



COMMUNICABLE DISEASE THREATS REPORT

CDTR Week 13, 26 March-1 April 2017

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary EU Threats

Influenza – Multistate (Europe) – Monitoring 2016/2017 season

Opening date: 13 October 2016 Latest update: 31 March 2017

Influenza transmission in Europe shows a seasonal pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes its weekly report on the <u>Flu News Europe website</u>.

→Update of the week

During week 12/2017, Greece reported medium intensity, and the other 42 countries reported a return to baseline levels.

Multidrug-resistant tuberculosis in migrants – Multistate (Europe) – 2016/2017

Opening date: 18 November 2016

Latest update: 31 March 2017

A cluster of multidrug-resistant tuberculosis (MDR TB) identified through whole genome sequencing (WGS) was notified to ECDC in December 2016, Cases were in asylum seekers, mainly from Somalia, Eritrea and Ethiopia. As of 31 March 2017, 26 cases have been reported from Germany (14), Switzerland (8), Austria (2), Finland (1) and Sweden (1).

→Update of the week

In the past week, Germany reported one additional case belonging to the WGS cluster, and two more cases are under investigation.

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 31 March 2017

A measles outbreak in Romania has been ongoing since February 2016 and cases continue to be reported despite ongoing response measures that have been implemented at national level through reinforced vaccination activities. Between September 2016 to 24 March 2017, Romania reported 3 911 cases.

In 2016, a number of EU/EEA countries reported measles outbreaks, and an increase in the number of cases continues to be observed in 2017. Previous and ongoing measles outbreaks in other EU countries have been epidemiologically linked to the current outbreak in Romania. However, additional knowledge (e.g. genotypic characterisation of the virus) is needed to carry out a successful epidemiological investigation.

→Update of the week

In Europe, measles cases have been reported in Austria, Belgium, Bulgaria, Denmark, France, Germany, Hungary, Italy, Spain and Sweden as well as in Romania, where 3 911 cases have been reported as of 24 March 2017.

Non EU Threats

Increase in travel-associated Legionnaires' disease – Dubai, UAE – 2016/2017

Opening date: 10 November 2016

Latest update: 31 March 2017

The ECDC ELDSNet surveillance scheme on travel-associated Legionnaires' disease (TALD) has observed an increase in the number of Legionnaires' disease cases associated with travel to Dubai, United Arab Emirates (UAE), in the past few months. Since October 2016, ten EU Member States as well as Switzerland have reported 50 confirmed cases with a history of travel to Dubai.

→Update of the week

During the last week, two additional TALD cases were reported by the United Kingdom. The cases are one female, aged 78 years, and one male, aged 53 years. One previously notified case reported by Denmark has now been characterised and reported as *Legionella pneumophila* serogroup 1, sequence type 2382. This is the first time this sequence type, which is closely related to sequence type 616, has been characterised.

Latest update: 31 March 2017

Yellow fever – South America – 2016/2017

Opening date: 16 January 2017

Yellow fever is a mosquito-borne viral infection present in some tropical areas of Africa and South America.

In South America, there are two transmission cycles of yellow fever:

- A sylvatic cycle, involving transmission of the virus between *Haemagogus* or *Sabethes* mosquitoes and primates. The virus is transmitted by mosquitoes from primates to humans when humans are visiting or working in the forest.

- An urban cycle, involving transmission of the virus between *Aedes aegypti* mosquitoes and humans. The virus is usually introduced in an urban area by a viraemic human who was infected in the forest.

Brazil has been experiencing an outbreak of yellow fever since December 2016. The outbreak was notified on 6 January 2017. From the beginning of the year to 29 March 2017, WHO PAHO has reported cases in Brazil, Colombia, Ecuador, Peru, Bolivia and Suriname.

→ Update of the week

Between 16 and 29 March 2017, national public health authorities in Brazil have reported 232 additional cases of yellow fever, 72 of which were confirmed.

On 29 March, the state of Pará reported four confirmed cases of yellow fever, all fatal.

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

Opening date: 24 September 2012 Latest update: 31 March 2017

Since April 2012 and as of 30 March 2017, 1 956 cases of MERS, including 748 deaths, have been reported by health authorities worldwide. The source of the virus remains unknown, but the pattern of transmission and virological studies point towards dromedary camels in the Middle East as 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 update of MERS-CoV on 9 March 2017, Saudi Arabia reported 13 cases of MERS-CoV. In Wadi Aldawasir city in Riyadh Region, ten cases were reported between 5 and 13 March 2017. Of the ten cases, eight were indicated as nosocomial transmission and two as household contacts. Five of the ten cases were asymptomatic. Two of the cases were healthcare workers. The ten cases can be identified as a cluster due to the close time of reporting and geographical proximity. On 21 March, the health authorities in <u>Qatar</u> reported a case. This is the first case in 2017, the last case prior to this one was reported in June 2016.

Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013

Latest update: 31 March 2017

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, and up to 30 March 2017, 1 307 cases have been reported to WHO, including at least 489 deaths. No autochthonous cases have been reported outside China. Most cases are isolated, and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak. Five dreddred and nine cases were reported since week 40/2016, representing a significant increase compared to previous seasons.

→Update of the week

Since the last update, no additional cases have been reported by WHO, however <u>WHO</u> has published additional details regarding the last 84 cases. On 24 March 2017, <u>highly pathogenic H7N9</u> was found in poultry in Hunan, China. This is the second area, besides Guangdong, reporting highly pathogenic A(H7N9) in poultry.

II. Detailed reports

Influenza – Multistate (Europe) – Monitoring 2016/2017 season

Opening date: 13 October 2016

Latest update: 31 March 2017

Epidemiological summary

Week 12/2017 (20-26 March 2017)

During week 12/2017, Greece reported medium intensity, and the other 42 countries reported a return to baseline levels. The percentage of influenza virus detections among sentinel specimens was 18%, which is similar to week 11/2017 (17%).

Season overview

Influenza activity started early this season in week 46/2016, which is the earliest week that the overall influenza-positivity rate in sentinel specimens reached 10% since the emergence of A(H1N1)pdm09 viruses in 2009/2010. Since week 40/2016, influenza A viruses have predominated, accounting for 94% of all sentinel detections. The great majority (99%) of subtyped influenza A viruses from sentinel sites being A(H3N2). Confirmed cases of influenza virus type A infection reported from hospitals have predominantly been in adults aged over 65 years. Excess all-cause mortality has been observed substantially in people aged 15–64 years and markedly in people aged 65 years or older in the majority of the 19 reporting countries. This is commonly seen when the predominant viruses circulating are A(H3N2). Two-thirds of the A(H3N2) viruses genetically characterised belong to a recently emerged genetic subclade (3C.2a1). However, viruses that were antigenically characterised are largely similar to the clade 3C.2a vaccine virus. Recent vaccine effectiveness estimates for all age groups against A(H3N2) illness from <u>Canada</u> (42%), the <u>US</u> (43%) and <u>Europe</u> (38%) are consistent with estimates from <u>Stockholm</u> county (28%) and <u>Finland</u> (32%) earlier in the season. Given typically suboptimal vaccination coverage and the partial effectiveness of influenza vaccines, rapid use of neuraminidase inhibitors (NAIs) for laboratory-confirmed or probable cases of influenza infection should be considered for vaccinated and non-vaccinated patients at risk of developing complications. Only one A(H3N2) virus (<1%) has shown reduced susceptibility to oseltamivir this season.

ECDC assessment

Influenza activity started early this season in week 46/2016, which is the earliest week that the overall influenza-positivity rate in sentinel specimens reached 10% since the emergence of A(H1N1)pdm09 viruses in 2009/10. The progression of the season confirms the conclusions of ECDC's <u>risk assessment</u> published on 25 January 2017.

Actions

ECDC monitors influenza activity in Europe during the winter season and publishes its weekly report on the <u>Flu News Europe</u> website. Risk assessments for the season are available on <u>ECDC</u> website and on <u>WHO Regional Office for Europe</u> website.

Multidrug-resistant tuberculosis in migrants – Multistate (Europe) – 2016/2017

Opening date: 18 November 2016

Latest update: 31 March 2017

Epidemiological summary

A cluster of multidrug-resistant tuberculosis (MDR TB) was notified to ECDC in December 2016, affecting asylum seekers from Somalia, Eritrea and Ethiopia. As of 31 March, 26 cases are part of this WGS cluster; cases have been reported from Germany (14), Switzerland (8), Austria (2), Finland (1) and Sweden (1). Cases are clustered within one SNP (single-nucleotide polymorphism) difference. France has two cases under investigation, with WGS pending. A preliminary analysis of the interviews with cases in Switzerland shows that most cases reported symptoms at arrival or before, suggesting that transmission did not likely occur in Switzerland. Six of the refugees had a long stay in Bani Waleed (Libya) where the conditions seem to be favourable for TB transmission. Bulgaria, Croatia, Cyprus, Denmark, Estonia, Hungary, Greece, Italy, Latvia, Luxembourg, Malta, Poland, Portugal and Romania have not reported cases with corresponding MIRU-VNTR 24 loci and/or a DST profile belonging to this cluster.

ECDC assessment

According to the latest <u>WHO TB Report</u>, the incidence of TB in Somalia was around 274 cases per 100 000 population in 2015. MDR TB was found in 8.7% of new TB cases, and in 47.0% of previously treated TB cases in Somalia. According to the International Organization of Migration (IOM), 2.1% of the refugees in Europe (i.e. about 10 000 people) are from Somalia.

Multi-country outbreak investigations coordinated by ECDC are focusing on identifying exposure risk factors including the travel itinerary and history of possible contacts among patients in this single-strain outbreak of MDR TB. Although the limited number of cases detected so far suggests a restricted event, more cases may be expected in association with this cluster. Sharing WGS-based typing information between affected countries on outbreak-related cases is important to delineate the extent of the outbreak.

The rate of TB in a foreign-born population does not have a significant impact on TB in the native population in the EU/EEA. Therefore, while there remains a risk of additional cases being detected among refugees, the risk of transmission to EU/EEA resident populations is very low.

Actions

ECDC is coordinating the international investigations. The Centre focuses on identifying exposure risk factors, which includes the analysis of travel itineraries and the results of contact tracing. A teleconference on this issue was held on 29 March 2017. ECDC published an <u>updated rapid risk assessment</u> on its website on 27 March 2017.

Measles – Multistate (EU) – Monitoring European outbreaks

Opening date: 9 February 2011

Latest update: 31 March 2017

Epidemiological summary

EU/EEA Member States report measles data to ECDC on a monthly basis. Between 1 March 2016 and 28 February 2017, 30 EU/EEA Member States reported 5 881 cases of measles to ECDC. The highest number of cases was reported by Romania (2 703) and Italy (1 387). Ten Member States reported zero cases, although Hungary did not report data for February 2017. Of all cases with known age, 41% were children below five years of age; 38% were aged 15 years or over. The highest incidence was reported in children below one year of age (128.2 per million) and children from 1 to 4 years of age (83.7 per million). Of all cases with known vaccination status, 88% were unvaccinated.

<u>Austria</u>

Since the beginning of 2017 and as of 20 March, Austria has reported 67 cases of measles, which exceeds the total number of cases reported in 2016.

<u>Belgium</u>

Since 20 December 2016, the region of Wallonia in Belgium has been affected by an outbreak of measles. Since mid-February 2017, the number of weekly notifications has been increasing, with an average of 36 new measles cases per week since week 8/2017. As of 12 March 2017, authorities reported 177 measles cases, including 96 confirmed cases. The outbreak affects the provinces of Hainaut, Liège, Namur and Walloon Brabant. All age groups are affected, and 50% of the cases are between 15 and 45 years of age. Eighteen cases are healthcare workers. Most of the cases were not vaccinated or did not know their vaccination status. Seventy-six cases (43%) were hospitalised. No deaths have been reported. The same genotype, B3, similar to the strain found in Romania, Italy and Austria at the end of 2016, has been identified. The index case of the epidemic travelled to Romania during incubation period. In Flanders, one isolated imported case was reported in January and another one in March, with possible links to a cluster in Wallonia. In the Brussels Capital Region, one isolated imported case was reported cases had a travel history to Romania during incubation period, and the national reference centre for measles, mumps and rubella (WIV-ISP) identified genotype B3 (same strain as mentioned above).

<u>Bulgaria</u>

Since mid-March 2017 and as of 23 March 2017, Bulgaria reported eight cases of measles in the city of Plovdiv. Of the five confirmed cases, two are women in their early twenties and three are children.

<u>Denmark</u>

On 15 March 2017, Denmark reported an imported case of measles in an unvaccinated adult who was infected during holidays in Asia.

<u>France</u>

Since the beginning of 2017, measles cases have been detected in several departments in France. From January 2017 to 28

February 2017, 79 cases were reported in <u>France</u>, mainly related to an outbreak in Lorraine where more than 50 cases were reported until end of February. Two cases of encephalitis and seven with severe pneumonia have been reported since the beginning of the year. The circulation of the virus remains active in several departments. Moselle and Meurthe-et-Moselle are currently the most affected areas, with 61 cases as of 13 March 2017.

<u>Germany</u>

According to the national public health institute, since the beginning of 2017 and by the end of February 2017, 235 cases have been reported in Germany, compared with 12 cases in the same period in 2016.

<u>Hungary</u>

Between 21 February 2017 and 8 March 2017, 13 cases of measles have been reported among <u>healthcare workers</u>. According to <u>media</u> reports, 41 cases compatible with measles were detected as per 13 March.

<u>Italy</u>

Since the beginning of 2017 and as of 26 March 2017, Italy reported 1 010 cases of measles, with 113 cases among healthcare workers. Nineteen of the 21 regions in Italy report cases. The majority of cases (86%) are from Piedmont, Lombardy, Lazio, Tuscany and Abruzzo. The majority of cases are above the age of 15 years, and 90% of the cases were not vaccinated. At least one complication was reported; 41% of the cases were hospitalised.

<u>Romania</u>

Between 1 January 2016 and 24 March 2017, Romania reported 3 911 cases of measles, including 17 deaths. Cases are either laboratory confirmed or have an epidemiological link to a laboratory-confirmed case. Infants and young children are the most affected population. Thirty-seven of the 42 districts are reporting cases, with Caras Severin being the most affected district with 853 cases. Vaccination activities are ongoing in order to cover communities with suboptimal vaccination coverage. On 28 March 2017, WHO posted a <u>press release</u> on the measles outbreaks across Europe. According to reported data, the three measles genotypes circulating in Romania since January 2016 have never been recorded in the country before, instead they have been reported in other locations in 2015, including several other European countries. Comprehensive laboratory and epidemiological data are needed before the origin of infection and the routes of transmission can be determined.

<u>Spain</u>

An outbreak started in the first week of January due to an imported measles case from China. As of 10 March, Barcelona and its metropolitan area reported 35 confirmed cases of measles. The cases are mostly adults who were either incompletely vaccinated or unvaccinated. Two of the cases are children, and six cases were hospitalised. A case of measles was identified on the Canary Islands, the first case after three years of eradication.

<u>Sweden</u>

Since the beginning of 2017 and as of 21 March 2017, Sweden reported 15 cases of measles, including three imported cases.

Switzerland

Since the beginning of 2017 and as of 21 March 2017, Switzerland has reported 52 cases of measles. In February 2017, a vaccinated man died of measles in Switzerland. He was undergoing strong immunosupressive treatment for leukaemia, which explains why the measles vaccination did not protect him. This is the first measles death in Switzerland since 2009.

ECDC assessment

Measles outbreaks continue to occur in EU/EEA countries, and there is the risk of spread and sustained transmission in areas with susceptible populations. The national vaccination coverage remains less than 95% for the second dose of MMR in the majority of EU/EEA countries. The progress towards elimination of measles in the European Region of WHO is assessed by The European Regional Verification Commission for Measles and Rubella Elimination (RVC). Member States of the WHO European Region are making steady progress towards the elimination of measles. At the fifth meeting of the RVC for Measles and Rubella in October 2016, of 53 countries in the WHO European Region, 24 (15 of which are in EU/EEA) were declared to have reached the elimination goal for measles, and an additional 13 countries (nine in the EU/EEA) were concluded to have interrupted endemic transmission for between 12 and 36 months, meaning they are on their way to achieving the elimination goal. However, six EU/EEA countries were judged to still have endemic transmission of measles: Belgium, France, Germany, Italy, Poland and Romania.

Source: WHO - Europe

Actions

ECDC has prepared a <u>Rapid Risk Assessment</u> published on 6 March 2017. ECDC monitors measles transmission and outbreaks in the EU/EEA on weekly basis through enhanced surveillance and epidemic intelligence activities.



New measles cases per week of reporting, week 2016-39 to 2017-12, Romania





Increase in travel-associated Legionnaires' disease – Dubai, UAE – 2016/2017

Opening date: 10 November 2016

Latest update: 31 March 2017

Epidemiological summary

As of 30 March 2017, eleven countries have reported 50 TALD cases with illness onset between October 2016 and March 2017: the UK (24), Sweden (6), the Netherlands (5), Denmark (4), France (3), Germany (3), Austria (1), Belgium (1), Hungary (1), Spain (1) and Switzerland (1). One of the 50 cases died. The most recent illness onset was on 15 March 2017. Three cases with complete laboratory investigation are characterised as Legionella *pneumophila* serogroup 1, sequence type 616, which is not common in Europe but has been identified before in returning travellers from Dubai.

ECDC assessment

Cases continue to be reported with onset of symptoms in recent weeks, indicating that there is a persistent source of *Legionella* exposure common to travellers with a history of travel to Dubai. However, it cannot be ruled out that some of these travellers may have acquired their infection elsewhere if their travel stay in Dubai was shorter than the range of the incubation period. The increase in cases observed between October 2016 and March 2017 is above that observed in previous years.

Actions

ECDC monitors this event through ELDSNet. ECDC is collating supplementary case questionnaires and is in contact with EU Member States, the ELDSNet network, WHO and UAE for information sharing. ECDC posted an <u>epi-update</u> on 9 March 2017. ECDC published a <u>rapid risk assessment</u> on 23 December 2016 and shared an updated rapid risk assessment with the European Commission and EU Member States on 13 January 2017. The conclusions of the RRA remain valid.

Distribution of travel-associated Legionnaires' disease cases with history of stay in Dubai, United Arab Emirates, by week of onset from 37-2016 and 11-2017, as reported to ELDSNet by 30 March 2017 (n=50 cases)



Yellow fever – South America – 2016/2017

Opening date: 16 January 2017

Latest update: 31 March 2017

Epidemiological summary

Two transmission cycles of yellow fever are taking place in South America:

- A sylvatic cycle, involving transmission of the virus between *Haemagogus* or *Sabethes* mosquitoes and primates. The virus is transmitted by mosquitoes from primates to humans when humans are visiting or working in the forest.

- An urban cycle, involving transmission of the virus between *Aedes aegypti* mosquitoes and humans. The virus is usually introduced in an urban area by a viraemic human who was infected in the forest.

Brazil:

Between 6 January and 29 March 2017, Brazil has reported 1 589 cases (1 093 suspected and 496 confirmed).

States reporting suspected and confirmed autochthonous cases:

- Minas Gerais has reported 1203 cases (828 suspected and 375 confirmed)
- Espírito Santo has reported 249 cases (140 suspected and 109 confirmed)
- São Paulo has reported 49 cases (44 suspected and five confirmed)
- Rio de Janeiro has reported 23 cases (20 suspected and three confirmed)
- <u>Pará</u> has reported four confirmed cases, all fatal

The following eleven states have reported suspected cases: Maranhão (12), Bahia (11), Goiás (10), Paraná (9), Santa Catarina (6), Tocantins (5), Rio Grande do Sul (4), Amapá (1), Ceará (1), Distrito Federal (1), Mato Grosso (1).

In addition, investigations are ongoing to determine the probable infection site of four further suspected cases.

Other countries in South America:

From week 1 to 13 of 2017, five other countries reported suspected and/or confirmed cases of yellow fever: Bolivia (1), Colombia (1), Ecuador (1), Peru (8) and Suriname (1).

Sources: Brazil MoH | PAHO | WHO vaccination recommendations

ECDC assessment

The ongoing outbreak should be carefully monitored, as the establishment of an urban cycle of yellow fever would have the potential to quickly affect a large number of people. EU/EEA citizens who travel to, or live in, areas where there is evidence of yellow fever virus transmission should check their vaccination status and obtain medical advice about being vaccinated against yellow fever. In Europe, *Aedes aegypti*, the primary vector of yellow fever virus. However, is present in Madeira. Recent studies have shown that *Aedes albopictus* can potentially transmit the yellow fever virus. However, the risk of the virus being introduced into local competent vector populations in the EU through viraemic travellers from Brazil is considered to be very low, as the current weather conditions in Europe are not favourable for vector activity.

Actions

ECDC closely monitors this event in collaboration with the World Health Organization. ECDC published a <u>rapid risk assessment on</u> the outbreak of yellow fever in Brazil on 26 January 2017 and a <u>rapid risk assessment on yellow fever among travellers returning</u> from South America on 15 March 2017. ECDC is also producing a <u>map for travel advice</u>.

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

Opening date: 24 September 2012

Latest update: 31 March 2017

Epidemiological summary

Since April 2012 and as of 30 March 2017, 1 956 cases of MERS, including 748 deaths, have been reported by health authorities worldwide.

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 risk of sustained human-to-human transmission in Europe remains very low. The ECDC's conclusion continues to be that the MERS-CoV outbreak poses a low risk to the EU, as stated in a <u>rapid risk assessment</u> published on 21 October 2015, which

9/14

provides details on the last case reported in Europe.

Actions

ECDC published the 21st update of its MERS-CoV rapid risk assessment on 21 October 2015.

Distribution of confirmed cases of MERS-CoV by first available month and place of infection, March 2012 to March 2017



* If month of onset is not available month of reporting has been used

Distribution of confirmed cases of MERS-CoV by reporting country and place of probable infection, March 2012 - 30 March 2017



Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013

Latest update: 31 March 2017

Epidemiological summary

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, and up to 30 March 2017, 1 307 cases have been reported to WHO, including at least 489 deaths. The A(H7N9) outbreak shows a seasonal pattern. The first wave in spring 2013 (weeks 7/2013–40/2013) included 135 cases; 320 cases were reported during the second wave (weeks 41/2013–40/2014), 224 cases were reported during the third wave (weeks 41/2014–40/2015), and 119 were reported in wave four (weeks 41/2015–40/2016). A fifth wave started in October 2016 (week 41/2016), with 509 cases as of 30 March 2017.

The 1 307 cases were reported from Zhejiang (299), Guangdong (253), Jiangsu (238), Fujian (100), Anhui (92), Hunan (66), Shanghai (56), Jiangxi (47), Hubei (26), Hong Kong (21), Henan (15), Guangxi (14), Shandong (14), Beijing (11), Sichuan (11), Guizhou (10), Xinjiang (10), Taiwan (5), Hebei (4), Liaoning (3), Jilin (2), Macau (2), Tianjin (2), Yunnan (2) and Chongqing (1). Three imported cases were reported: one in Malaysia and two in Canada.

Web sources: Chinese CDC | WHO |WHO FAQ page | ECDC | Hong Kong CHP

ECDC assessment

This is the fifth winter season in the northern hemisphere with human cases caused by A(H7N9) infections. During this wave, the number of human cases has been higher than in previous waves. This is most likely due to greater environmental contamination in live bird markets and increased circulation of the virus among poultry.

In February 2017, a new A(H7N9) virus with mutations in the haemagglutinin gene – indicating high pathogenicity in poultry – was detected in three cases related to Guangdong, as well as in environmental and poultry samples. It is unclear at the moment if the newly emerged, highly pathogenic avian influenza (HPAI) virus A(H7N9) will replace the low-pathogenic virus or if both will co-circulate in the bird population. Although the genetic changes in A(H7N9) may have implications for poultry in terms of pathogenicity, surveillance and control strategies, there is no evidence to date of increased transmissibility to humans or sustainable human-to-human transmission.

The continued transmission of A(H7N9) to humans in China poses the risk that sporadic imported cases may be detected in Europe. The following options for prevention and control of the infection should be considered: -people travelling to China should avoid direct exposure to poultry and refrain from visiting live poultry markets or backyard farms;

-travellers who have visited affected areas and develop respiratory symptoms and fever upon their return should consult a physician and mention their recent travel history to enable early diagnosis and treatment.

In addition, travellers who have visited affected areas should avoid entering farms for the entire duration of the 10-day incubation period (and during the symptomatic period in the event that they develop symptoms) in order to prevent a possible virus introduction to poultry in the EU. The possibility of humans infected with A(H7N9) returning to the EU/EEA cannot be excluded. However, the risk of the disease spreading within Europe via humans is still considered low, as there is no evidence of a sustained human-to-human transmission.

Actions

ECDC published a sixth update of the <u>Rapid Risk Assessment</u> on 9 March 2017, addressing the genetic evolution of influenza A (H7N9) virus in China and the implications for public health.



Distribution of confirmed cases of A(H7N9) by five periods (weeks 7-2013 to 11-2017)

Distribution of confirmed cases of A(H7N9) by first available month, February 2013 to 30 March 2017

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