COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 5, 25-31 January 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 5 January 2015 Latest update: 29 January 2015

Since December 2014, there have been ten cases of botulism in Norway (3) and Scotland (7) affecting people who inject drugs. These cases raise the possibility that a batch of contaminated heroin is in circulation.

➔Update of the week

On 26 January 2015, Norway reported two new probable cases of botulism in drug-injecting heroin users in the Oslo area. Both cases are currently hospitalised.

On 26 January 2015, Scotland reported two new probable cases of botulism among people who inject drugs. One of the new cases is from the Greater Glasgow and Clyde area and the second case is from the Lanarkshire area. Both are currently hospitalised in Glasgow and are in a serious condition.

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

Opening date: 9 October 2014 Latest update: 23 January 2015

Following the 2009 pandemic, influenza transmission in Europe has returned to its seasonal epidemic pattern, with peak activity during winter months. ECDC monitors influenza activity in Europe during the winter season and publishes the results on its website in the weekly Flu News Europe.

➔Update of the week

For week 04/2015, 26 countries reported increasing influenza activity and the overall proportion of influenza-positive sentinel specimens reached 48%, the same level as in the previous week.

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Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 18 December 2014

Measles, a highly transmissible vaccine-preventable disease, is still endemic in many EU countries where vaccination uptake remains below the level required to interrupt the transmission cycle. ECDC monitors measles transmission and outbreaks in EU and neighbouring countries in Europe on a monthly basis through enhanced surveillance and epidemic intelligence activities. 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.

➔Update of the week

In the EU, since the last monthly update, a new outbreak has been reported in Berlin, Germany in January 2015.

In the rest of the world, large outbreaks are ongoing in Bosnia and Herzegovina, Serbia, Kyrgyzstan, the US, China, Sudan and Papua New Guinea.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 18 December 2014

Rubella, caused by the rubella virus and commonly known as German measles, is usually a mild and self-limiting disease and is an infection 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.

➔Update of the week

No new outbreaks have been detected in the EU since the last monthly update.

Non EU Threats

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 22 January 2015

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, 487 cases have been reported including 185 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. Sustained person-to-person transmission has not been documented and transmission peaked during the winter of 2013-2014. The reason for this pattern is not obvious.

➔Update of the week

Since the last update of 22 January 2015, WHO has reported one additional laboratory-confirmed case of human infection with avian influenza A(H7N9) virus in China.

On 26 January 2015 the health authorities in Canada notified of an imported case of A(H7N9) in an individual who recently returned to Canada from China. On 30 January 2015 media report that the co-traveller of the case was also diagnosed with the same influenza subtype.

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Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 23 January 2015

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

➔Update of the week

According to WHO, a combined total of 99 confirmed cases were reported from the three countries in the week ending 25 January: 30 in Guinea, four in Liberia, and 65 in Sierra Leone.

As of 29 January 2015, WHO has reported 22 136 confirmed, probable, and suspected cases of Ebola virus disease, with 8 833 deaths, in the three affected countries (Guinea, Liberia and Sierra Leone) and the five previously-affected countries (Mali, Nigeria, Senegal, Spain, UK and USA).

According to WHO, the response to the EVD epidemic has now moved to a second phase, as the focus shifts from slowing transmission to ending the epidemic.

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

Opening date: 24 September 2012 Latest update: 22 January 2015

Since April 2012, 981 cases of MERS-CoV have been reported by local health authorities worldwide, including 399 deaths. To date, all cases have either occurred in the Middle East, have direct links to a primary case infected in the Middle East, or have returned from this area. The source of the virus remains unknown, but the pattern of transmission and virological studies points towards dromedary camels in the Middle East being a reservoir from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission is amplified among household contacts and in healthcare settings.

➔Update of the week

Since the last CDTR, Saudi Arabia has reported one new case of MERS-CoV infection. According to WHO Oman has reported one asymptomatic case following contact tracing of a previously reported fatal case of MERS-CoV infection.

Plague outbreak - Madagascar - 2014 - 2015

Opening date: 24 November 2014 Latest update: 29 January 2015

An outbreak of plague has been evolving in Madagascar since 31 August 2014, when the first case was notified in a male child from Soamahatamana village in the district of Tsiroanomandidy. The child died on 3 September. As of 8 January 2015, 220 cases and 61 deaths (case-fatality ratio 28%) have been reported by health authorities in Madagascar.

➔Update of the week

Seven cases, including four deaths, have been reported in Amparafaravola district (north-east from Antananarivo) by the media. Among these seven cases, six are pulmonary plague and one is bubonic plague.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 29 January 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission stops and the world is polio-free.

Polio was declared a public health emergency of international concern (PHEIC) on 5 May 2014 due to concerns regarding the increased circulation and the international spread of wild poliovirus during 2014. On 14 November, the Temporary Recommendations in relation to PHEIC were extended for a further three months.

➔Update of the week

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

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II. Detailed reports

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

Opening date: 5 January 2015 Latest update: 29 January 2015

Epidemiological summary

On 29 December 2014, the Norwegian Institute of Public Health (NIPH) was notified of one case of wound botulism in a heroin-injecting drug user residing in the Oslo area. The patient developed symptoms on 26 December. On 26 January 2015, NIPH was notified of two additional cases in the Oslo area, bringing the number of cases in Norway to three.

As of 26 January 2015, NHS Greater Glasgow and Clyde, NHS Lanarkshire, Police Scotland and Health Protection Scotland notified seven confirmed, probable and possible cases of botulism among people who inject drugs. Of these cases, four are currently hospitalised in Glasgow. The source of these infections is contaminated heroin. Media report that batches of contaminated heroin may be linked to one dealer. The dealer had buried some of the heroin in the ground for four years. It is feared that the contaminated batch could have been cut into more than 700 smaller amounts and sold on the street as 'tenner bags'.

Web sources: NHS | Folkhelseinstitutet

ECDC assessment

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

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

Actions

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

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

Opening date: 9 October 2014 Latest update: 23 January 2015

Epidemiological summary

- Respiratory Syncytial Virus (RSV) circulation seems to have decreased across Europe with a peak of activity during the first two weeks of 2015.
- Excess all-cause mortality among the elderly (65+), concomitant with increased influenza activity and A(H3N2) viruses predominating, has been observed during recent weeks in France, Portugal, the United Kingdom (England, Scotland and Wales), the Netherlands, and Spain (see the EuroMOMO project at http://www.euromomo.eu/).
- Although the majority of A(H3N2) viruses characterized so far exhibit antigenic differences to the virus included in the 2014–2015 northern hemisphere influenza vaccine, vaccination of the elderly and other risk groups is still recommended, since the A(H3N2) component is expected to induce some cross-reactive immunity that can reduce the likelihood of severe influenza-infection related outcomes.

Web sources: Flu News Europe | ECDC Influenza |

ECDC assessment

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

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Actions

ECDC and WHO produce the Flu News Europe bulletin weekly.

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 18 December 2014

Epidemiological summary

EU Member States

***Slovenia* - update**

As of 31 December 2014, the National Institute of Public Health (NIJZ) has been informed of 44 patients diagnosed with measles connected to an international dog show on 8 and 9 November that was attended by dog owners from 27 countries. Of these, 23 were visitors and 21 secondary and tertiary cases. Twelve of the cases reported vaccination with two doses of vaccine, 8 had a single dose of vaccine, and the rest were unvaccinated.
In addition, the NIJZ was informed of six additional cases of measles, connected to an introduction from Bosnia and Herzegovina and not associated with the dog show.

Germany

According to the media, in Berlin, 153 cases have been reported to health authorities since 1 January 2015 affecting several schools.

Rest of the world

Bosnia and Herzegovina

National authorities in Bosnia and Herzegovina report a very large outbreak of measles that started in February 2014. By the end of the year there were 3 426 reported measles cases. The largest proportion of patients were aged 15-19 years. Most cases were unvaccinated or incompletely vaccinated.
In addition, during 2014, there were 1 008 measles cases notified in Republika Srpska, of which 43 were laboratory confirmed. Most of the cases belonged to the age group 20 to 25 years.

Serbia

Since November 2014 and as of 23 January 2015, 123 cases of measles have been reported by national authorities in Serbia in several outbreaks affecting numerous areas of the country.

Kyrgyzstan
According to media, there is an ongoing outbreak with more than five hundred cases in Bishkek since late December 2014.

US

There is a large ongoing measles outbreak in California that began after several people were exposed to measles while visiting Disneyland between 17 and 20 December 2014. The confirmed cases include five Disney employees. Patients range in age from seven months to 70 years. Twenty-five percent of the patients in California needed hospitalisation. There are now 87 confirmed cases connected to Disneyland (73 cases in California and 14 elsewhere, including 1 in Mexico).

During 2014, 644 cases of measles were reported in the US which is the highest number of cases since 2000 when measles was declared eliminated in the Americas.

China

Media report an outbreak in Beijing with 91 cases reported during 2015 as of 26 January.

Sudan

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UNICEF reports an outbreak of measles in the Gedarif and Kassala States in eastern Sudan. As of 15 January, twelve localities have been affected with 593 confirmed cases, the majority being children under five years. A week long vaccination campaign was launched on 19 January.

Papua New Guinea

Media report an outbreak in Papua New Guinea in Chimbu province with six fatalities and an unknown number of cases.

Web sources: ECDC measles and rubella monitoring | ECDC/Euronews documentary | MedISys Measles page | EUVAC-net ECDC | ECDC measles factsheet

ECDC assessment

During 2014, eight EU Member States reported measles outbreaks. The target year for measles elimination in Europe is 2015. The current situation suggests that endemic measles transmission continues in many EU Member States and the prospect of achieving the 2015 objective is not feasible.

Actions

On 10 December, ECDC published a rapid risk assessment on the outbreak of measles linked to the international dog exhibition in Slovenia.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 18 December 2014

Epidemiological summary

Twenty-seven EU/EEA countries reported 6 396 cases during the recent 12-month period between November 2013 and October 2014. In 21 countries, the rubella notification rate was less than one case per million population during the last 12 months.

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 |Towards rubella elimination in Poland

ECDC assessment

As rubella is typically a mild and self-limiting disease with few complications, the rationale for eliminating rubella would be weak if it were not for the virus' teratogenic effect. When a woman is infected with the rubella virus within the first 20 weeks of pregnancy, the foetus has a 90% risk of being born with congenital rubella syndrome (CRS), which entails a range of serious incurable illnesses. The increase in the number of rubella cases reported in Romania and Poland during the last two years and the number of babies born with CRS are cause for concern. Rubella occurs predominantly in age and sex cohorts historically not included in vaccination recommendations. To achieve rubella elimination, supplemental immunisation activities in these cohorts are needed.

Actions

ECDC closely monitors rubella transmission in Europe by analysing the cases reported to the European Surveillance System and through its epidemic intelligence activities on a monthly basis. Twenty-four EU and two EEA countries contribute to the enhanced rubella surveillance. The purpose of the enhanced rubella monitoring is to provide regular and timely updates on the rubella situation in Europe in support of effective disease control, increased public awareness and the achievement of the 2015 rubella and congenital rubella elimination target.

An ECDC report is available online: Survey on rubella, rubella in pregnancy and congenital rubella surveillance systems in EU/EEA countries

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 22 January 2015

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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 29 January 2015, there were 487 cases including 185 deaths: Zhejiang (145), Guangdong (112), Jiangsu (63), Shanghai (43), Fujian (28), Hunan (24), Anhui (18), Jiangxi (6), Henan (4), Beijing (5), Guangxi (4), Shandong (4), Hebei (1), Guizhou (1), Jilin (2), Xinjiang Uygur Autonomous Region (9), Hong Kong (12), Taiwan (4), one imported case in Malaysia and one imported case in Canada.

Most cases have developed severe respiratory disease.

Web sources: Chinese CDC | WHO | WHO FAQ page | ECDC | WHO DON 30 December|

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 in 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.

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 26 February 2014 and is preparing an updated risk assessment.

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

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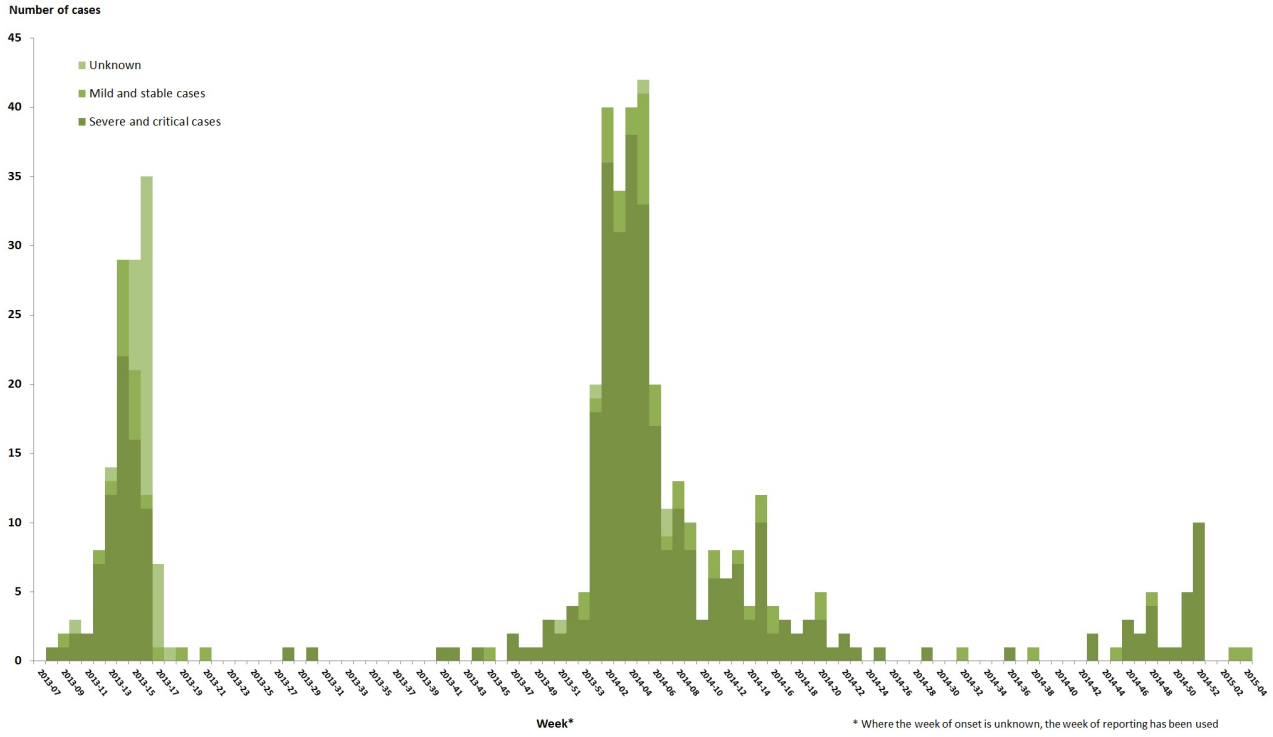
Distribution of avian influenza A(H7N9) cases by first available week*, as of 29 January 2015 (n=487)

Source: ECDC



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Distribution of cumulative number of human cases of avian influenza A(H7N9), by province and date, China, week 14/2013 to week 4/2015

Source: ECDC

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 23 January 2015

Epidemiological summary

Distribution of cases as of 26 January:

Countries with intense transmission:

- Guinea: 2 921 cases and 1 911 deaths (as of 26 January 2015).
- Liberia: 8 643 cases and 3 700 deaths (as of 26 January 2015)
- Sierra Leone: 10 537 cases and 3 199 deaths (as of 26 January 2015).

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

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

Situation in specific West African countries

According to WHO, case incidence continues to fall in all the intense transmission countries and all three have sufficient capacity to isolate and treat patients, with more than two treatment beds per reported confirmed, probable and suspected case. The planned numbers of beds in each country has now been reduced in accordance with falling case incidence.
Between 89% and 99% of registered contacts are being monitored in the three countries with intense transmission, though the number of contacts traced per EVD case remains lower than expected in many districts.
Since the beginning of 2015, around 50% of new confirmed cases in Guinea and Liberia arose from known contacts; equivalent data are not yet available for Sierra Leone.
The cumulative case-fatality rate in the three transmission-intense countries among hospitalised patients is between 54 and 62%.
According to WHO, a total of 27 sub-prefectures in Guinea reported at least one security incident or other form of refusal to cooperate in the week up to 21 January. A total of two districts in Liberia and four districts in Sierra Leone reported at least one similar incident during the same reporting period.

Mali

On 18 January 2015, the Government of Mali and WHO declared the country Ebola free, 42 days after the last patient tested negative on 6 December 2014.

Situation among healthcare workers

Up to the end of 25 January 2015, 834 healthcare workers (HCWs) are known to have been infected with EVD, 495 of whom have died.
Distribution of cases: 162 HCWs in Guinea, 371 HCWs in Liberia, 283 HCWs in Sierra Leone, two HCWs in Mali, 11 HCWs infected in Nigeria, one HCW infected in Spain while treating an EVD-positive patient, one HCW in the UK who became infected in Sierra Leone, and three HCWs in the USA (one HCW infected in Guinea, and two HCWs infected during the care of a patient in Texas).

Situation outside of West Africa

The United Kingdom

One case was reported in Scotland in a patient who travelled from Sierra Leone via Casablanca and London and arrived in Glasgow late on 28 December 2014. Media report that the Scottish nurse has been discharged from hospital on 24 January 2015, after being declared free of the virus. Public Health England has completed contact tracing following this confirmed case of Ebola. No high-risk contacts have been identified in connection with the case.

Medical evacuations and repatriations from EVD-affected countries

Thirty-two individuals have been evacuated or repatriated from the EVD-affected countries. As of 28 January, there have been 13 medical evacuations of confirmed EVD-infected patients to Europe (three to Germany, three to Spain, two to France, one to the UK, one to Norway, one to Italy, one to the Netherlands and one to Switzerland). Nine persons exposed to Ebola who then tested negative have been repatriated to Europe (two to Sweden, two to UK, two to the Netherlands, one to Denmark, one to Germany and one to Switzerland).
According to the media a Red Cross aid worker who got in contact with EVD in Sierra Leone has been medically evacuated to Sweden. The woman does not present any symptoms and has already been discharged. Results of the tests are still pending.

Figures

First epi-curve: distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Nigeria, Mali and Senegal, weeks 48/2013 to 05/2015 **

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

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

Second epi-curve: Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 05* 2015.

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

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

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

Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO Ebola Factsheet | CDC | WHO Roadmap | Sweden Medical evacuation |Mali Ebola free |

ECDC assessment

This is the largest ever documented epidemic of EVD in terms of numbers and geographical spread. The evolving epidemic of EVD increases the likelihood that EU residents and travellers to the EVD-affected countries will be exposed to infected or ill persons. The risk of infection for residents and visitors in the affected countries through exposure in the community is considered low if they adhere to the recommended precautions. Residents and visitors to the affected areas run a risk of exposure to EVD in healthcare facilities. The level of this risk is related to how well the infection control measures are being implemented in these settings and the nature of the care required. As the epidemic is still evolving and more international staff are deployed to the affected countries to support the epidemic control, there remains a risk of importation of EVD cases to the EU. The risk of Ebola virus spreading from an EVD patient who arrives in the EU as result of a planned medical evacuation is considered to be low when appropriate measures are strictly adhered to, but cannot be excluded in exceptional circumstances. If a symptomatic case of EVD presents in an EU Member State, secondary transmission to caregivers in the family and in healthcare facilities cannot be excluded. The highest risk is at an early stage of the disease, before the risk of EVD has been recognised, and at the late stage of the disease when patients have very high viral loads and undergo invasive therapeutic procedures.

Actions

An epidemiological update is published weekly on the EVD ECDC page.
On 4 December 2014, EFSA-ECDC published a Scientific report assessing Risk related to household pets in contact with Ebola cases in humans.
On 18 November 2014, ECDC published an updated rapid risk assessment.
On 10 September 2014, ECDC published an EU case definition.
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 6 October 2014, ECDC published risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU.
On 13 October 2014, ECDC published Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures.
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 23 October 2014, ECDC published Public health management of persons having had contact with Ebola virus disease cases in the EU.
On 29 October 2014, ECDC published a training tool on the safe use of PPE and options for preparing for gatherings in the EU

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Distribution of cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (as of week 04/2015)

Source: Adapted from national situation reports

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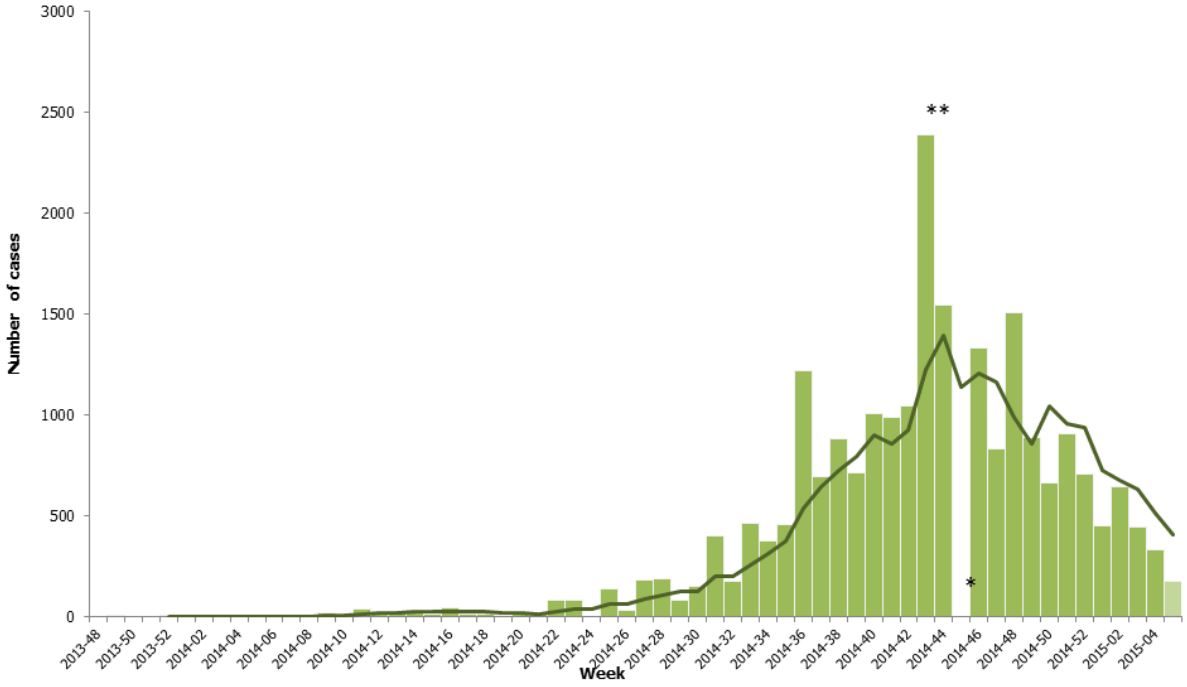
Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Mali, Nigeria and Senegal, weeks 48/2013 to 05*/2015

Source: Adapted from WHO figures; *data for week 05/2015 are incomplete



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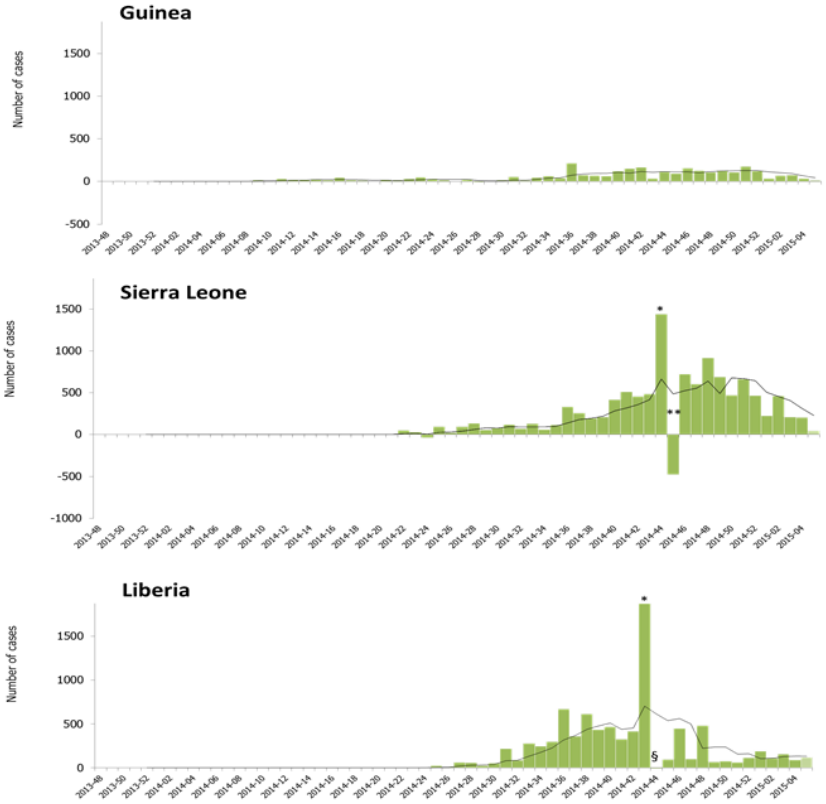
Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 05* 2015

Source: Adapted from WHO figures; *data for week 05/2015 are incomplete



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

Opening date: 24 September 2012 Latest update: 22 January 2015

Epidemiological summary

Since April 2012 and as of 29 January 2015, 983 cases of MERS-CoV have been reported by local health authorities worldwide, including 400 deaths. The distribution is as follows:

Confirmed cases and deaths by region:
Middle East
Saudi Arabia: 843 cases/364 deaths
United Arab Emirates: 73 cases/9 deaths
Qatar: 9 cases/4 deaths
Jordan: 19 cases/6 deaths
Oman: 5 cases/3 deaths
Kuwait: 3 cases/1 death

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Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths
Iran: 5 cases/2 deaths

Europe
Turkey: 1 case/1 death
UK: 4 cases/3 deaths
Germany: 2 cases/1 death
France: 2 cases/1 death
Italy: 1 case/0 deaths
Greece: 1 case/1 death
Netherlands: 2 cases/0 deaths
Austria: 1 case/0 deaths

Africa
Tunisia: 3 cases/1 death
Algeria: 2 cases/1 death

Asia
Malaysia: 1 case/1 death
Philippines: 1 case/0 deaths

Americas
United States of America: 2 cases/0 deaths

Web sources: ECDC's latest rapid risk assessment | ECDC novel coronavirus webpage | WHO | WHO MERS updates | WHO travel health update | WHO Euro MERS updates | CDC MERS | Saudi Arabia MoH | ECDC factsheet for professionals

ECDC assessment

The source of MERS-CoV infection and the mode of transmission have not been identified. Dromedary camels are a host species for the virus, and many of the primary cases in MERS-CoV clusters have reported direct or indirect camel exposure. There is therefore a continued risk of cases presenting in Europe following exposure in the Middle East and international surveillance for MERS-CoV cases remains essential.

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

Actions

ECDC published an epidemiological update on 6 November 2014.
The last rapid risk assessment was updated on 21 January 2015.
ECDC is closely monitoring the situation in collaboration with WHO and EU Member States.
ECDC published a factsheet for health professionals regarding MERS-CoV on 20 August 2014.

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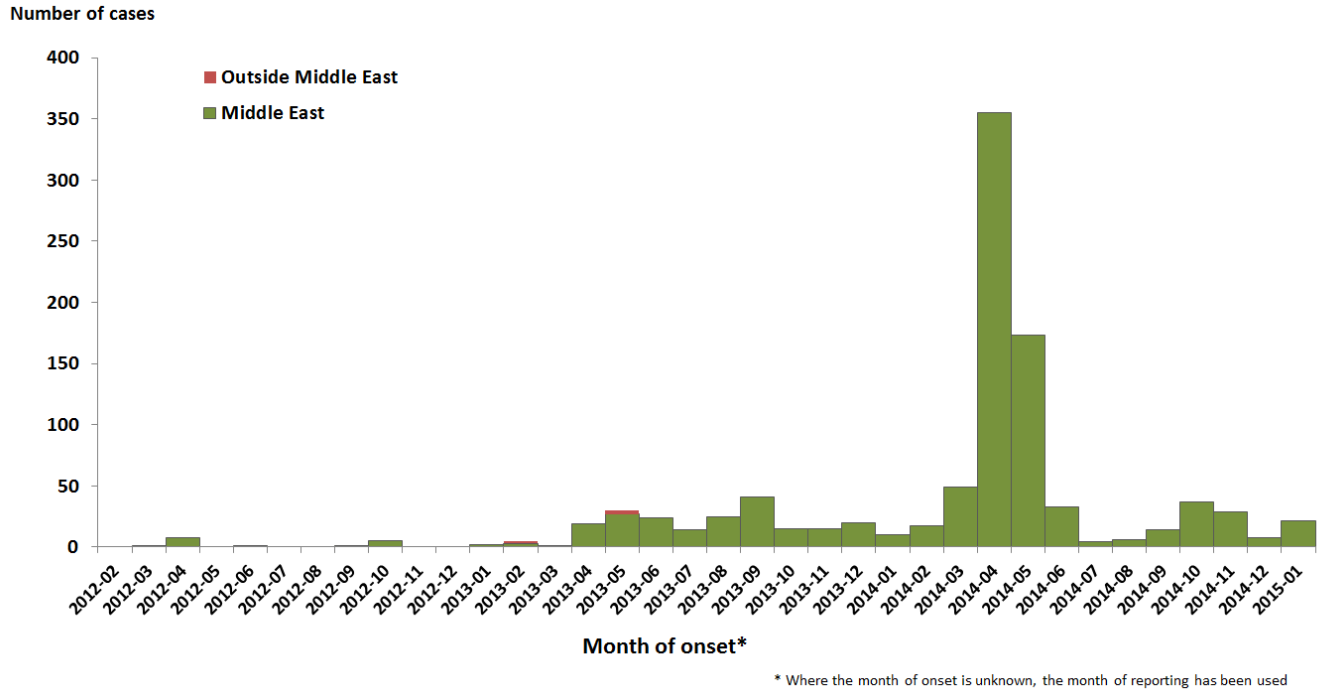
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 29 January 2015 (n=983)

Source: ECDC



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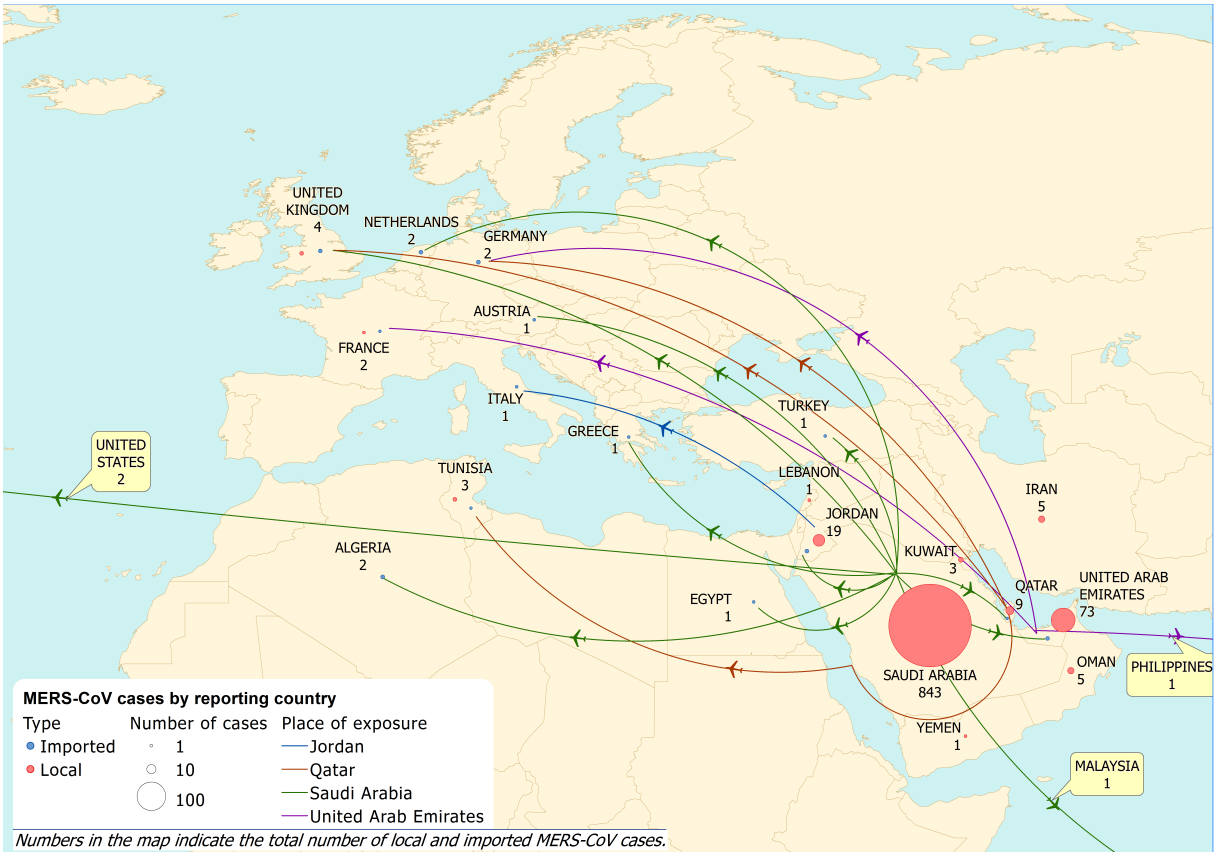
Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 29 January 2015 (n=983)

Source: ECDC



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

Plague outbreak - Madagascar - 2014 - 2015

Opening date: 24 November 2014 Latest update: 29 January 2015

Epidemiological summary

Since 1 September 2014 and as of 8 January 2015, health authorities in Madagascar have reported 220 cases, including 61 deaths, due to plague. Of the 220 cases, 11 (5%) are pulmonary plague. Cases have been reported in 23 out of 136 districts in different regions.

Two confirmed and 13 suspected cases have been reported in the capital Antananarivo during the outbreak.

Web sources: WHO | Media | InVS |

ECDC assessment

Cases of bubonic and pneumonic plague are not unexpected events in Madagascar. However, the recent occurrence of cases in the capital city highlights the risk of a rapid spread of the disease when occuring in densely populated areas with poor sanitation

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and a weak healthcare system. In addition, the resistance of fleas to insecticides, and a recent tropical cyclone which brought floods, sparked internal population movements in mid-January and are jeopardising the response.

According to ECDC the risk of contracting plague for EU travellers to the affected area in Madagascar is very low if they avoid contact with rats and fleas.

Actions

ECDC published a rapid risk assessment on 5 December 2014.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 29 January 2015

Epidemiological summary

Worldwide in 2014, 356 cases had been reported to WHO, compared with 416 in 2013. In 2014, nine countries reported cases: Pakistan (303 cases), Afghanistan (28 cases), Nigeria (6 cases), Equatorial Guinea (5 cases), Somalia (5 cases), Cameroon (5 cases), Iraq (2 cases), Syria (1 case), and Ethiopia (1 case). There have been three cases reported so far in 2015 (compared with 6 for the same period in 2014).

After the declaration of a PHEIC, WHO issued a set of Temporary Recommendations that call for the vaccination of all residents in, and long-term visitors to, countries with polio transmission prior to international travel.

Web sources: Polio Eradication: weekly update | MedISys Poliomyelitis | ECDC Poliomyelitis factsheet |Temporary Recommendations to Reduce International Spread of Poliovirus

ECDC assessment

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

The confirmed circulation of WPV in several countries and the documented exportation of WPV to other countries support the fact that there is a potential risk for WPV being re-introduced to the EU/EEA. The highest risk of large poliomyelitis outbreaks occurs in areas with clusters of unvaccinated populations and in people living in poor sanitary conditions, or a combination of the two.

References: ECDC latest RRA | Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA | Wild-type poliovirus 1 transmission in Israel - what is the risk to the EU/EEA? | WHO statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus, 5 May 2014 | WHO statement on the third meeting of the International Health Regulations Emergency Committee regarding the international spread of wild poliovirus, 14 November 2014

Actions

ECDC follows reports of polio cases worldwide through epidemic intelligence in order to highlight polio eradication efforts and identify events that increase the risk of wild poliovirus being re-introduced to the EU.

Following the declaration of polio as a PHEIC, ECDC updated its risk assessment. ECDC has also prepared a background document with travel recommendations for the EU.

On 4 September 2014, ECDC published a news item regarding the WHO IHR Emergency Committee decision to add Equatorial Guinea as a wild-poliovirus-exporting country and the renewal of the WHO PHEIC recommendations.

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

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