



## COMMUNICABLE DISEASE THREATS REPORT

# CDTR

## Week 24, 7-13 June 2015

### All users

This weekly bulletin provides updates on threats monitored by ECDC.

## I. Executive summary

### EU Threats

#### Toxigenic diphtheria, Spain - May 2015

Opening date: 4 June 2015

Latest update: 12 June 2015

On 31 May, Spain issued an Early Warning and Response System (EWRS) message about a toxigenic diphtheria case in an unvaccinated 6-year-old child. Spain reported that they were in urgent need of diphtheria antitoxin (DAT) to treat the patient and made a call to EU Member States for support with securing DAT. Ireland, Sweden, France, Germany offered Spain DAT but at the same time reported that their stocks of DAT had passed the expiry date.

→Update of the week

On 31 May 2015, Spain reported a case of toxigenic diphtheria in a 6-year-old unvaccinated. After the contact tracing, [media](#) reported that eight additional children tested positive to the diphtheria bacteria after coming into contact with the index case. All eight children have been vaccinated, so they have not developed the illness but are considered carriers.

#### West Nile virus - Multistate (Europe) - Monitoring season 2015

Opening date: 2 June 2015

Latest update: 11 June 2015

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

No human cases of West Nile fever were detected in EU Member States or neighbouring countries this week.

### Non EU Threats

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

Opening date: 24 September 2012

Latest update: 12 June 2015

Since April 2012 and as of 12 June 2015, 1 307 cases of MERS-CoV have been reported by local health authorities worldwide, including 500 deaths. South Korea reported 125 cases occurring in the country in relation with further nosocomial transmissions from a symptomatic case returning from the Arabian Peninsula. The source of the virus remains unknown but the pattern of transmission and virological studies point 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

1/16

Since the last update on 5 June, [South Korea](#) has reported 85 additional cases including six deaths. All cases are linked to the same transmission chain originating from a case imported from the Middle East. One of the cases reported by South Korea travelled to China where they were diagnosed and hospitalised. ECDC prepared a Rapid Risk Assessment with additional information.

Since the last update on 5 June, [Saudi Arabia](#) has reported ten additional cases of MERS-CoV infection and two additional deaths.

On 9 June 2015 [WHO](#) was notified of an additional case in the United Arab Emirates.

## **Ebola Virus Disease Epidemic - West Africa - 2014 - 2015**

Opening date: 22 March 2014

Latest update: 11 June 2015

An epidemic of Ebola virus disease (EVD) has been ongoing in West Africa since December 2013, mainly affecting Guinea, Liberia and Sierra Leone. On 8 August 2014, WHO declared the Ebola epidemic in West Africa a Public Health Emergency of International Concern (PHEIC). On 9 May, Liberia was declared free of Ebola virus disease. Transmission is still on-going in Sierra Leone and Guinea.

→Update of the week

On 11 June 2015, [WHO](#) reported 27 287 cases of Ebola virus disease related to the outbreak in West Africa, including 11 178 deaths.

According to WHO, the continued shrinking of the geographic area affected by Ebola and the decline in case incidence has stalled. From 1 June up to 7 June, WHO reported 31 new confirmed cases: 16 in Guinea and 15 in Sierra Leone. This is the second consecutive weekly increase in case incidence and the highest weekly total number of cases reported from Sierra Leone since late March. Cases have been reported from a widening geographical area in Guinea and Sierra Leone, and the continued occurrence of cases that arise from unknown sources of infection highlights the challenges still faced in finding and eliminating every chain of transmission.

WHO reported that efforts are ongoing to increase the ability of contact tracing and case-investigation teams to engage effectively with affected communities in Guinea and Sierra Leone. In Guinea, WHO reported 19 unsafe burials during the week up to 7 June. Although no unsafe burials have been reported for many weeks in Sierra Leone, investigations into recent cases in Kambia have found clear evidence that they are still taking place in some areas. Improved communication with local communities is essential to understand and address any concerns that prevent cases and deaths from being reported, and chains of transmission from being detected.

## **Poliomyelitis - Multistate (world) - Monitoring global outbreaks**

Opening date: 8 September 2005

Latest update: 12 June 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until all transmission of the virus stopped and the world becomes 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 6 May 2015, the Temporary Recommendations in relation to PHEIC were extended for another three months.

→Update of the week

In the past week, one new case of poliovirus type 1 (WPV1) was reported in Afghanistan.

## **Influenza A(H5N1) and other strains of avian flu - Multistate (world) - Monitoring globally**

Opening date: 15 June 2005

Latest update: 12 June 2015

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 last week, there has been no new update from WHO.

## Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 14 May 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 657 cases have been reported, including 227 deaths. No autochthonous cases have been reported from outside of China. Most cases have been unlinked, and sporadic zoonotic transmission from poultry to humans is the most likely explanation for the outbreak.

→ Update of the week

Since the last update, WHO did not report any new influenza A(H7N9) virus cases.

## II. Detailed reports

### Toxigenic diphtheria, Spain - May 2015

Opening date: 4 June 2015

Latest update: 12 June 2015

#### Epidemiological summary

On 31 May, Spain issued an EWRS message about a toxigenic diphtheria case in a 6-year-old unvaccinated who first developed symptoms on 25 May 2015. He was hospitalised on 27 May and was found on admission to have fever, general malaise, headache, odynophagia, and pseudo-membranes covering the tonsils. His condition deteriorated and on 30 May a sample from the boy received at the National Centre for Microbiology tested positive for toxigenic diphtheria with PCR. Samples were sent to the WHO collaborating laboratory in UK to perform the confirmatory Elek's test. The child was transferred to a reference hospital in Barcelona on 30 May where he remains in a serious condition. He is being treated with antibiotics and has received DAT that was sourced from outside of the EU. Before developing symptoms the child attended a school camp. Local and regional public health agencies are following between 100 and 150 people who have been in contact with the child, mainly family, classmates and healthcare workers who attended the sick child. All contacts are being vaccinated and throat swabs are being taken from close contacts. Vaccinations against diphtheria are given at two, four and six months in Spain, with booster doses at 15 – 18 months and 13 – 14 years of age. The last indigenous case of diphtheria in Spain was notified in 1986. The case has been posted in the Epidemic Intelligence Information System - Vaccine-preventable Diseases (EPIS-VPD).

#### ECDC assessment

This health threat has highlighted a number of risks associated with diphtheria in Europe: there are children who are unvaccinated against diphtheria, the rarity of cases can delay clinical recognition of the disease, limitations in diagnostic capacities can delay laboratory confirmation, and limited access to DAT can delay treatment. All these factors play important roles for timely detection and management of cases of diphtheria.

#### Actions

ECDC is preparing a Rapid Risk Assessment.

### West Nile virus - Multistate (Europe) - Monitoring season 2015

Opening date: 2 June 2015

Latest update: 11 June 2015

#### Epidemiological summary

As of 11 June 2015, no human cases of West Nile fever have been reported in the EU or neighbouring countries since the beginning of the 2015 transmission season.

In Italy, on 8 June the [National Reference Centre for Foreign Animal Diseases](#) reported the detection of West Nile virus in a sedentary bird species captured in the Lombardy region.

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

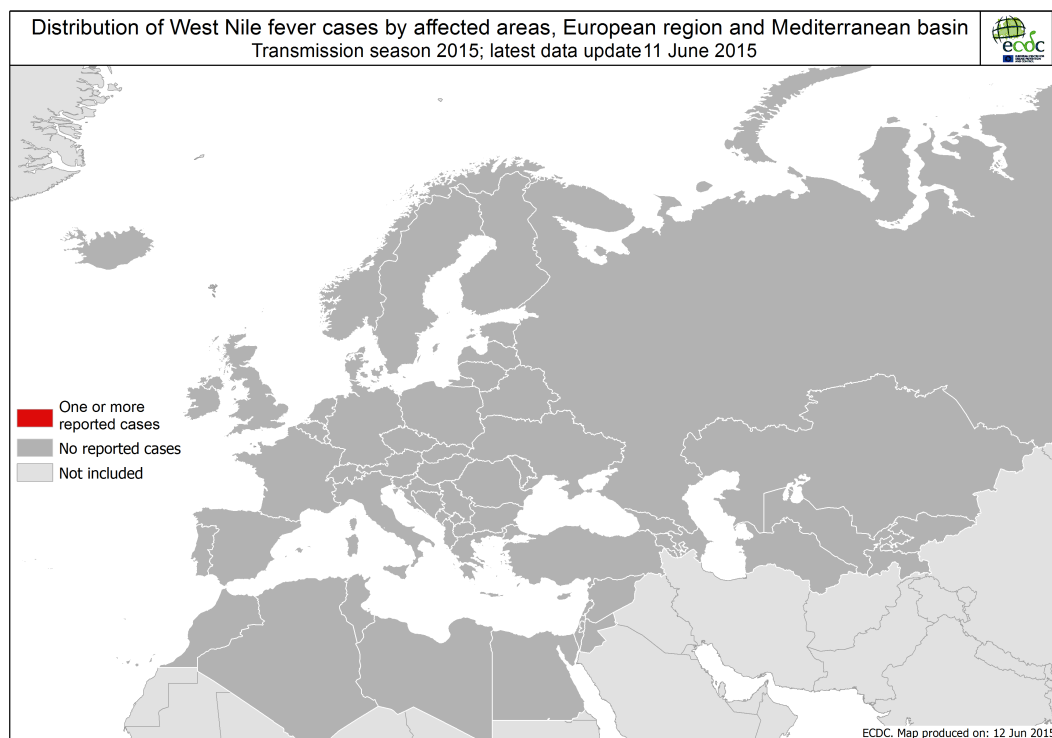
#### ECDC assessment

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

#### Actions

From week 23 onwards, ECDC will produce weekly West Nile fever (WNF) risk maps during the transmission season (June-November) to inform blood safety authorities regarding WNF affected areas.

Source: ECDC



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

Opening date: 24 September 2012

Latest update: 12 June 2015

### Epidemiological summary

Since April 2012 and as of 11 June 2015, 1 307 cases of MERS-CoV have been reported by local health authorities worldwide, including 500 deaths.

The distribution is as follows:

Confirmed cases and deaths by region:

#### Middle East

Saudi Arabia: 1 029 cases/452 deaths

United Arab Emirates: 77 cases/10 deaths

Qatar: 13 cases/5 deaths

Jordan: 19 cases/6 deaths

Oman: 6 cases/3 deaths

Kuwait: 3 cases/1 death

Egypt: 1 case/0 deaths

Yemen: 1 case/1 death

Lebanon: 1 case/0 deaths

Iran: 6 cases/2 deaths

#### Europe

Turkey: 1 case/1 death

UK: 4 cases/3 deaths

Germany: 3 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: 2 cases/0 deaths  
South Korea: 125 cases/10 deaths  
China: 1 cases/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**

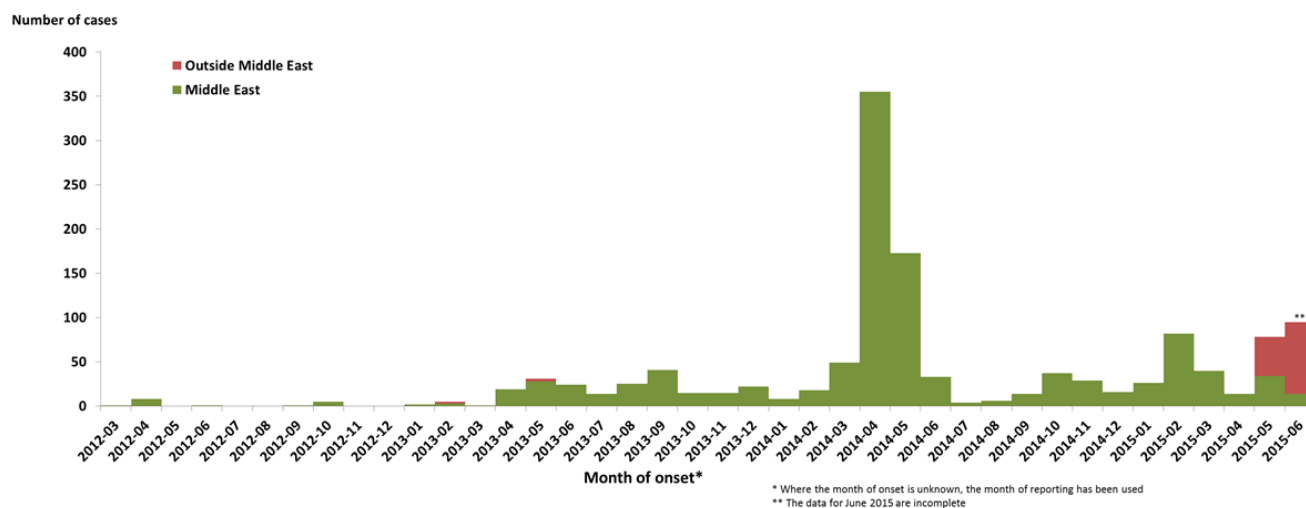
ECDC's assessment continues to be that the MERS-CoV outbreak poses a low risk to the EU. Because of the continued risk of case importation to Europe after exposure in the Middle East and South Korea, international surveillance for MERS-CoV cases among travellers remains essential. Moreover, rapid efforts to contain the nosocomial clusters in the affected countries are vital to prevent broader transmission. Although sustained human-to-human community transmission is unlikely, secondary transmission to unprotected close contacts, especially in healthcare settings, remains possible, as now documented in South Korea. Many of the cases detected in the Middle East continue to be caused by nosocomial exposure.

### **Actions**

ECDC published a [rapid risk assessment](#) on 11 June 2015.

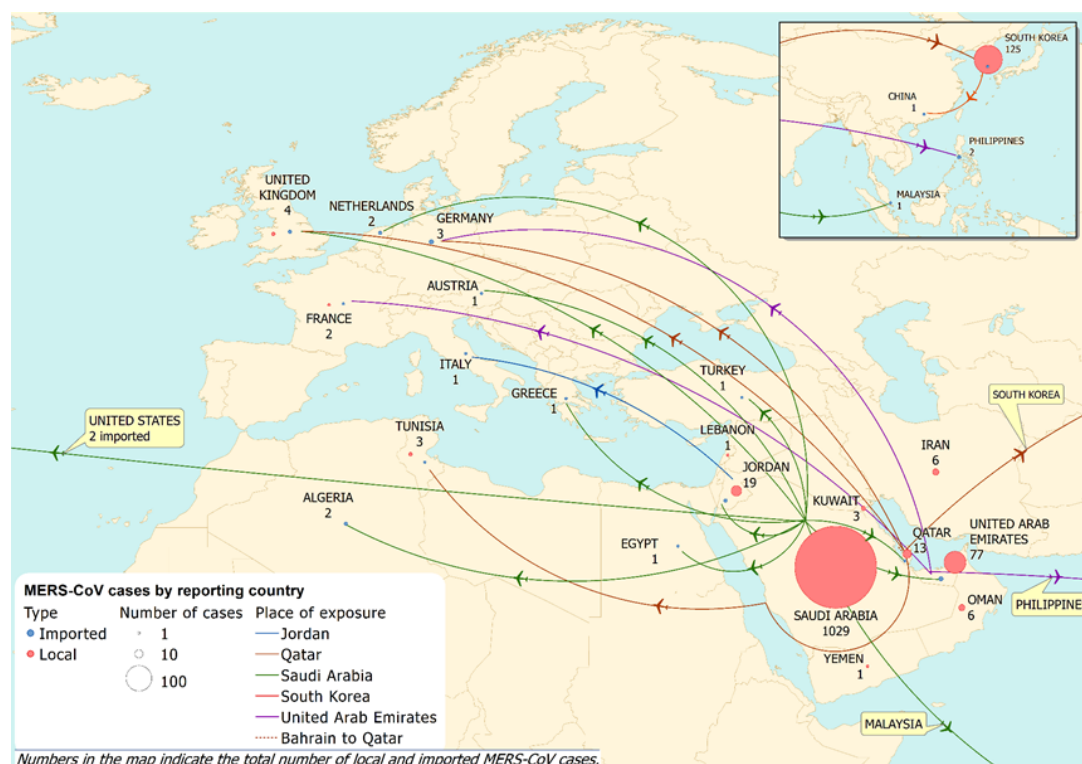
## Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 11 June 2015 (n=1 307)

ECDC



## Distribution of confirmed cases of MERS-CoV by probable place of infection, March 2012 – 11 June 2015

ECDC



## Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

7/16



Opening date: 22 March 2014

Latest update: 11 June 2015

## Epidemiological summary

Distribution of cases as of 9 June 2015:

Countries with intense transmission

• **Guinea:** 3 674 cases of which 3 243 are confirmed and 2 440 deaths.

• **Sierra Leone:** 12 911 cases of which 8 638 are confirmed and 3 917 deaths.

Countries with previously widespread and intense transmission:

• Liberia: declared Ebola-free on 9 May 2015

Countries that have reported an initial case or localised transmission:

• Nigeria, Senegal, the USA, Spain, Mali, the UK and Italy (one confirmed case declared Ebola free on 10 June 2015).

### Situation in West African countries

In **Guinea**, WHO reported 16 new confirmed cases in the week up to 7 June, compared with 13 cases during the previous week. Cases have been reported in Forecariah (eight), Kindia (three), Conakry (two), Dubreka (two) and Boke (one). Conakry and Kindia had previously not reported a case for over 40 days.

The case in Boke was a registered contact of a previous case in the sub-prefecture of Kamsar, site of a localised cluster of cases for the past month. However, according to WHO, the contact was lost to follow-up during a period of civil unrest in the area, and was re-identified post mortem as a community death. An intensive search for the many high-risk contacts thought to be associated with this case is underway.

Five of the 16 cases reported from WHO arose from unknown sources of infection (including all three cases reported from Kindia). Investigations are ongoing to trace the origin of those cases. In addition, three cases, including one of those from Kindia, were identified after post-mortem testing of community deaths.

In **Sierra Leone**, WHO reported 15 new confirmed cases in the week up to 7 June, compared with 12 cases during the previous week. Cases have been reported from Port Loko (10) and Kambia (five).

According to WHO the Western Urban Area of Sierra Leone, which includes the capital Freetown, reported no cases for the first time since August 2014. However, there were still 195 contacts under follow-up in the district as at 7 June.

Situation among healthcare workers

According to WHO, the last healthcare worker infected in Guinea was reported on 6 April, and 14 May in Sierra Leone. Overall, 869 cases and 507 deaths have been recorded among healthcare workers in Guinea (187 cases and 94 deaths), Sierra Leone (304 cases and 221 deaths) and Liberia (378 cases and 192 deaths).

Outside of the three most affected countries, 2 Ebola-infected healthcare workers were reported in Mali, 11 in Nigeria, 1 in Spain (infected while caring for an evacuated EVD patient), 2 in the UK (both infected in Sierra Leone), 6 in the USA (2 infected in Sierra Leone, 2 in Liberia, and 2 infected while caring for a confirmed case in Texas) and 1 in Italy (infected in Sierra Leone).

### Medical evacuations and repatriations from EVD-affected countries

Since the beginning of the epidemic and as of 12 June 2015, 65 individuals have been evacuated or repatriated worldwide from the EVD-affected countries. Of these, 38 individuals have been evacuated or repatriated to Europe. Thirteen were medical evacuations of confirmed EVD-infected patients to: Germany (3), Spain (2), France (2), UK (2), Norway (1), Italy (1), Netherlands (1) and Switzerland (1). Twenty-five asymptomatic persons have been repatriated to Europe as a result of exposure to Ebola in West Africa: UK (13), Denmark (4), Sweden (3), Netherlands (2), Germany (1), Spain (1) and Switzerland (1).

Twenty-seven persons have been evacuated to the United States.

No new medical evacuations have taken place since 18 March 2015.

### Other news

**Italy:** On 12 May 2015, the [health authorities](#) in Italy reported an EVD case in a volunteer healthcare worker who returned to Italy from Sierra Leone on 7 May. The patient developed symptoms on 10 May and was hospitalised the day after. After he was confirmed with EVD on 12 May, he was securely transferred to the National Institute for Infectious Diseases in Rome.

The [Spallanzani hospital](#) in Rome discharged the nurse on 10 June after he tested negative for Ebola. All contacts associated with



the case have now completed the 21-day follow-up period.

### Images

- Epicurve 1: the epicurve shows the confirmed cases in the three most affected countries.
- Epicurve 2: the epicurve shows the confirmed cases in Guinea and Sierra Leone.
- Map: this map is based on country situation reports and shows only confirmed cases of EVD in the past six weeks.

**Web sources:** [ECDC Ebola page](#) | [ECDC Ebola and Marburg fact sheet](#) | [WHO situation summary](#) | [WHO Roadmap](#) | [WHO Ebola Factsheet](#) | [CDC](#) | [Medical bulletins from Lazzaro Spallanzani hospital](#) | [Italian health ministry](#)

### ECDC assessment

This is the largest ever documented epidemic of EVD, both in terms of numbers and geographical spread. The 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 importing EVD into the EU and the risk of transmission within the EU following an importation remain low or very low as a result of the range of risk reduction measures that have been put in place by the Member States and by the affected countries in West Africa. However, continued vigilance is essential. 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.

According to WHO, decline in case incidence and the contraction of the geographic area affected by Ebola has stalled during the last weeks. Both in Guinea and Sierra Leone new confirmed cases are still identified among unregistered contacts and people continue to be diagnosed with Ebola post mortem. These patterns indicate that the disease is circulating in unrecognised chains of transmission. In order to achieve zero cases, there is a need for stronger community engagement, improved contact tracing and earlier case identification.

### Actions

As of 12 June 2015, ECDC has deployed 74 experts from within and outside the EU in response to the Ebola outbreak. This includes an ECDC-mobilised contingent of experts to Guinea. Furthermore, additional experts are already confirmed for deployment to Guinea over the next few months.

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. For further information, please contact Alice Friaux at [alice.friaux@ecdc.europa.eu](mailto:alice.friaux@ecdc.europa.eu) with copy to [support@ecdc.europa.eu](mailto:support@ecdc.europa.eu).

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

The latest (11th) update of the [rapid risk assessment](#) was published on 11 May 2015.

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 and 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](#).

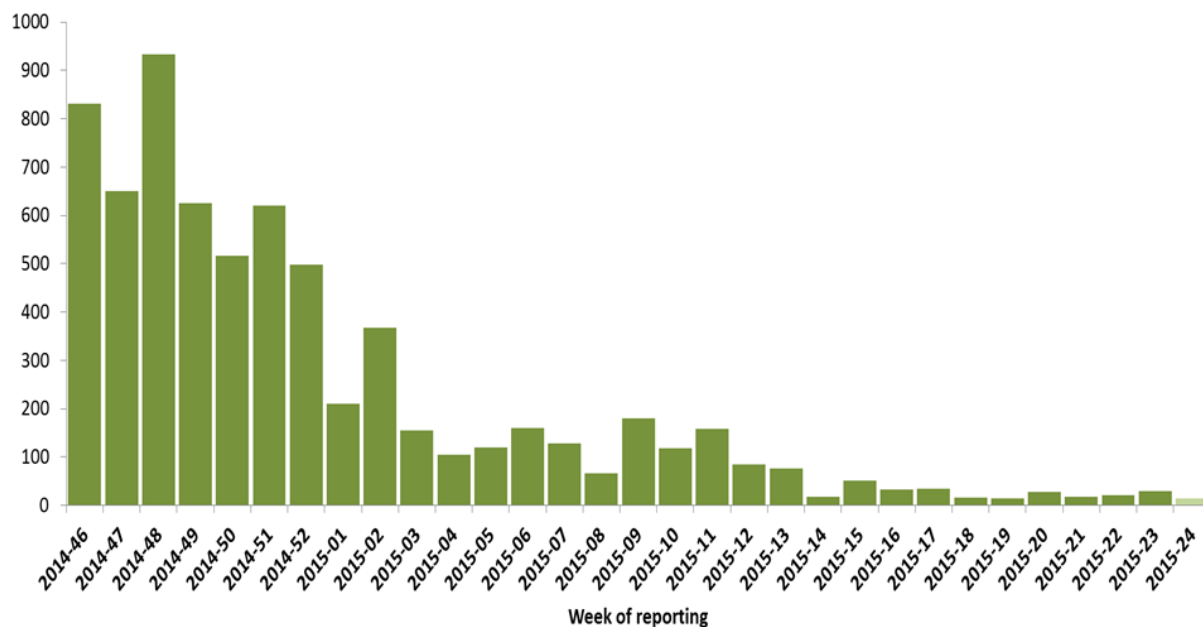
On 6 October 2014, ECDC published [risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU](#).

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](#).

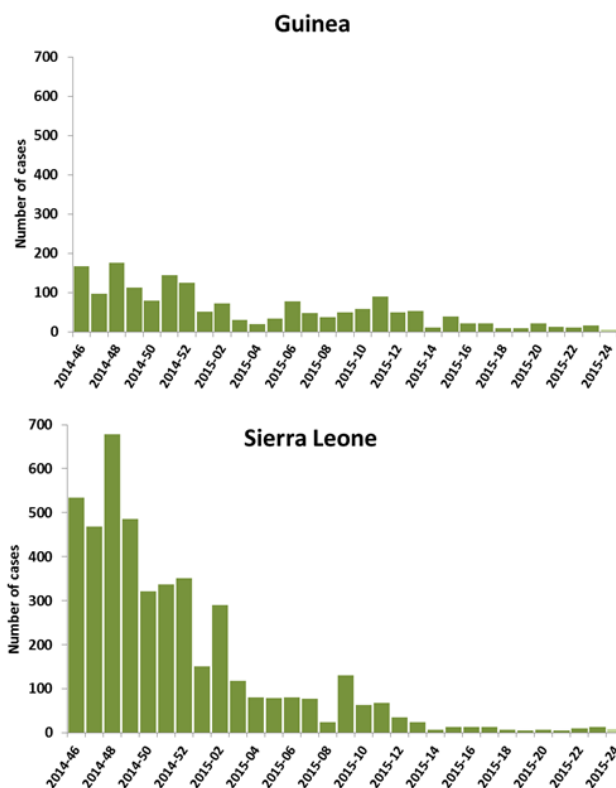
## Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 46/2014 to 24/2015)

Adapted from WHO figures; \*data for week 24/2015 are incomplete



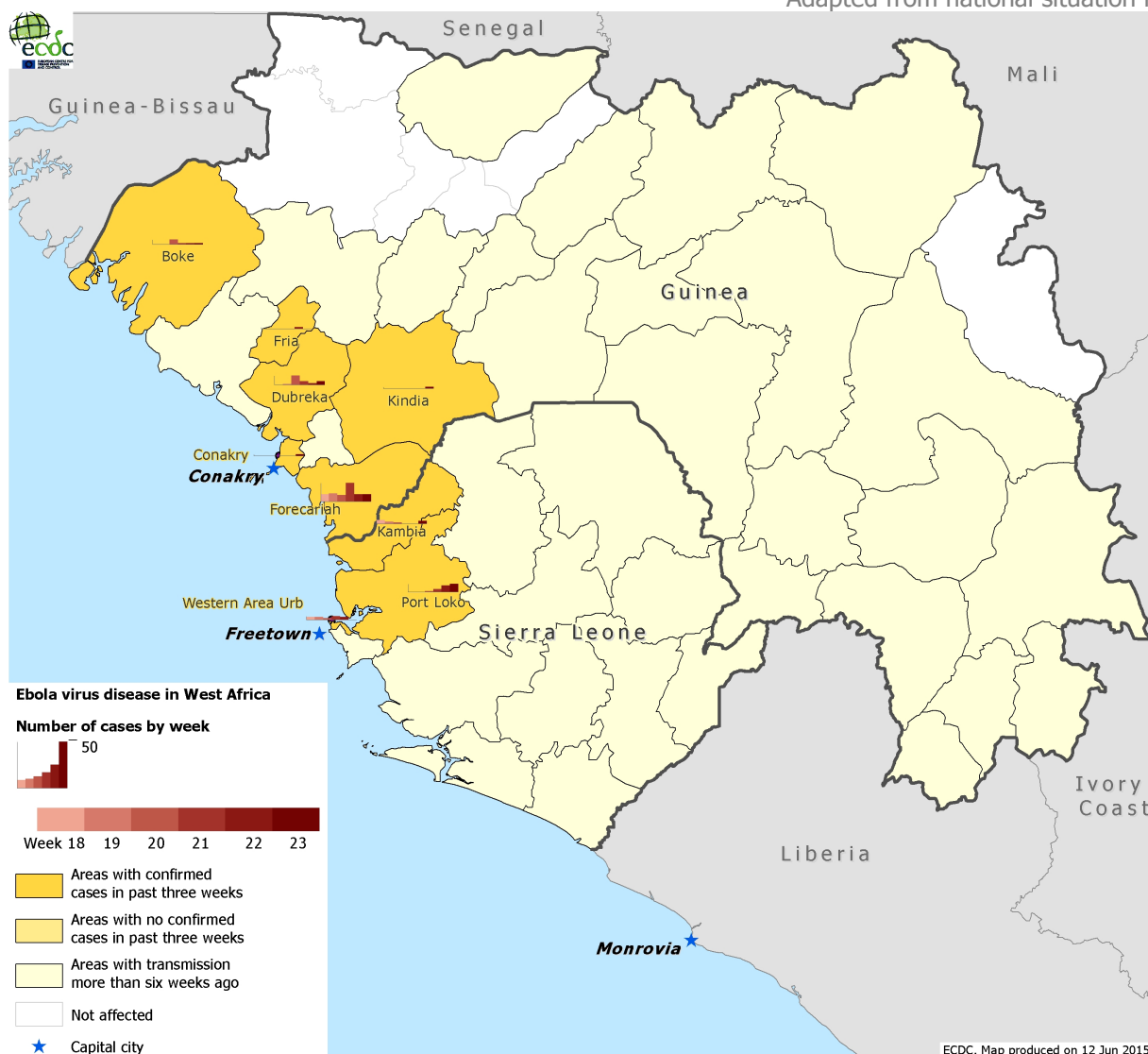
## Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (weeks 46/2014 to 24/2015)

Adapted from WHO figures; \*data for week 24/2015 are incomplete



## Distribution of confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (as of week 23/2015)

Adapted from national situation reports



## Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005

Latest update: 12 June 2015

### Epidemiological summary

Worldwide in 2015, 27 wild poliovirus type 1 (WPV1) cases have been reported to WHO so far, compared with 94 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (24 cases) and Afghanistan (3 cases).

No circulating vaccine-derived poliovirus (cVDPV) cases have been reported so far in 2015.

**Web sources:** [Polio Eradication: weekly update](#) | [MedISys Poliomyelitis](#) | [ECDC Poliomyelitis factsheet](#) | [Temporary Recommendations to Reduce International Spread of Poliovirus](#) | [Statement on the 4th IHR Emergency Committee meeting regarding the international spread of wild poliovirus](#)

### ECDC assessment

Europe is polio-free. The last locally acquired wild-polio cases within the current EU borders were reported from Bulgaria in 2001.

12/16

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 wild poliovirus in several countries and the documented exportation of wild poliovirus to other countries support the fact that there is a potential risk of wild poliovirus 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 both.

**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?](#) |

## Actions

ECDC monitors 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 into 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.

## Influenza A(H5N1) and other strains of avian flu - Multistate (world) - Monitoring globally

Opening date: 15 June 2005

Latest update: 12 June 2015

### Epidemiological summary

#### Egypt

In Egypt, as of 28 May 2015, the Ministry of Health and Population reported 140 human cases of influenza A(H5N1), including 39 deaths in 2015. There is no new update from the Egyptian Ministry of Health. Since 2006, Egypt has reported 342 human cases, according to WHO/Food and Agriculture Organisation (FAO).

#### Worldwide

From 2003 to 1 May 2015, 840 laboratory-confirmed human cases of avian influenza A(H5N1) virus infection have been officially reported to WHO from 16 countries. Of these cases, 447 have died.

#### Other strains of avian influenza

No new update from WHO.

#### Non-human cases

In the past week, the USA reported influenza A(H5N2) Highly Pathogenic Avian Influenza (HPAI) virus among wild Canada geese in Michigan and a new outbreak of HPAI H5 virus was detected in Iowa. During the same week, influenza A(H5N1) HPAI virus was reported in wild birds in Russia and a new outbreak of HPAI A(H5N1) was detected in birds in Greater Accra, Ghana.

**Web sources:** [ECDC Rapid Risk Assessment](#) | [Avian influenza on ECDC website](#) | [EMPRES](#) | [OIE](#) |

### ECDC assessment

Most human infections of A(H5N1) are the result of direct contact with infected birds or contaminated environments, and countries with large poultry populations in close contact with humans are considered to be most at risk of bird flu outbreaks. Therefore additional human cases would not be unexpected. 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. However, vigilance for avian influenza in domestic poultry and wild birds in Europe remains important.

Although an increased number of animal-to-human infections have been reported by Egypt over the past few months, it is not thought to be related to virus mutations but rather to more people becoming exposed to infected poultry. Although all influenza viruses evolve over time, preliminary laboratory investigation has not detected major genetic changes in the limited number of viruses isolated from the patients and animals in Egypt compared with previously circulating isolates thus far, but further in depth analysis is ongoing.

13/16

Various influenza A(H5) and A(H7) subtypes, such as influenza A(H5N1), A(H5N2), A(H5N3), A(H5N6), A(H5N8) and A(H7N3), have recently been detected in birds in West Africa, Asia, Europe, and North America, according to the World Organisation of Animal Health (OIE). Although these influenza viruses might have the potential to cause disease in humans, to date, there have been no reported human infections with these viruses with the exception of human infections with influenza A(H5N1) and A(H5N6) viruses. The risk to people from these infections in wild birds, backyard flocks and commercial poultry is considered to be low.

## Actions

ECDC monitors the worldwide A(H5N1) situation through epidemic intelligence activities on a weekly basis 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) in Egypt on 13 March 2015.

ECDC published an [epidemiological update](#) about A(H5N1) in Egypt on 10 April 2015.

## Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013

Latest update: 14 May 2015

### Epidemiological summary

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, human cases have continued to be reported, and as of 11 June 2015, there were 657 laboratory-confirmed cases: Zhejiang (179), Guangdong (181), Jiangsu (74), Fujian (62), Shanghai (47), Hunan (26), Anhui (26), Hong Kong (13), Xinjiang Uygur Zizhiqu (10), Jiangxi (8), Beijing (5), Shandong (6), Guangxi (4), Henan (4), Taiwan (4), Jilin (2), Guizhou (2) and Hebei (1), one imported case in Malaysia and two imported cases in Canada.

Most cases have developed severe respiratory disease.

**Web sources:** [Chinese CDC](#) | [WHO](#) | [WHO FAQ page](#) | [ECDC](#) |

### ECDC assessment

This outbreak is caused by a novel reassortant avian influenza virus capable of causing severe disease in humans. This is a zoonotic outbreak, in which the virus is transmitted sporadically to humans in close contact with the animal reservoir, similar to the influenza A(H5N1) situation. It is expected that there may be further sporadic cases of human infection with the virus in affected and possibly neighbouring areas in China. Affected provinces and municipalities continue to maintain surveillance and response activities.

Imported cases of influenza A(H7N9) may be detected in Europe, as indicated by the recent importation of two travel-related cases to Canada. However, the risk of the disease spreading among humans following an importation to Europe is considered to be very low. People in the EU presenting with severe respiratory infection and a history of potential exposure in the outbreak area will require careful investigation in Europe.

ECDC will close the threat this week.

## Actions

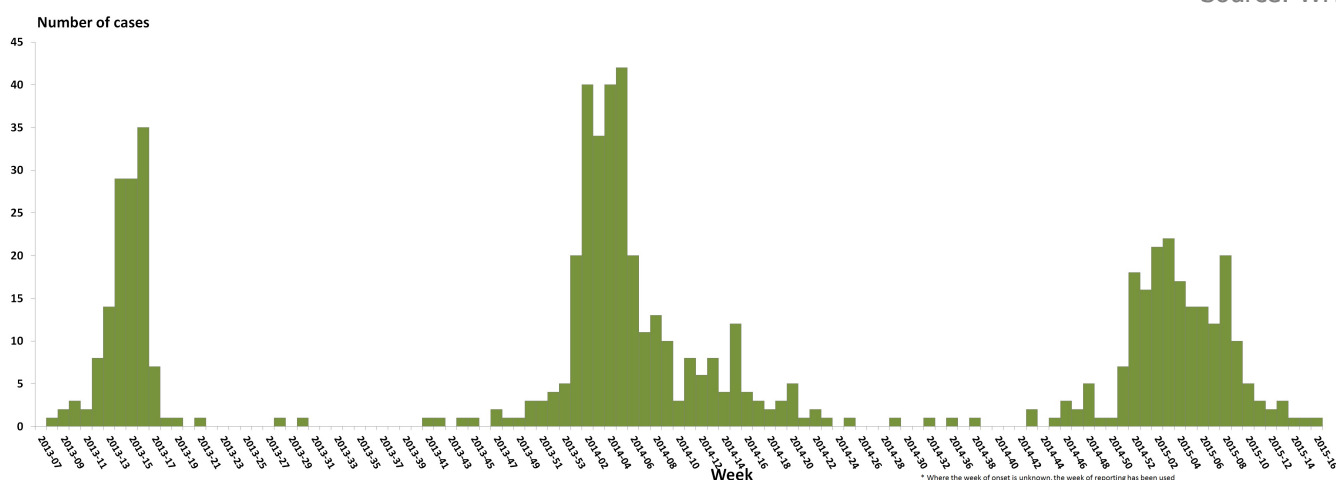
The Chinese health authorities continue to respond to this public health event with enhanced surveillance, epidemiological and laboratory investigation, including scientific research. ECDC is monitoring developments and updates reports on a monthly basis.

ECDC published an updated [Rapid Risk Assessment](#) on 3 February 2015.

ECDC published a guidance document [Supporting diagnostic preparedness for detection of avian influenza A\(H7N9\) viruses in Europe](#) for laboratories on 24 April 2013.

## Distribution of avian influenza A(H7N9) cases by first available week as of 14 May 2015 (n=657)

Source: WHO



## Distribution of cumulative number of human cases of avian influenza A(H7N9), by province and date, China, week 14/2013 to week 16/2015 (n=657)

Source: ECDC





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