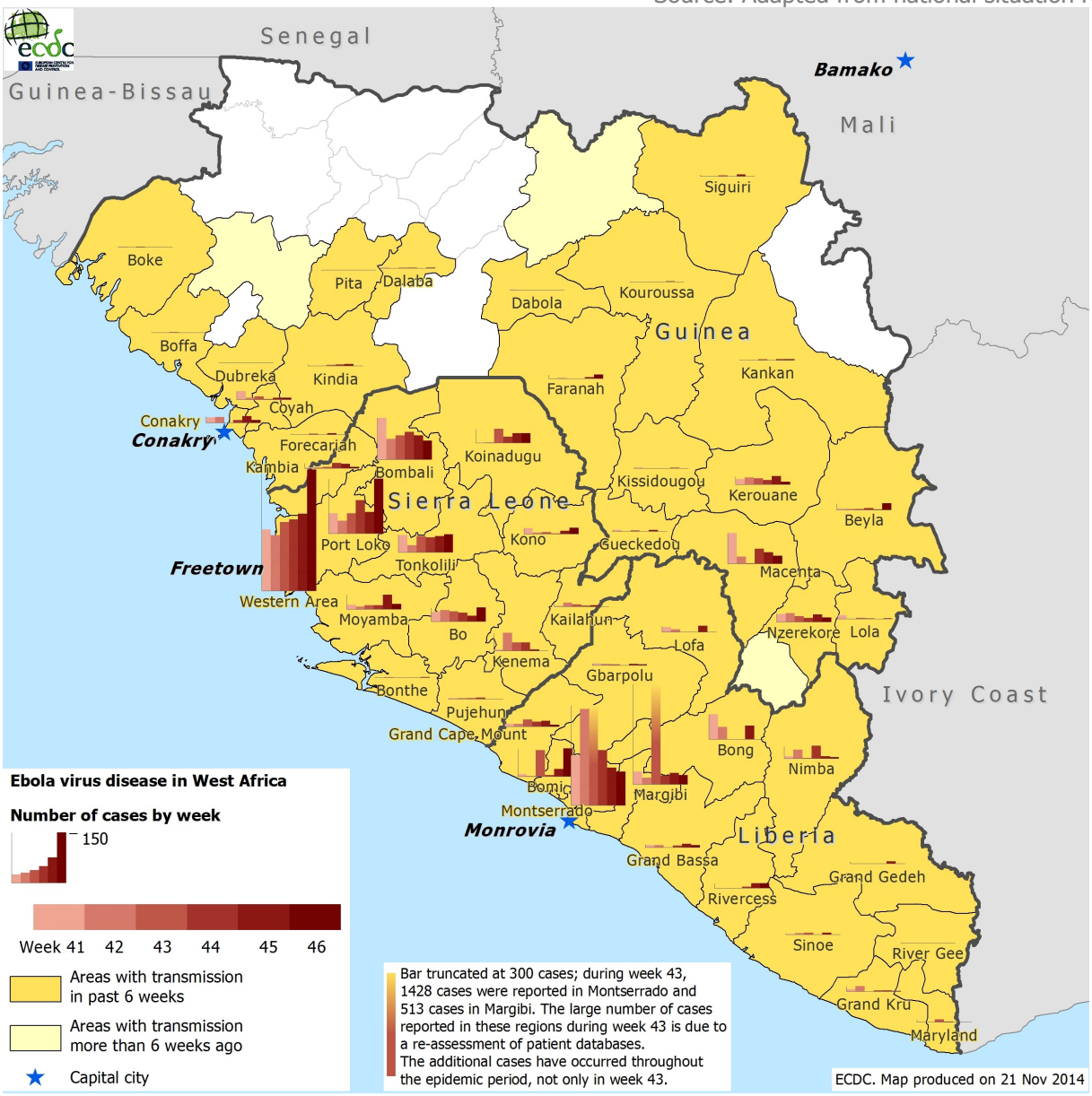
Distribution of cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 46/2014)

Source: Adapted from national situation reports



Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 20 November 2014

Epidemiological summary

Worldwide in 2014, 291 cases have been reported to WHO so far, compared with 341 for the same time period in 2013. In 2014, nine countries have reported cases: Pakistan (246 cases), Afghanistan (20 cases), Nigeria (6 cases), Equatorial Guinea (5 cases), Somalia (5 cases), Cameroon (5 cases), Iraq (2 cases), Syria (1 case), and Ethiopia (1 case).

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.

On 14 November, after a third meeting on PHEIC, WHO recommended the extension of the Temporary Recommendations for a further three months.

As of last week, WHO reports one case of cVDPV1 in Madagascar and 48 cases of cVDPV2 (26 in Nigeria, 20 in Pakistan and 2 in

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South Sudan).

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 | 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.

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.

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

Opening date: 24 September 2012 Latest update: 20 November 2014

Epidemiological summary

Since April 2012 and as of 20 November 2014, 943 cases of MERS-CoV have been reported by local health authorities worldwide, including 379 deaths. The distribution is as follows:

Confirmed cases and deaths by region:
Middle East
Saudi Arabia: 807 cases/345 deaths
United Arab Emirates: 73 cases/9 deaths
Qatar: 9 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

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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 06 November 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.

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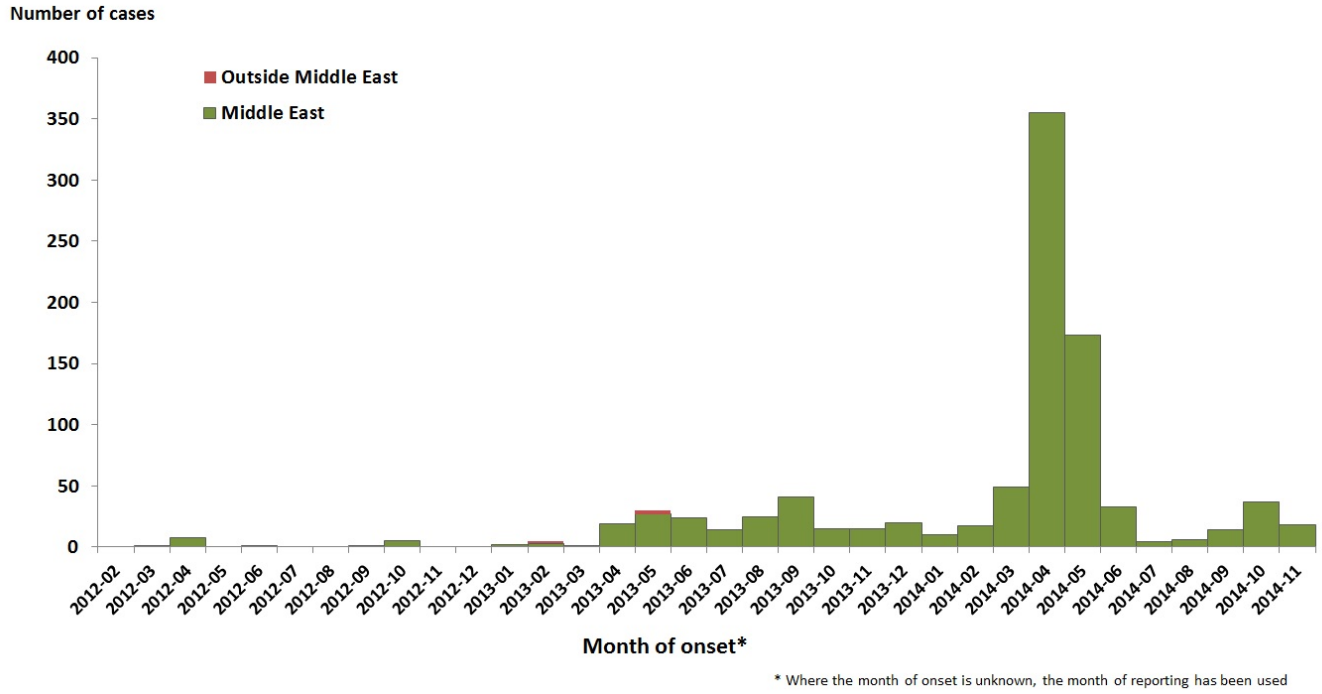
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 20 November 2014 (n=943)

Data for November 2014 is incomplete



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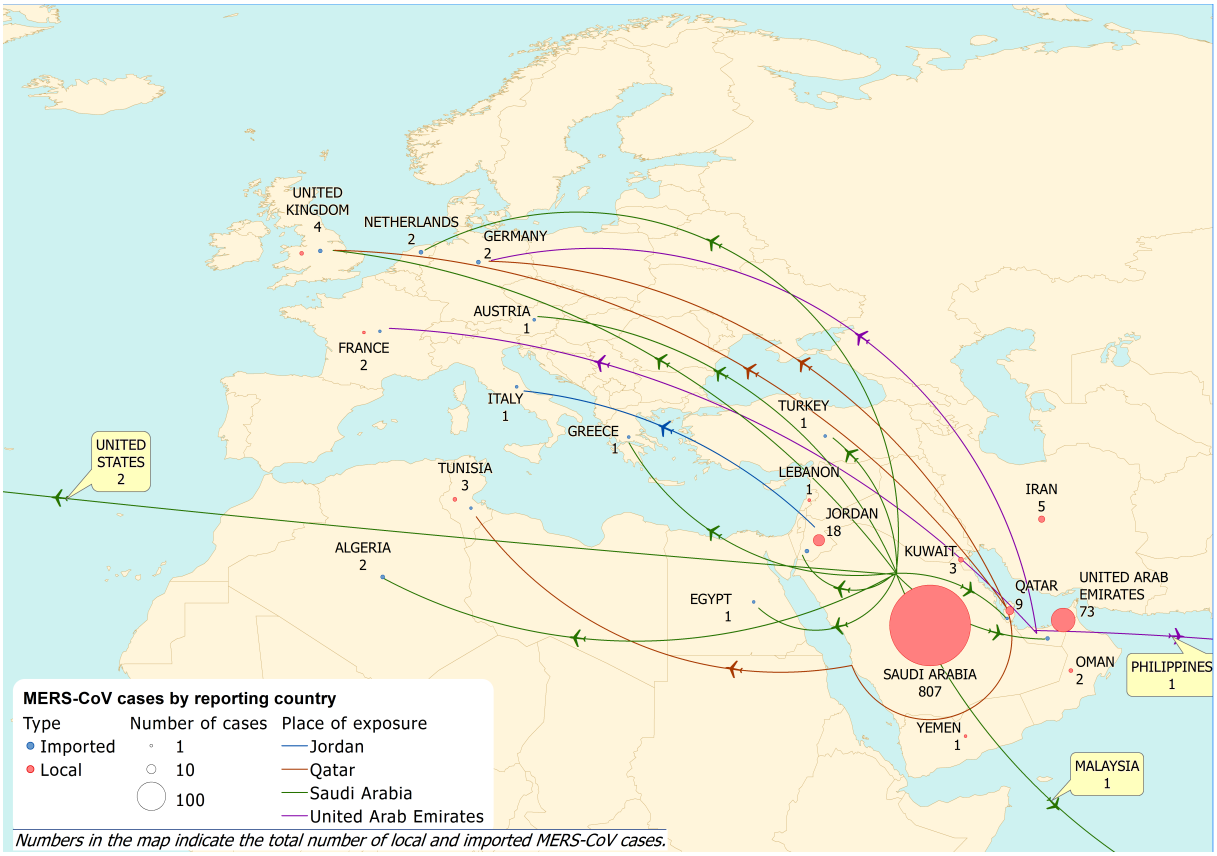
Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 20 November 2014 (n=943)

Source:ECDC



Numbers in the map indicate the total number of local and imported MERS-CoV cases.

Influenza A(H5N1) - Multistate (world) - Monitoring human cases

Opening date: 15 June 2005 Latest update: 20 November 2014

Epidemiological summary

During the month of November the Ministry of Health of Egypt published information regarding three cases in the country, two cases in Minya on 7 November 2014 and one fatal case in Assiut on 16 November 2014. All three cases had direct contact with poultry.
The Ministry of Health of Egypt reports that since 2006 there have been 180 cases including 65 deaths in Egypt, and seven of the 180 cases have occurred during 2014.

According to the WHO update on 2 October 2014 there have been four non-fatal human cases of A(H5N1) in Egypt in 2014.

From 2003 to 2 October 2014, 668 cases including 393 deaths have been reported from 16 countries to WHO.

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Web sources: ECDC Rapid Risk Assessment | Avian influenza on ECDC website | WHO update | WHO EMRO |

ECDC assessment

The risk of secondary cases in Europe is considered to be very low. Europeans travelling to China and South-East Asia should avoid live poultry markets and contact with chickens, ducks, wild birds and their droppings. This reduces the risk of exposure to both A(H5N1) and A(H7N9). Poultry meat and eggs should be well cooked.

Hong Kong reported the world's first outbreak of bird flu among humans in 1997, when six people died. Most human infections are the result of direct contact with infected birds, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. There are currently no indications of a significant change in the epidemiology associated with any clade or strain of the A(H5N1) virus from a human health perspective. This assessment is based on the absence of sustained human-to-human transmission, and on the observation that there is no apparent change in the size of clusters or reports of chains of infection. However, vigilance for avian influenza in domestic poultry and wild birds in Europe remains important.

Actions

ECDC follows the worldwide A(H5N1) situation through epidemic intelligence activities in order to identify significant changes in the epidemiology of the virus. ECDC re-assesses the potential of a changing risk for A(H5N1) to humans on a regular basis.

ECDC published a rapid risk assessment covering A(H5N1) and other human infections with avian influenza viruses in China on 26 February 2014.

WHO is now reporting H5N1 cases on a monthly basis. ECDC will continue monthly reporting in the CDTR to coincide with WHO reporting.

Outbreak of Enterovirus D68 - Global - 2014

Opening date: 10 September 2014 Latest update: 20 November 2014

Epidemiological summary

Hospitals in Missouri and Illinois were the first to document an increase of severe respiratory illness in children in the USA in mid-August 2014. As of 20 November, the US CDC has reported 1 121 confirmed cases in 47 states and the District of Columbia caused by EV-D68 infection. Almost all confirmed cases have been diagnosed among children, most of them with a medical history of asthma and wheezing. EV-D68 has been detected in specimens from 12 patients who died. On 26 September 2014, the US CDC issued a National Health Advisory with a case definition to investigate the possible linkage of clusters of acute neurologic disease to the EV-D68 outbreak.

The current outbreak in Canada began on 15 September 2014, when Alberta Health Services reported 18 cases of EV-D68 among hospitalised patients under the age of 18 years. As of 4 November 2014, 214 specimens have tested positive for EV-D68. One fatality in a young man with severe asthma was linked to EV-D68. Health authorities in Canada are also investigating possible links to EV-D68 in cases of paralysis in children.

Sporadic cases of EV-D68 have been documented in several EU/EEA countries in recent years.

On 12 November 2014, the media reported in Finland that EV-D68 has been confirmed in five hospitalised children in Turku. There have been ten reported cases in Turku this autumn, but no other cases have been reported in any other part of the country.

On 7 November, Eurosurveillance published an article about one case of acute flaccid paralysis following enterovirus D68 associated pneumonia in France.

On 23 October 2014, an article describing the EV-D68 situation in the Netherlands was published in Eurosurveillance.

According to media on 17 November 2014 two non-paralytic EV-D68 cases in children have been detected in Israel among 280 respiratory patients.

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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, and continous to monitor the evolution of the situation.

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