COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 4, 22-28 January 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: 27 January 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 Flu News Europe website.

➔Update of the week

Influenza activity remained elevated across the region with 29 of 43 countries reporting widespread influenza activity.

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 27 January 2017

Measles, a highly transmissible vaccine-preventable disease, is still endemic in some EU countries where vaccination uptake remains below the level required to interrupt the transmission cycle. Elimination of measles requires consistent vaccination uptake above 95% with two doses of measles vaccine in all population groups, strong surveillance and effective outbreak control measures. In 2015, 16 EU/EEA countries were above the measles vaccination coverage target of 95% for the first dose, and six countries for the second dose. Fourteen countries in the EU have coverage rates of less than 95% for the first dose and 20 countries for the second dose.

➔Update of the week

In the EU/EEA Member States, a large measles outbreak is ongoing in Romania with 2 319 cases reported as of 20 January 2017. Outside of the EU, outbreaks were detected in Switzerland, Republic of South Sudan and USA (California).

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 27 January 2017

Rubella, caused by the rubella virus and commonly known as German measles, is usually a mild and self-limiting disease which often passes unnoticed. The main reason for immunising against rubella is the high risk of congenital malformations associated with rubella infection during pregnancy. All EU Member States recommend vaccination against rubella with at least two doses of vaccine for both boys and girls. The vaccine is given at the same intervals as the measles vaccine as part of the MMR vaccine. No new outbreaks have been detected in the EU since June 2015.

➔Update of the week

No new outbreaks have been detected since June 2015.

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Non EU Threats

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015 Latest update: 27 January 2017

From 1 February to 18 November 2016, Zika virus infection and the related clusters of microcephaly cases and other neurological disorders constituted a public health emergency of international concern (PHEIC). Since 2015, and as of 27 January 2017, 72 countries and territories have reported evidence of mosquito-borne transmission of the virus.

➔Update of the week

ECDC maps

Dominica and Trinidad and Tobago have been removed from the map of countries and territories with autochthonous vector-borne transmission of Zika virus infection in the past three months.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 27 January 2017

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission of the virus has completely stopped and the world becomes polio-free. Polio was declared a public health emergency of international concern (PHEIC) by the World Health Organization (WHO) on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus during 2014. On 11 November 2016, at the eleventh meeting of the Emergency Committee, the temporary recommendations in relation to the PHEIC were extended for another three months. WHO recently declared wild poliovirus type 2 (WPV2) eradicated worldwide.

➔Update of the week

There were no new cases of wild poliovirus type 1 (WPV1) and no new cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) reported by WHO this week. Two countries reported environmental positive samples of wild poliovirus type 1 (WPV1): Afghanistan (one sample) and Pakistan (one sample).

The 12th meeting of the IHR Emergency Committee for Polio will take place on 7 February 2017. The Committee will provide views to the Director-General on the current risk of international spread of polio and recommendations to mitigate the risk.

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 26 January 2017

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, and up to 26 January 2017, 918 cases have been reported to WHO, including at least 359 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.

➔Update of the week

Since the previous update on 19 January 2017, WHO has published detailed information regarding the cases reported in the previous week.

According to the health authorities in Hong Kong, the number of human cases of A(H7N9) since March 2013 have reached 1 033. Since November 2016 and as of 23 January 2017, 235 cases have been recorded.

Due to the large increase in human infection with avian influenza A(H7N9) virus in China, September 2016 – January 2017 ECDC is updating the rapid risk assessment published in February 2015.

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Yellow fever - Brazil - 2016-2017

Opening date: 16 January 2017 Latest update: 27 January 2017

Yellow fever is a viral infection that is present in some tropical areas of Africa and South America. The virus is transmitted by mosquitoes, which also act as an important reservoir. Since 6 January 2017, Brazil is experiencing an outbreak of yellow fever.

➔Update of the week

Since the publication of the last CDTR, when only the states of Minas Gerais and Espírito Santo reported cases of yellow fever, four additional states (Bahia, São Paulo, Goiás and Mato Grosso do Sul) have reported cases. Among these four states, only São Paulo has reported confirmed cases.

As of 26 January, the most affected state remains Minas Gerais, reporting 467 cases. Suspected and confirmed cases are also reported in Espírito Santo (33), Bahia (6), São Paulo (3), Goiás (1) and Mato Grosso do Sul (1). The Ministry of Health in Brazil has launched mass vaccination campaigns targeting the affected areas.

On 26 January 2017, the Regional Office for the Americas of the World Health Organization reported new municipalities at risk for yellow fever transmission in Bahia, Espirito Santo and Rio de Janeiro states.

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

Opening date: 10 November 2016 Latest update: 26 January 2017

The ECDC ELDSNet surveillance scheme on travel-associated Legionnaires' disease (TALD) has observed an increase in the number of legionellosis cases associated with travel to Dubai in the past few months. Since October 2016, seven countries from the European Union as well as Switzerland have reported confirmed cases among travellers coming back from Dubai.

➔Update of the week

Since the last CDTR on 19 January, three additional cases of Legionnaires' disease associated with travel to Dubai have been reported to ECDC: one from the UK, one from Switzerland and one from the Netherlands.

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II. Detailed reports

Influenza - Multistate (Europe) - Monitoring 2016-2017 season

Opening date: 13 October 2016 Latest update: 27 January 2017

Epidemiological summary

Week 3/2017 (16–22 January 2017)
Influenza activity remained elevated across the region with 29 of 43 countries reporting widespread influenza activity
The proportion of influenza virus detections among sentinel surveillance specimens was 49%, similar to the previous week.
Excess all-cause mortality among the elderly has been observed in some countries mainly due to the circulation of influenza virus A(H3N2).
The great majority of influenza viruses detected were type A (97%) and, of those subtyped, 98% were A(H3N2).
Most of the hospitalised laboratory-confirmed cases reported have occurred in people aged 65 years or older.

Season overview Influenza activity started early this season compared with previous seasons.
Week 46/2016 is the earliest week that the overall influenza-positivity rate in sentinel specimens reached 10% since the emergence of A(H1N1)pdm09 viruses in the 2009 season; during the last six seasons this occurred between weeks 48 and 51.
Since week 40/2016, influenza A viruses have predominated, accounting for 96% of all sentinel detections; the great majority (99%) of subtyped influenza A viruses from sentinel sites have been A(H3N2). This is in contrast to the same period during the 2015-2016 season in which influenza A(H1N1)pdm09 viruses predominated, but similar to the 2014–2015 influenza season, when influenza A(H3N2) was predominant.
In an influenza season in which A(H3N2) viruses predominate, elderly populations can be expected to be most severely affected. Indeed, confirmed cases of influenza A infection reported from hospitals have predominantly been in adults aged over 65 years.
So far, circulating A(H3N2) viruses are antigenically similar to the vaccine strain. While about two-thirds of the A(H3N2) viruses characterised belong to a new genetic subclade (3C.2a1), these viruses are antigenically similar to the vaccine strain (clade 3C.2a).
Early monitoring of vaccine effectiveness in Finland and Sweden suggests levels of effectiveness similar to estimates from multi-country studies during the seasons 2011–2012 to 2014–2015 with 26% (95% CI 22%–30%) and 24% (95% CI 11%–34%) vaccine effectiveness, respectively, in persons aged 65 years and older with laboratory-confirmed influenza A. Given the partial effectiveness of influenza vaccines, rapid use of neuraminidase inhibitors for laboratory-confirmed or probable cases of influenza infection should be considered for vaccinated and non-vaccinated patients at risk of developing complications.
No reduced antiviral susceptibility has been observed among the viruses tested.

ECDC assessment

This season, influenza viruses, mainly A(H3N2), began circulating early in the EU/EEA. It is too early to predict the intensity in primary care and the severity in secondary care, but if A(H3N2) continues to predominate, there is a risk that people over 65 years of age will be the most severely affected, possibly increasing pressure on healthcare systems.

A risk assessment on seasonal influenza in EU/EEA countries was published by ECDC on 24 December 2016.

Actions

ECDC monitors influenza activity in Europe during the winter season and publishes its weekly report on the Flu News Europe website. Risk assessments for the season are available from the European Centre for Disease Prevention and Control (ECDC) and the WHO Regional Office for Europe websites.

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 27 January 2017

Epidemiological summary

EU/EEA Member States

Romania – update
On 20 January 2017, the National Institute of Public Health in Bucharest published an overview of the current nationwide measles

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epidemic ongoing since the beginning of 2016. As of 20 January 2017, 2 319 confirmed measles cases have been reported affecting 34 counties. Fourteen deaths attributed to measles have been confirmed, affecting infants in particular.

On 16 December 2016, the Romanian Ministry of Health announced an action plan in order to respond to the outbreak:
- lower the age of first dose administration to nine months to provide protection as early as possible. The National Immunization Programme recommends vaccination at 12 months and five years old.
- ensure that all children up to 9 years of age are vaccinated according to the NIP recommendation (all children under the age of 5 years should have received one dose of measles vaccines and two dose for those aged 5 to 9 years)
- for physicians, identify children not adequately vaccinated and offer catch-up vaccination.
It is reported that supplies of MMR vaccines are sufficient to respond to the outbreak.

During the fourth European Regional Verification Commission for Measles and Rubella Elimination meeting in 2015 and based on 2012-2014 data, Romania was classified as a country with endemic measles transmission. Recommendations made included to 'strengthen population immunity by reaching and maintaining >95% coverage with both doses of MRCV (Measles and Rubella Containing Vaccine) at national and sub-national level' and to 'consider conducting a wide age-range SIA (Supplementary Immunisation Activities) to boost population immunity.'

In 2011, Romania experienced a nationwide measles epidemic with over 4 000 cases reported.

Rest of the world
Switzerland
Media, quoting the Federal Office of Public Health (FOPH), reported 70 cases of measles in 2016 (compared with 36 in 2015). The majority of the cases are among unvaccinated people. The cases are mainly linked to two outbreaks in Lausanne (22 cases) and in Engadine (13 cases).

Republic of South Sudan
For the year 2016, WHO reported 2 294 measles cases of measles including at least 28 deaths.

USA (California)
Since December 2016 and as of 21 January 2017, Los Angeles County's public health department is reporting a measles outbreak in Los Angeles Orthodox Jewish community, with 20 cases reported. Most of the cases are among unvaccinated people.

Web sources: ECDC measles and rubella monitoring | ECDC/Euronews documentary |MedISys Measles page | EUVAC-net ECDC | ECDC measles factsheet | NPHI Romania | Media | UNICEF | Eurosurveillance | MoH Romania | European Regional Verification Commission

ECDC assessment

Although progress has been made towards elimination in the EU, it has not yet been achieved, as exemplified by the worrying situation currently reported in Romania. According to the results of the fifth Regional Verification Commission meeting for the elimination of measles and rubella in Europe, held 24-26 October 2016, 24 countries in the region have been judged to have eliminated measles.

Web source: WHO-EU

Actions

ECDC monitors measles transmission and outbreaks in the EU and neighbouring countries through enhanced surveillance and epidemic intelligence activities.

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Vaccination status among measles cases, from week 2016-39 to 2017-03, Romania (n=2 319)

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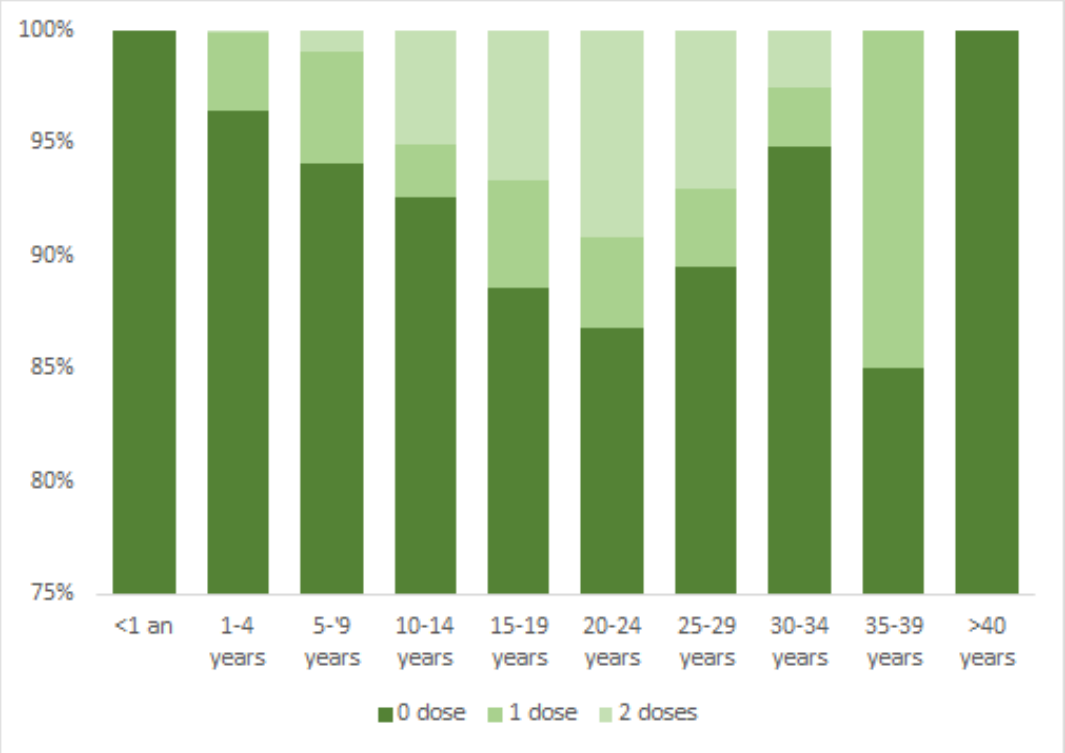
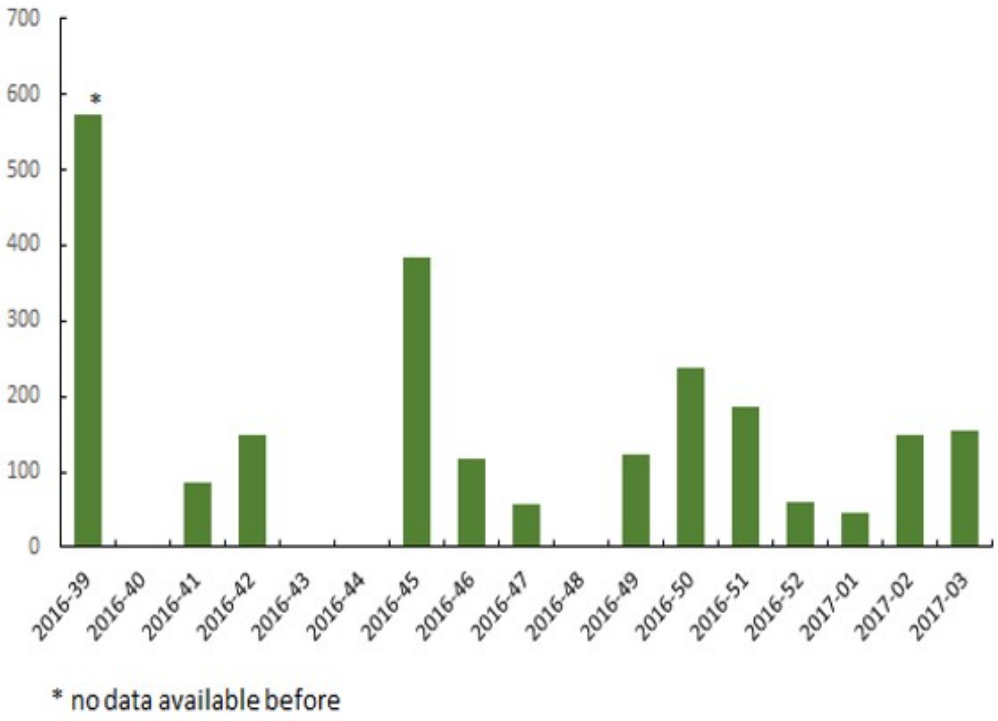


Distribution of measles cases, by week of reporting, week 39-2016 to 03-2017, Romania (n= 2319)

ECDC



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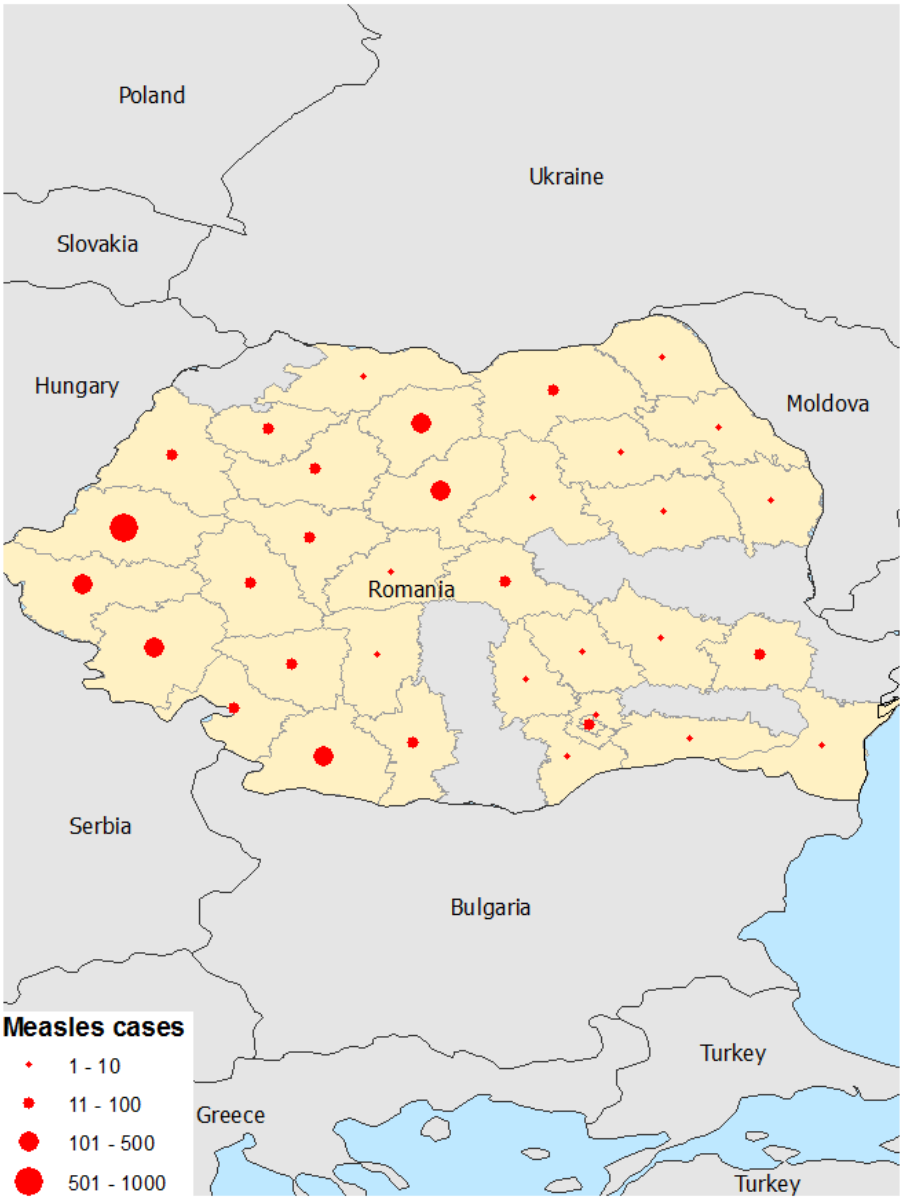
Distribution of measles cases, by region, from week 2016-39 to 2017-03, Romania

ECDC



Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 27 January 2017

Epidemiological summary

No new outbreaks have been detected in the EU since June 2015.

Web sources: ECDC measles and rubella monitoring | ECDC rubella factsheet | WHO epidemiological brief summary tables | WHO epidemiological briefs | Progress report on measles and rubella elimination | European Regional Verification Commission for Measles and Rubella Elimination (RVC) (2016)

ECDC assessment

The World Health Organization (WHO) has targeted the elimination of measles and rubella in the 53 Member States of the WHO European Region. Elimination is defined as the absence of endemic cases in a defined geographical area for a period of at least 12 months, in the presence of a well-performing surveillance system. Regional elimination can be declared after 36 or more months of the absence of endemic measles or rubella in all Member States of the WHO European Region. Although progress has been made towards elimination, this goal has not yet been achieved. The fifth Regional Verification Commission meeting was held 24-

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26 October 2016. According to the results, 24 countries in the WHO EURO region have been judged to have eliminated rubella.

Web source: WHO-EU

Actions

ECDC closely monitors rubella transmission in Europe by analysing the cases reported to The European Surveillance System and through its epidemic intelligence activities. Twenty-four EU and two EEA countries contribute to the enhanced rubella surveillance. The purpose of the enhanced rubella surveillance is to provide regular and timely updates on the rubella situation in Europe in support of effective disease control, increased public awareness, and achieving the target of rubella and congenital rubella elimination.

Zika - Multistate (world) - Monitoring global outbreaks

Opening date: 16 November 2015 Latest update: 27 January 2017

Epidemiological summary

Worldwide

Since 2015 and as of 27 January 2017, 72 countries and territories have reported evidence of mosquito-borne transmission of the virus. Since February 2016 and as of 18 January 2017, 13 countries or territories have reported evidence of person-to-person transmission of the virus, probably via sexual transmission.

EU/EEA imported cases

Since June 2015 (week 26), 21 countries (Austria, Belgium, the Czech Republic, Denmark, Finland, France, Greece, Hungary, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom) have reported 2 081 travel-associated Zika virus infections through The European Surveillance System (TESSy). Over the same time period, nine EU/EEA Member States have reported 103 Zika cases among pregnant women.

Update on microcephaly and/or central nervous system malformations potentially associated with Zika virus infection

According to WHO and as of 18 January 2017, 29 countries or territories have reported microcephaly and other central nervous system malformations in newborns which are potentially associated with Zika virus infection. Brazil is reporting the highest number of cases. Twenty-one countries or territories have reported Guillain-Barré syndrome potentially associated with Zika virus infection.

Web sources: ECDC Zika Factsheet | PAHO | WHO situation reports | Brazilian MoH | Brazilian microcephaly case definition | SAGE MOH Brazil |

ECDC assessment

The spread of the Zika virus in the Americas and Asia is likely to continue as the vectors (*Aedes aegypti* and *Aedes albopictus* mosquitoes) are widely distributed there. The likelihood of travel-related cases in the EU is increasing. ECDC is preparing an update of the risk assessment published on 28 October 2016. As neither treatment nor vaccines are available, prevention is based on personal protection measures. Pregnant women should consider postponing non-essential travel to Zika-affected areas.

Actions

ECDC publishes an epidemiological update every Friday together with maps containing information on countries or territories which have reported confirmed autochthonous cases of Zika virus infection. A Zika virus infection atlas is also available on the ECDC website.

ECDC publishes information concerning vector distribution on the ECDC website, showing the distribution of the vector species at 'regional' administrative levels (NUTS3).

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Countries or territories with reported confirmed autochthonous cases of Zika virus infection in the past three months, as of 27 January 2017

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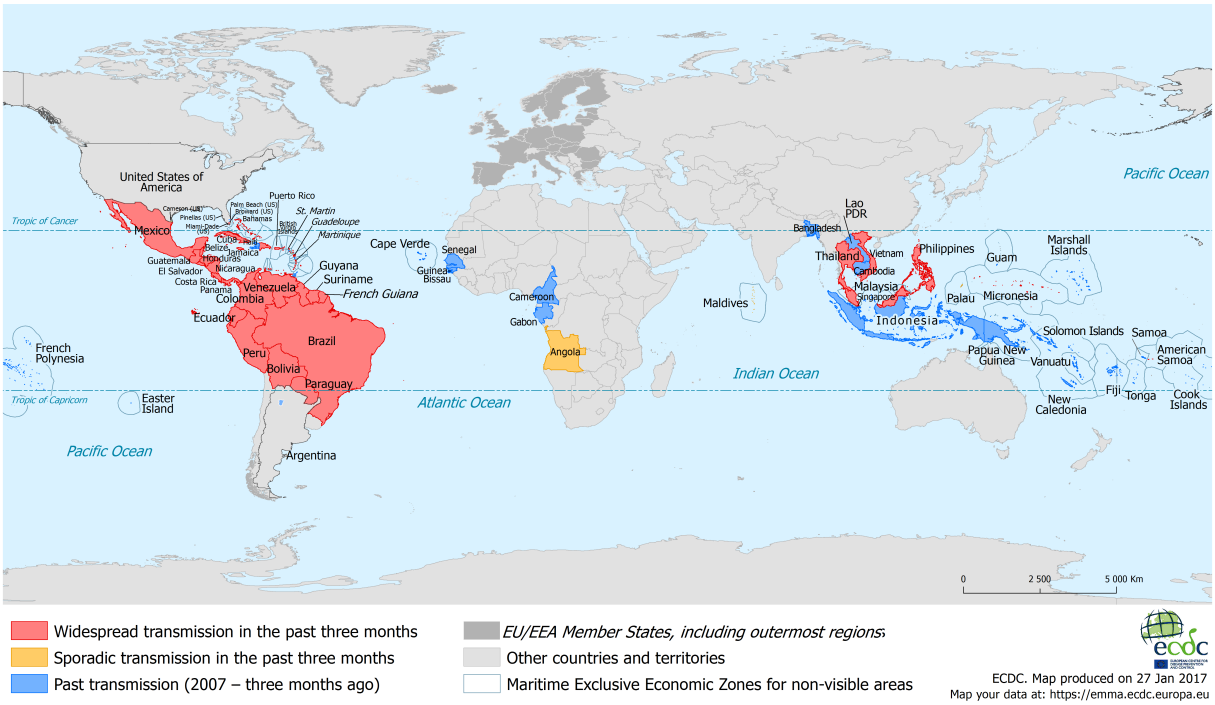

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 27 January 2017

Epidemiological summary

As of 24 January 2017, no cases of WPV1 have been reported to WHO in 2017. In 2016, there were 37 officially reported WPV1 cases (compared with 74 in 2015), 13 from Afghanistan, 20 from Pakistan, and four from Nigeria. Three cVDPV1 cases were detected in 2016, all from Lao People's Democratic Republic and two cVDPV2 cases, one from Pakistan and one from Nigeria.

Web sources: Polio eradication: weekly update | ECDC Poliomyelitis factsheet | Temporary Recommendations to Reduce International Spread of Poliovirus | WHO Statement on the Seventh Meeting of the International Health Regulations Emergency Committee on Polio

ECDC assessment

The last locally-acquired wild polio cases within the current EU borders were reported from Bulgaria in 2001. The most recent wild polio outbreak in the WHO European Region was in Tajikistan in 2010, when importation of WPV1 from Pakistan resulted in 460

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cases.

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? |RRA Outbreak of circulating vaccine-derived poliovirus type 1 (cVDPV1) in Ukraine

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 reintroduced 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(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 26 January 2017

Epidemiological summary

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, and up to 26 January 2017, 918 cases have been reported to WHO, including at least 359 deaths.

The A(H7N9) outbreak shows a seasonal pattern peaking in the winter months with only sporadic cases during the summer. Cases reported between weeks 41 and 40 in the subsequent year are considered to belong to one epidemic wave. The first wave in spring 2013 (week 07/2013 to week 40/2013) included 135 cases, 319 cases were reported during the second wave (week 41/2013–40/2014), 223 cases during the third wave (week 41/2014–40/2015), and 121 in wave four (week 41/2015–40/2016). A fifth wave started in October 2016 (week 41/2016) with 120 cases as of 24 January 2017.

According to the health authorities in Hong Kong, the 1 033 human cases of influenza A(H7N9) reported since March 2013 have the following geographical distribution: Zhejiang (264), Guangdong (221), Jiangsu (195), Fujian (82), Anhui (64), Shanghai (55), Hunan (44), Jiangxi (25), Shandong (11), Xinjiang Uygur (10), Beijing (9), Guizhou (5), Hebei (4), Henan (4), Guangxi (3), Hubei (3), Jilin (2), Tianjin (2), Liaoning (1), Hong Kong (20) and two case in Macau and four cases in Taiwan.

Three imported cases have also been 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 Northern Hemisphere winter season with human cases due to A(H7N9) infections. During this wave the number of human cases is already higher than during the whole last wave in 2015/16 with a significantly higher number than in the last two waves within the same period of time. A steep increase of human cases has been reported since the beginning of December 2016 from China, the epidemiology however, does not seem to have changed during this season.

The majority of recently reported human cases are associated with exposure to infected live poultry or contaminated environments, including markets where live poultry are sold. The age of the infected humans is comparable to previous waves. Influenza A(H7N9) viruses continue to be detected in poultry and their environments in the areas where human cases are occurring, however more human cases are detected in rural areas. The upsurge of human cases is most likely due to a higher environmental contamination particularly related to live bird markets.

At present, the most immediate threat to EU citizens is to those living or visiting influenza A(H7N9)-affected areas in China. It is advisable to avoid live bird markets or backyard farms as well as contact with live poultry or their droppings. Food should be only consumed properly cooked. The environmental contamination and thus higher risk of exposure to A(H7N9) highlights the possibility of travel-related cases also being detected in Europe, especially also related to the upcoming Chinese New Year 28th of January. The recent upsurge of human cases due to a higher risk of exposure indicates the possibility of sporadic imported cases to Europe. However, the risk of the disease spreading within Europe via humans is still considered low, as the virus does not appear to transmit easily from human to human and the investigations do not support sustained human-to-human transmission.

Actions

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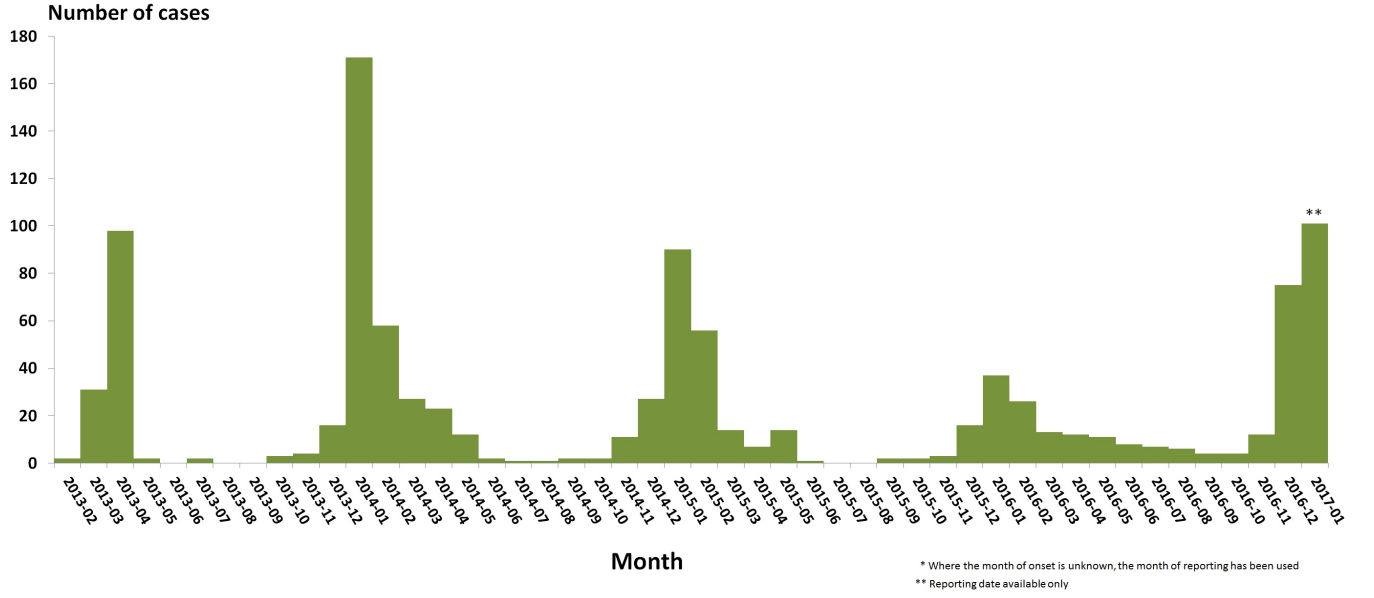
ECDC published a guidance document entitled Supporting diagnostic preparedness for detection of avian influenza A(H7N9) viruses in Europe for laboratories on 24 April 2013.

ECDC published an updated Rapid Risk Assessment on 3 February 2015. ECDC is preparing an updated risk assessment.

Distribution of A(H7N9) cases in China, by month, February 2013 – 24 January 2017



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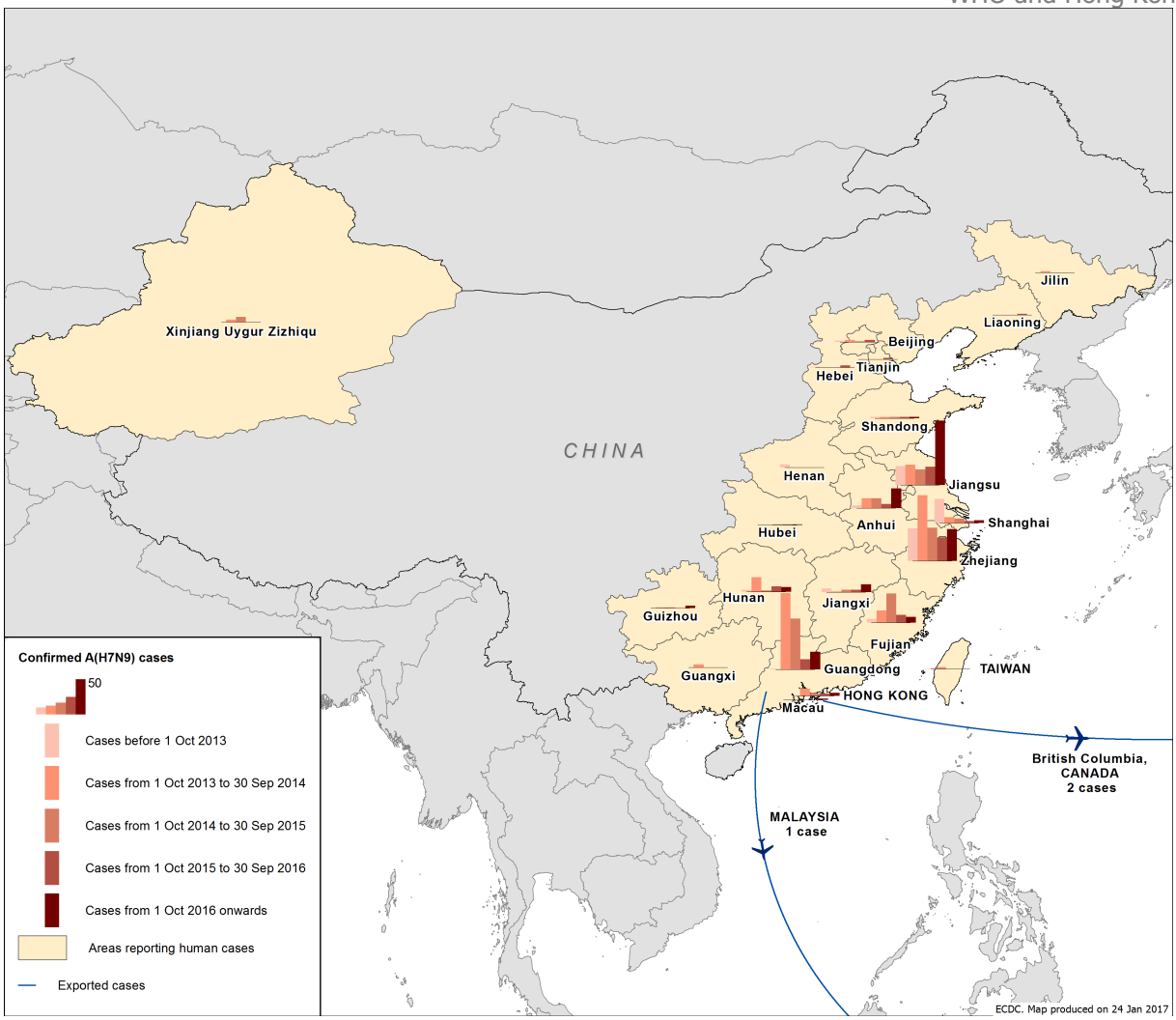
Distribution of confirmed cases of A(H7N9) by place of reporting and season (February 2013 to January 2017)

WHO and Hong Kong CHP



Yellow fever - Brazil - 2016-2017

Opening date: 16 January 2017 Latest update: 27 January 2017

Epidemiological summary

Since 6 January 2017, Brazil has been reporting an outbreak of yellow fever. The index case had onset of symptoms on 18 December 2016. The first laboratory confirmation was reported on 19 January 2017.

As of 26 January, authorities report 511 cases (including 88 confirmed) in six different states.

States reporting confirmed and suspected cases as of 26 January:
Minas Gerais has reported 467 (383 suspected and 84 confirmed) cases in 48 municipalities, including 97 deaths for which 40 are confirmed. The case fatality rate (CFR) is currently 20.7% among all cases, and 47.6% among confirmed cases.
Espírito Santo has reported 33 cases, including one confirmed in 18 municipalities.
São Paulo has reported three confirmed cases in three municipalities, all of whom died.

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States reporting suspected cases as of 26 January:
Bahia has reported six suspected cases in three municipalities, with no death recorded.
Goiás has reported one suspected case in one municipality, who died.
Mato Grosso do Sul has reported one suspected case in one municipality, with no death recorded.

The Brazilian Ministry of Health has launched mass vaccination campaigns targeting the affected areas.

Sources: Brazil MoH | WHO | Minais Gerais MoH | Espírito Santo MoH | PAHO

ECDC assessment

The risk of yellow fever transmission in the EU/EEA is currently very low as it depends on the virus being introduced by viraemic travellers to an area with an established, competent and active mosquito vector population.

In Brazil, the authorities have reported only sylvatic cases in 2016 and 2017. However, this outbreak should be carefully monitored as the establishment of an urban yellow fever cycle would have the potential to quickly affect a large number of people. Therefore, EU/EEA Member States should consider a range of options for response.

EU citizens who travel to, or live in, areas where there is evidence of yellow fever virus transmission, especially those in affected regions, are advised to:
- Be aware of the risk of yellow fever in endemic areas of Brazil, particularly in the states with confirmed autochthonous cases: Minas Gerais, Espírito Santo and São Paulo;
- Check their vaccination status and get vaccinated if necessary. Vaccination against yellow fever is recommended from nine months of age for people visiting, or living in yellow fever risk areas. An individual risk benefit analysis should be conducted prior to vaccination, taking into account the season (December to July in Brazil), destination, duration of travel and the likelihood of exposure to mosquitoes (e.g. rural areas, forests).

Actions

ECDC monitors closely this event, in collaboration with the World Health Organization (WHO). ECDC published a rapid risk assessment on 26 January 2017. ECDC also published a map showing the distribution of confirmed cases of locally-acquired yellow fever, provided to evaluate the risk for people who are planning to travel to Brazil.

European Centre for Disease Prevention and Control (ECDC)
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Link to ECDC CDTR web page – including related PowerPoint© slides

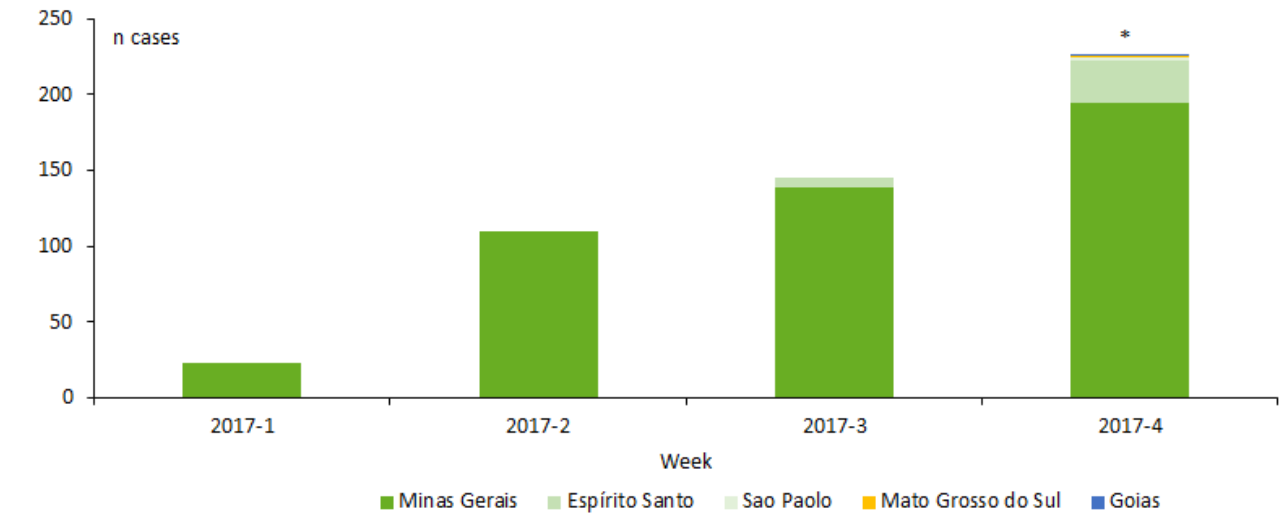
Municipalities reporting yellow fever confirmed cases, week 2017-01 to 2017-04, Brazil

ECDC

States and municipalities with confirmed locally-acquired cases
Minas Gerais State
Alvarenga
Conceição de Ipanema
Entre Folhas
Frei Gaspar
Imbé de Minas
Inhapim
Ipanema
Itambacuri
Januária
Ladainha
Malacacheta
Manhuaçu
Minas Novas
Novo Cruzeiro
Piedade de Caratinga
Pocrane
Poté
Santana do Manhuaçu
Setubinha
Simonésia
Teófilo Otoni
Ubaporanga
Bom Jesus do Galho
Caratinga
José Raydan
São Sebastião do Maranhão
São Jose do Mantimento
São Paulo State
Américo Brasiliense
Batatais
Espiritu Santo State
Ibatiba

Cases of yellow fever (suspected and confirmed), Week 2017-01 to 2017-04, Brazil

ECDC



* uncomplete data for this week

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

Opening date: 10 November 2016 Latest update: 26 January 2017

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Epidemiological summary

The ECDC ELDSNet surveillance scheme on travel-associated Legionnaires' disease (TALD) reports an increase in the number of cases associated with travel to Dubai, United Arab Emirates (UAE). As of 26 January 2017, there are 37 TALD cases with illness onset between October 2016 and January 2017, reported from eight countries: the UK (17), the Netherlands (5), Sweden (5), France (3), Germany (3), Denmark (2), Belgium (1) and Switzerland (1). One of the 37 cases died. The most recent illness onset was on 16 January. Three cases with complete laboratory investigation are characterised as *Legionella pneumophila* serogroup 1 sequence base type 616, which is not common in Europe, but has been identified among returning travellers from Dubai before.

The delay between week of onset and week of reporting to ELDSNet is around two weeks on average, ranging from one to six weeks. Therefore, the number of cases reported in the past six weeks may be underestimated.

ECDC assessment

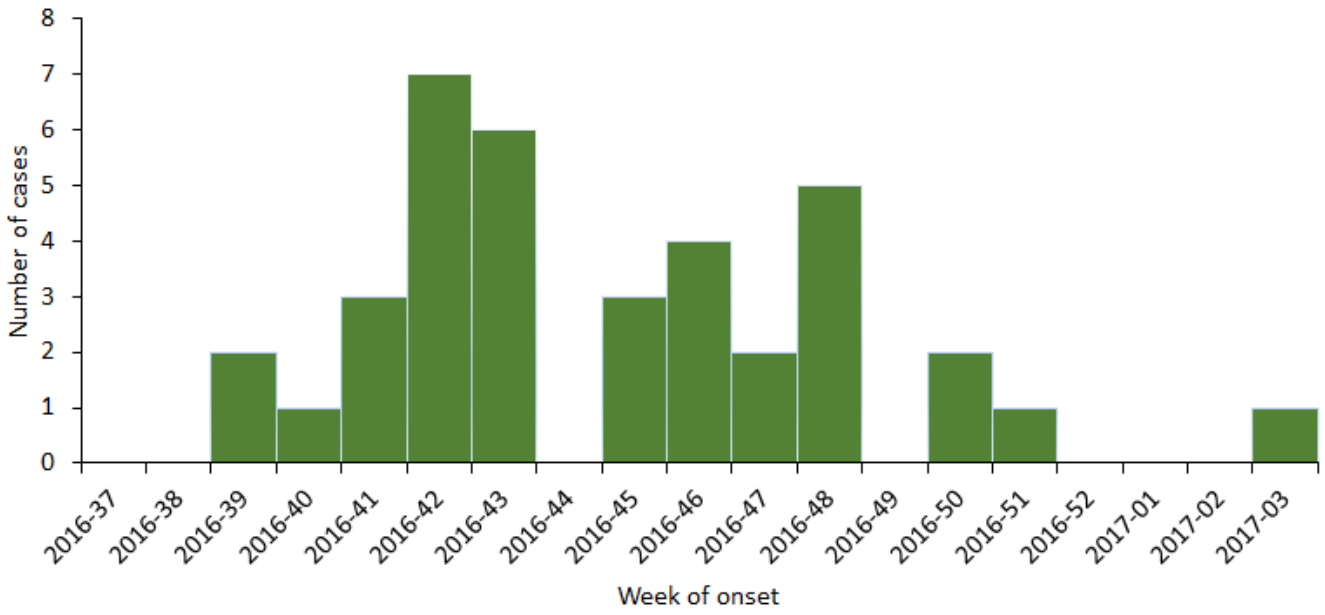
An increase in cases of Legionnaires' disease compared with previous years is reported in EU travellers returning from Dubai. It cannot be ruled out that some travellers might have acquired their infection elsewhere than in Dubai, if their travel stay in Dubai was shorter than the incubation period range. The increase in cases observed between October 2016 and January 2017 cannot only be explained by the increase in the number of travellers to Dubai from the EU.

Actions

ECDC is working on the analysis of the investigation questionnaires and is in contact with EU Member States, the ELDSNet network, WHO and UAE for information sharing and assessment.
ECDC published a rapid risk assessment on 23 December 2016. An Epi-update was published on the ECDC website on 18 January 2017.

Distribution of travel associated Legionnaires' disease cases with history of stay in Dubai, UAE, by week of onset, week 37-2016 to 03-2017

ELDSNet



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

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