COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 44, 29 October-4 November 2017

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Influenza – Multistate (Europe) – Monitoring season 2017/2018

Opening date: 11 October 2017 Latest update: 3 November 2017

Influenza transmission in Europe shows a seasonal pattern, with peak activity during the winter months.

➔Update of the week

Update Week 2017-43 (23 to 29 October 2017)

The intensity of the influenza activity in Europe is still low. Sporadic or local influenza virus detections were reported by 10 out of 38 countries. Overall, 2.5% of sentinel specimens tested positive for influenza virus. Data from the 19 countries or regions reporting to the EuroMOMO project indicated that all-cause mortality was at expected levels for this time of the year.

Additional information on global influenza activity is available from WHO's biweekly global updates.

Travel-associated Legionnaires' disease - Palmanova area, Spain - 2017

Opening date: 11 October 2017 Latest update: 3 November 2017

A rapidly evolving cluster of travel-associated Legionnaires' disease (TALD) involving 22 cases with a travel history to the Palmanova area in Mallorca, Spain, has been reported to the European Legionnaires' Disease Surveillance Network (ELDSNet).

➔Update of the week

Since the previous report (27 October 2017), the United Kingdom and Sweden reported one case each of travel-associated legionnaires' disease with date of onset on 5 and 17 October, respectively. Both had travelled to Palmanova, Mallorca, Spain.

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West Nile virus – Multistate (Europe) – Monitoring season 2017

Opening date: 30 May 2017 Latest update: 3 November 2017

During the West Nile virus transmission season (June to November), ECDC monitors the occurrence of cases of West Nile fever in the EU Member States and neighbouring countries on a weekly basis in order to inform blood safety authorities about areas with ongoing virus transmission. In 2016, 225 human cases of West Nile fever were reported in EU Member States, and 267 cases were reported in the neighbouring countries.

➔Update of the week

Between 26 October and 2 November 2017, Hungary reported one case in Budapest. Eleven new cases were reported by Israel. All cases were notified in areas already considered to be affected.
In addition, Hungary reported one death due to West Nile fever in a previously reported case.

No equine West Nile fever cases were reported through the Animal Disease Notification System (ADNS) of the European Commission.

Sources: TESSy and ADNS

Chikungunya - Europe - 2017

Opening date: 15 September 2017 Latest update: 3 November 2017

Since August 2017, both France and Italy have reported autochthonous transmission of chikungunya virus. In France, the Var department is affected while in Italy, the Lazio and Calabria regions reported autochthonous transmission. The two events involve strains of different origin and are therefore not related.

➔Update of the week

As of 27 October 2017, the Ministry of Health in Italy reports 331 cases in Lazio region, 176 of which are confirmed. Guardavalle marina, Calabria region, reports 63 cases 45 of which are confirmed. The latest date of onset in the Lazio region was 17 October while in the Calabria region the latest date of onset was 9 October. In addition, the Emilia-Romagna region reports one probable case. The case has a travel history to Rome.

Since the previous CDTR and as of 3 November 2017, France has not reported any additional chikungunya cases.

Non EU Threats

Malaria – Cape Verde – 2017

Opening date: 10 August 2017 Latest update: 3 November 2017

In July 2017, Cape Verde reported a sudden increase in malaria cases. According to WHO, Cape Verde is categorised as having a 'very limited risk of malaria transmission area', with limited local transmission from September to November, coinciding with the rainy season.

➔Update of the week

Since July 2017 and as of 29 October, the Ministry of Health in Cape Verde reported 398 cases of malaria. This is an increase of 98 cases since the previous report, which is dated 15 October 2017.

Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013 Latest update: 3 November 2017

In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then, cases continue to be reported from China. 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

No new cases have been reported since 15 September 2017.

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

Opening date: 24 September 2012 Latest update: 3 November 2017

Since the disease was first identified in Saudi Arabia in September 2012, approximately 2 000 MERS-CoV cases have been detected in over 20 countries. In Europe, eight countries have reported confirmed cases, all with direct or indirect connection with the Middle East. The majority of MERS-CoV cases continue to be reported from the Middle East. The source of the virus remains unknown, but the pattern of transmission and virological studies point towards dromedary camels in the Middle East as being a reservoir from which humans sporadically become infected through zoonotic transmission. Human-to-human transmission is amplified among household contacts and in healthcare settings.

➔Update of the week

Between 3 and 31 October 2017, Saudi Arabia reported ten primary MERS-CoV cases. Of the ten cases, nine were male and one was female. Eight of the ten primary cases reported direct or indirect contact with camels; for two cases the exposure is unknown.

Sources: WHO | MoH Saudi Arabia

Plague - Madagascar - 2017

Opening date: 15 September 2017 Latest update: 3 November 2017

An outbreak of plague in Madagascar began in August 2017 and expanded rapidly. More than half of the cases reported are due to pneumonic plague. The number of cases and deaths exceeds the previous outbreaks and the majority of the cases have been recorded in the capital of Antananarivo and the main port of Toamasina, the largest cities in Madagascar.

➔Update of the week

According to the WHO Regional Office for Africa, there have been 1 801 cases and 127 deaths (CFR: 7.1%) due to plague in Madagascar in 2017 (as of 30 October 2017). Among the 1 801 cases, 1 111 are pneumonic, 261 are bubonic, one is septicaemic and 428 are unspecified. Of the 1 111 pneumonic plague cases, 257 were confirmed, 374 are classified as probable, and 480 are suspected cases. Due to the ongoing reclassification process in Madagascar the distribution of cases may vary in the following updates. So far, the plague has affected 71 healthcare workers. Overall, 16 of the 22 regions of Madagascar have been affected (51 of 114 districts). Analamanga region has been the most affected, with 1 149 of all recorded cases.

Travel-associated Legionnaires' disease – Dubai, UAE – 2016/2017

Opening date: 10 November 2016 Latest update: 3 November 2017

In October 2016, ECDC observed an increase in the number of cases of Legionnaires' disease associated with travel (TALD) to Dubai, United Arab Emirates (UAE). In the last months, TALD cases associated with travel to Dubai have returned to the baseline values observed from 2012 through 2016.

➔Update of the week

On 30 October 2017, the United Kingdom reported an additional case of travel-associated legionnaires' disease with travel history to Dubai. The case stayed in a commercial accommodation in Dubai from 29 September to 5 October and fell ill on 6 October 2017.

Poliomyelitis – Multistate (World) – Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 3 November 2017

Global public health efforts are ongoing to eradicate polio 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 3 August 2017, WHO agreed that the spread of poliovirus remains a public health event of international concern and extended the temporary recommendations for an additional three months. The last locally-acquired wild polio cases within the current EU borders were reported from Bulgaria in 2001. In June 2002, the WHO European Region was officially declared polio-free.

➔Update of the week

Since the last CDTR on 6 October 2017 and as of 25 October 2017, Afghanistan has reported two cases of new wild poliovirus type 1 (WPV1). Syria has reported six cases. The Democratic Republic of the Congo (DRC) reported one case of type 2 circulating vaccine-derived poliovirus (cVDPV2). In 2017, as of 25 October, 13 wild poliovirus cases have been reported, eight cases from Afghanistan and five cases from Pakistan. In addition, 63 circulating cVDPV2 cases have been reported in 2017, ten from the Democratic Republic of Congo and 53 from Syria.

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II. Detailed reports

Influenza – Multistate (Europe) – Monitoring season 2017/2018

Opening date: 11 October 2017 Latest update: 3 November 2017

Epidemiological summary

2017/18 season overview

Since week 40/2017, only few influenza viruses have been detected in sentinel specimens.

Because of changes in A(H3N2) influenza viruses that were circulating in the 2017 southern hemisphere season and reports of low vaccine effectiveness against this strain, WHO recently recommended changing the A(H3N2) component in seasonal influenza vaccines for use in the 2018 southern hemisphere influenza season. In addition, the influenza B lineage in trivalent vaccines was changed to a B/Yamagata-lineage virus. This represents two changes compared to the current trivalent vaccine recommended for the 2017–2018 northern hemisphere influenza season. See also the ECDC summary report for September and the ECDC commentary.

A report on the antigenic and genetic characteristics of zoonotic influenza viruses and development of candidate vaccine viruses developed for potential use in human vaccines is available here.

ECDC assessment

As is usual for this time of year, influenza activity is low in the European Region.

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 on the ECDC website and on the WHO Regional Office for Europe website.

Travel-associated Legionnaires' disease - Palmanova area, Spain - 2017

Opening date: 11 October 2017 Latest update: 3 November 2017

Epidemiological summary

A Legionnaires' disease outbreak has been detected in Palmanova, Mallorca, Spain. As of 2 November, 24 travel-associated cases were reported to ELDSNet, with onset dates from 11 September to 17 October 2017. The cases, 14 men and ten women, are between 46 and 87 years old and were in Palmanova two to ten days before falling ill.
An additional case of Legionnaires' disease is reported in an employee at a hotel not associated with any TALD cases. The 24 cases stayed in nine accommodations in Palmanova. One accommodation is associated with ten cases, and two accommodations are associated with three cases each. Two hotels are associated with two cases each. Four cases stayed in hotels in Palmanova not associated with other cases. The majority of travel-associated cases are from the United Kingdom (19 cases), but cases are also from France (two cases), the Czech Republic (one case), Denmark (one case) and Sweden (one case). ELDSNet contact points and tour operators are informed, and the Spanish health authorities are currently conducting follow-ups.

ECDC assessment

According to ELDSNet data, the number of reported TALD cases with an association to an accommodation site in Palmanova is about one to four cases per year.
The clustering of TALD cases in this short time period and the involvement of several accommodation sites indicate a community outbreak. The case reported in a local resident working in a hotel not previously identified among the travel-associated cases is a further indicator that this is a community outbreak in a limited geographical area of Palmanova.

Actions

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Network members and tour operators subscribing to ELDSNet updates have been informed. ECDC continues to monitor this event through the ELDSNet surveillance scheme. ECDC published a rapid risk assessment on 23 October 2017.

West Nile virus – Multistate (Europe) – Monitoring season 2017

Opening date: 30 May 2017 Latest update: 3 November 2017

Epidemiological summary

Since the beginning of the 2017 transmission season and as of 2 November 2017, the EU Member States reported 198 cases: Romania (64 cases), Italy (55), Greece (48), Hungary (20), Croatia (5), Austria (4), France (1) and Bulgaria (1). Eighty-two cases were reported in neighbouring countries: Serbia (49), Turkey (5) and Israel (28).

Twenty-five deaths due to West Nile fever have been reported since the start of the transmission season: Romania (13 deaths), Greece (5), Hungary (2), Italy (1), Croatia (1), Serbia (2) and Turkey (1).

In equids, EU Member States reported 121 West Nile fever cases through ADNS: 96 in Italy, 14 in Greece, five in Spain, three in Hungary, two in Austria, and one in Portugal.

ECDC link: ECDC West Nile fever web page | ECDC: equine West Nile fever web page | ECDC atlas
Sources: TESSy and ADNS

ECDC assessment

The current West Nile fever epidemiological situation is consistent with observations of seasonal virus transmission from previous years. In accordance with Commission Directive 2014/110/EU, prospective donors should be deferred for 28 days after leaving a risk area for locally-acquired West Nile virus unless the results of an individual nucleic acid test (NAT) are negative.

Actions

Since 6 October 2017, ECDC has been publishing three types of West Nile fever maps: 1) human West Nile fever cases; 2) equine West Nile fever cases; 3) combined human and equine West Nile fever cases. Human cases are collected through The European Surveillance System (TESSy) and equine cases are collected through the Animal Disease Notification System (ADNS) of the European Commission. While the distribution of human cases covers EU/EEA countries and neighbouring countries, equine cases cover only EU/EEA countries.

Following a One Health approach, the new maps aim to highlight areas, at the NUTS3 level, where West Nile virus circulates in incidental hosts. Currently, deferral or testing of prospective donors applies to blood donors leaving areas with one or more autochthonous human West Nile virus cases. This set of maps aims to provide better information for European Union Member States so that they can implement preventive measures.

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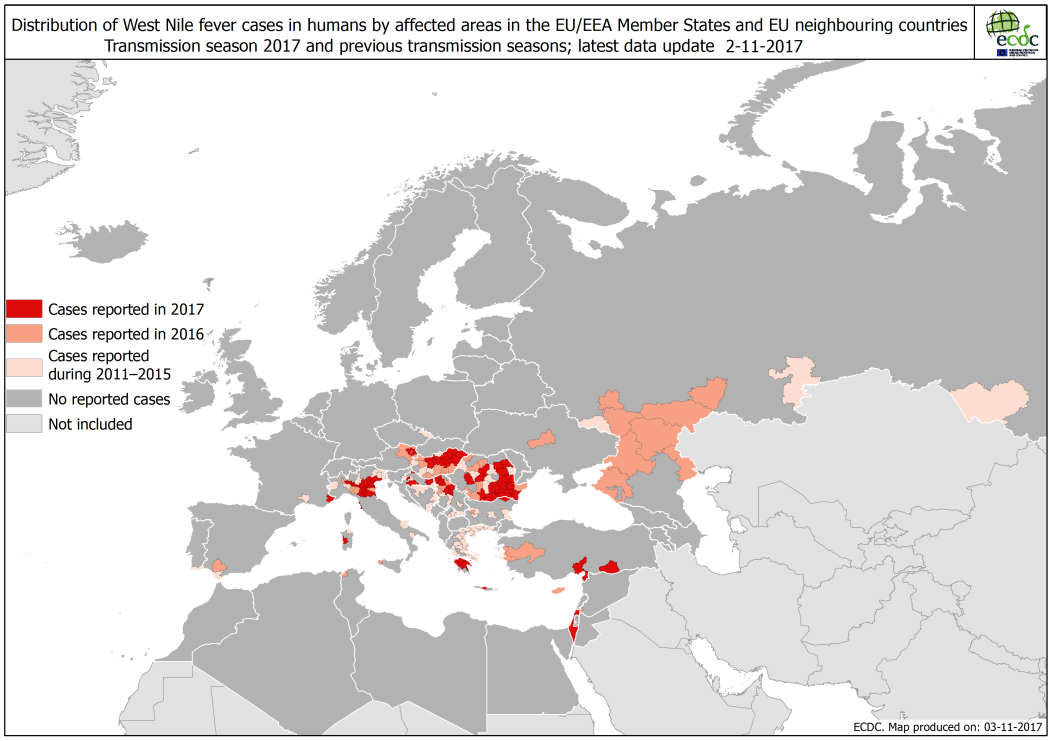
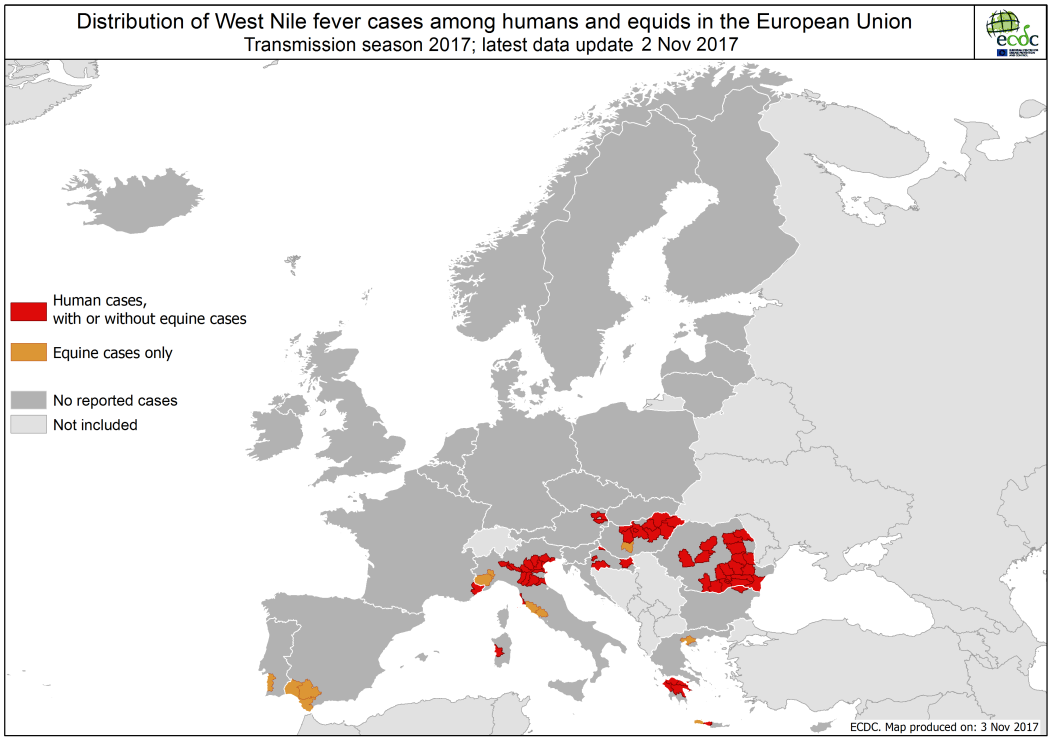
Distribution of human West Nile fever cases by affected areas as of 2 November 2017.

ECDC



Distribution of West Nile fever cases among humans and equids in the EU as of 2 November 2017.

TESSy and ADNS



Distribution of West Nile fever cases among equids in the EU as of 2 November 2017.

ADNS

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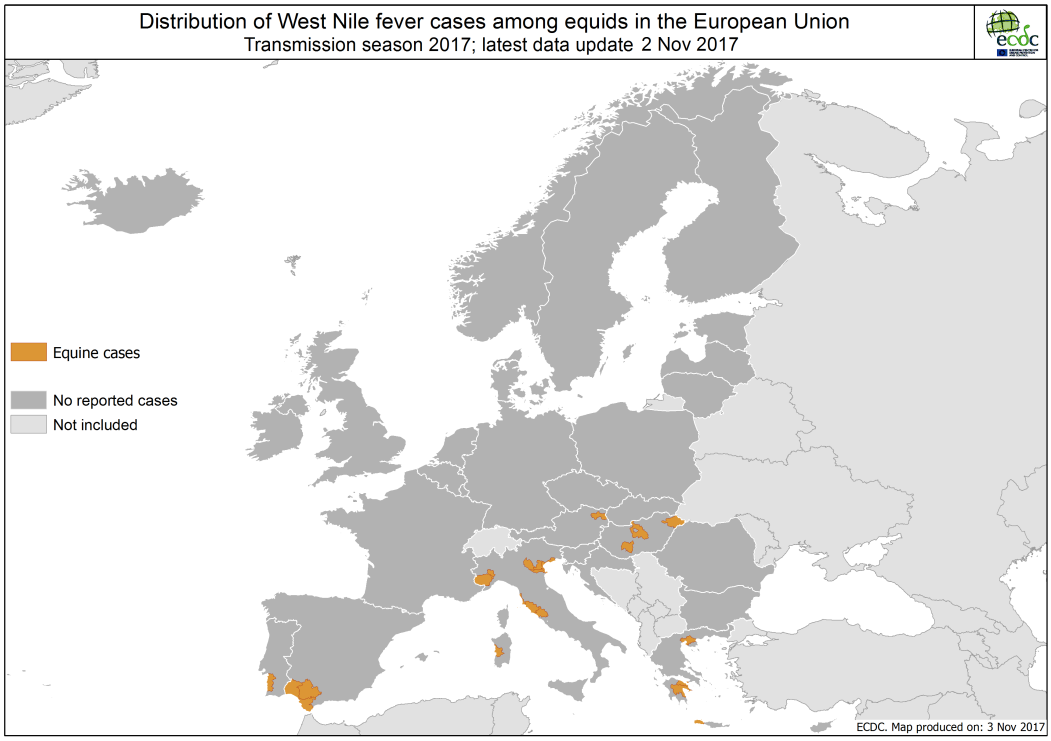

Chikungunya - Europe - 2017

Opening date: 15 September 2017 Latest update: 3 November 2017

Epidemiological summary

The two events described below in France and in Italy are two distinct events. There is epidemiological and microbiological evidence highlighting the fact that the clusters in France and in Italy are not related.

On 11 August 2017, France reported through the EWRS an outbreak of autochthonous chikungunya cases in the Var department, southern France. As of 27 October 2017, France has reported two clusters including 17 cases. The first cluster, in Cannet-des-Maures, includes eleven cases (eight confirmed, two probable and one suspected). The second cluster, in Taradeau, includes six confirmed cases. Taradeau commune is 13 kilometres away from Cannet-des-Maures. There is an epidemiological link between the cases in Taradeau and Cannet-des-Maures, indicating that the two clusters are related. As stated in the Eurosurveillance article 'Preliminary report of an autochthonous chikungunya outbreak in France, July to September 2017' published 28 September 2017, the virus circulating in France belongs to an East Central South African (ECSA) sub-lineage that includes isolates from the Central African region (e.g. Gabon, Republic of Congo). The virus isolated from the index patient is carrying the E1-A226V mutation. Full genome analysis is ongoing and the sequence will be submitted to GenBank.

As of 27 October 2017, Italy has reported 402 cases of chikungunya. Of these, 331 cases have been reported in the Lazio region, 175 of which are confirmed, and 63 were reported in Guardavalle marina, Calabria region (45 of the 63 cases are confirmed). In addition, three confirmed cases with a travel history to Anzio have been reported in Emilia-Romagna (1), Marche (1) and France (1). One confirmed case with travel history to Rome was reported in Germany. Furthermore, four probable cases with travel history to Guardavalle marina (3) and Rome (1) were reported in Emilia-Romagna. As stated in an Eurosurveillance article entitled 'Detection of a chikungunya outbreak in Central Italy, August to September 2017' (published 28 September 2017), the virus circulating in Italy belongs to the East Central South African (ECSA) lineage and does not carry the E1-A226V mutation. The outbreak sequence is available in GenBank.

Sources: Lazio Region | MoH Italy | ISS | France MoH
ECDC links: Rapid risk assessment on cluster of autochthonous chikungunya cases in France | Rapid risk assessment on clusters of autochthonous chikungunya cases in Italy

ECDC assessment

The two outbreaks in France and Italy are unrelated and result from separate introductions of the virus, probably from Africa and Asia, respectively. Having concurrent, distinct outbreaks of chikungunya in France and Italy highlights that the environmental conditions in 2017 are favourable for the local transmission of introduced chikungunya virus strains.

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In France, response measures, including vector control, have been implemented. The fact that the strain harbours the E1-A226V mutation may explain the relatively larger number of autochthonous cases observed this year compared to the 2010 outbreak in the same region (i.e. two cases reported in 2010). The conclusions of the latest ECDC rapid risk assessment published on 24 August 2017 ('Cluster of autochthonous chikungunya cases in France') remain valid.

In Italy, this is the first known transmission of chikungunya in central and southern Italy. In the absence of herd immunity, most of the inhabitants should be considered as susceptible to chikungunya virus disease. In the areas already affected, more cases can be expected to be identified in the near future. There is a low likelihood of the virus being introduced to other EU countries. There is an equally low likelihood of subsequent local transmission in other EU countries where *Aedes albopictus* is present and active.

Actions

ECDC has published a rapid risk assessment on the cluster of autochthonous chikungunya cases in France on 24 August 2017 and a rapid risk assessment on the clusters of autochthonous chikungunya cases in Italy on 14 September 2017. ECDC published the first update of the risk assessment on the clusters of autochthonous chikungunya cases in Italy on 9 October 2017.

Malaria – Cape Verde – 2017

Opening date: 10 August 2017 Latest update: 3 November 2017

Epidemiological summary

In July 2017, Cape Verde reported a sudden increase in the number of malaria cases. According to WHO, Cape Verde is categorised as a 'very limited risk of malaria transmission area', with limited local transmission from September to November, coinciding with the rainy season. As of 29 October 2017, 398 cases are reported. The epicentre of the outbreak is located in the capital city of Praia in Santiago Island.

The UK National Travel Health Network and Centre (NaTHNaC) updated the travel recommendation on 5 September, stating that there was a 'very low' risk of malaria on the Island of Santiago (Sao Tiago), except in the city of Praia where the risk had risen to 'low'. For all travellers, bite avoidance is recommended. Also, travellers should be me made aware of the risk. Travellers to the city of Praia who are at a higher risk of malaria (such as long-term travellers, or those who are at risk of severe complications from malaria, e.g. pregnant women, infants and young children, the elderly, and travellers who do not have a functioning spleen) should consider taking chemoprophylaxis with atovaquone-proguanil, doxycycline or mefloquine.

Background: According to WHO, the risk of malaria for Cape Verde is considered 'type A' (very limited risk of malaria transmission). The most recent major outbreaks were reported in 1999 (140 cases) and 2001 (95 cases). In the past ten years, autochthonous cases in Praia have not exceeded 30 per year.

ECDC link: ECDC malaria page
Sources: Cape Verde Ministry of Health | WHO| NaTHNaC | Portugal | media | media

ECDC assessment

The increase of autochthonous malaria cases in Cape Verde during the rainy season, between August and November, is of concern. More cases are likely to be reported in the coming weeks. EU Member States should consider to reinforce malaria prevention measures for travellers.

Actions

ECDC is monitoring this event through epidemic intelligence.

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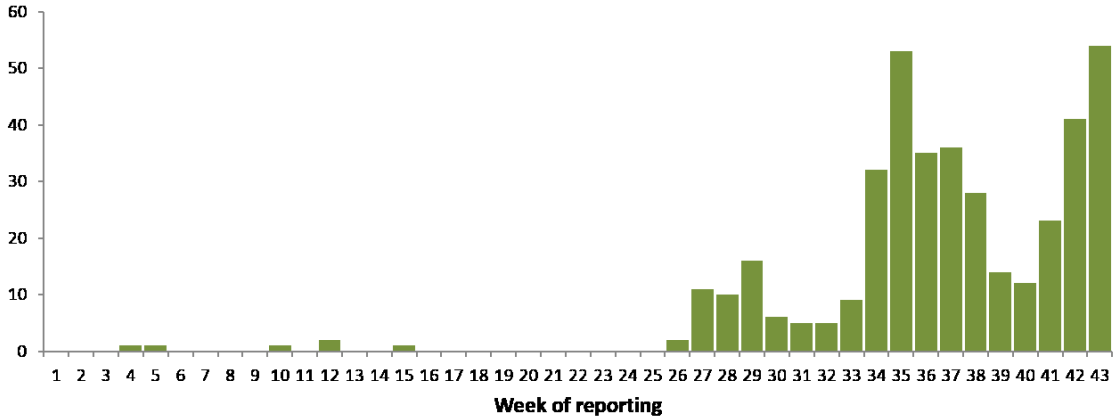
Number of autochthonous malaria cases by week of reporting as of week 43 - 2017, Cape Verde

MoH Cape Verde



Influenza A(H7N9) – China – Monitoring human cases

Opening date: 31 March 2013 Latest update: 3 November 2017

Epidemiological summary

According to WHO WPRO, 27 human cases with highly pathogenic avian influenza (HPAI) A(H7N9) virus were reported during the fifth wave. In March 2013, a novel avian influenza A(H7N9) virus was detected in patients in China. Since then and up to 31 October 2017, 1 564 cases have been reported, including 568 deaths. The outbreak shows a seasonal pattern. The first wave in spring 2013 (weeks 2013-7 to 2013-40) resulted in 135 cases, the second wave (weeks 2013-41 to 2014-40) led to 320 cases, the third wave (weeks 2014-41 to 2015-40) caused 223 cases, and 120 cases were reported as a result of the fourth wave (weeks 2015-41 to 2016-40). A fifth wave started in October 2016 (week 2016-41), with 766 cases as of 3 October 2017. The 1 564 cases were reported from Zhejiang (310), Guangdong (258), Jiangsu (253), Fujian (108), Anhui (101), Hunan (95), Shanghai (56), Jiangxi (50), Sichuan (38), Beijing (35), Guangxi (32), Hubei (31), Hebei (29), Henan (28), Shandong (27), Hong Kong (21), Guizhou (20), Xinjiang (13), Chongqing (9), Gansu (5), Shaanxi (7), Yunnan (7), Taiwan (5), Tianjin (5), Liaoning (5), Jilin (3), Tibet (3), Shanxi (3), Inner Mongolia (2), and Macau (2). Three imported cases were reported in Canada (2) and Malaysia (1).

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ECDC links: Zoonotic influenza web page | ECDC rapid risk assessment Influenza A(H7N9) virus in China - implications for public health - 7th update, 3 July 2017
Sources: Chinese CDC | Hong Kong CHP | WHO | WHO FAQ page | ECDC

ECDC assessment

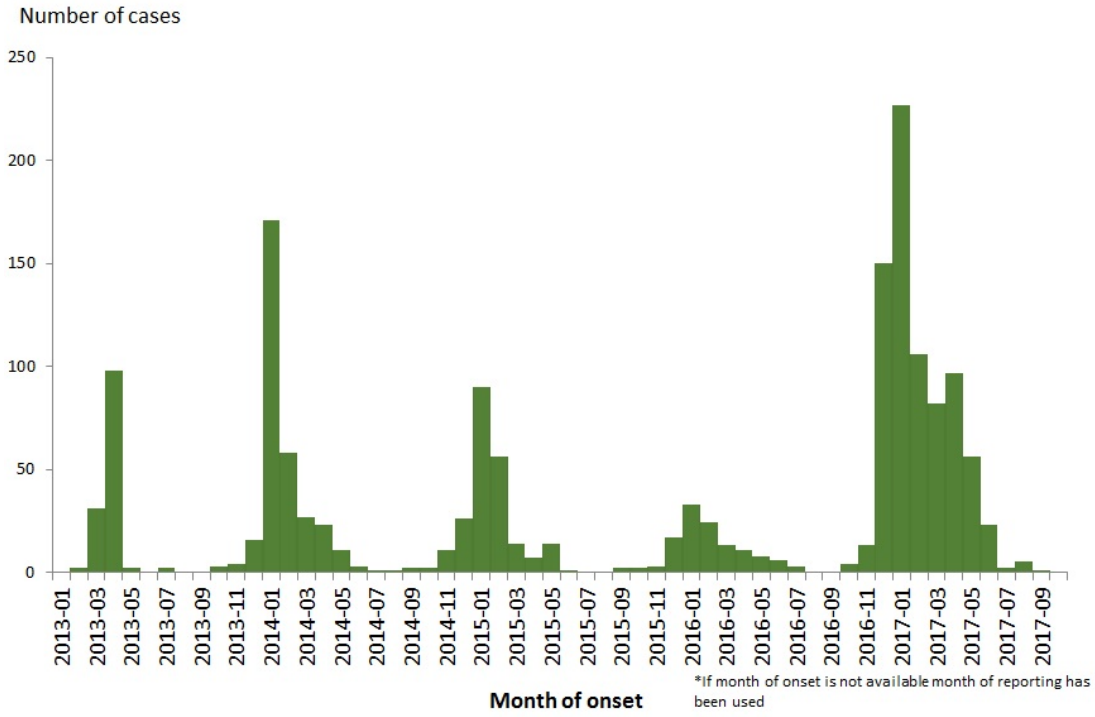
During the fifth wave, the number of human cases was higher than in previous waves. This is most likely due to greater environmental contamination in live bird markets and increased circulation of the virus among poultry. In contrast to the situation observed during the summer months in previous years, influenza A(H7N9) viruses are continuously circulating in the poultry population, with transmission to humans causing a substantial number of cases.
During the fifth wave, a new influenza A(H7N9) virus was detected, with mutations in the haemagglutinin gene, indicating high pathogenicity in poultry. This resulted in 27 human cases from Guangdong, Guangxi, Hebei, Hunan, Shaanxi and Taiwan (the case had travel history to Guangdong) with illness onset date before July 2017. It is unclear at the moment whether the newly emerged, highly-pathogenic avian influenza virus A(H7N9) will replace the low-pathogenic virus or if both will co-circulate in the bird population. Although the genetic changes in influenza A(H7N9) may have implications for poultry in terms of pathogenicity, there is no evidence to date of increased transmissibility to humans or sustainable human-to-human transmission.
The possibility of humans infected with influenza A(H7N9) returning to the EU/EEA cannot be excluded. However, the risk of the disease spreading in Europe through humans is still considered low, as there is no evidence of sustained human-to-human transmission.

Sources: WHO

Actions

ECDC published the seventh update of its rapid risk assessment on 3 July 2017, addressing the genetic evolution of influenza A (H7N9) virus in China and the implications for public health. ECDC monitors this event through epidemic intelligence and will report monthly.

Distribution of confirmed cases of A(H7N9) by first available month, February 2013 to 31 October 2017



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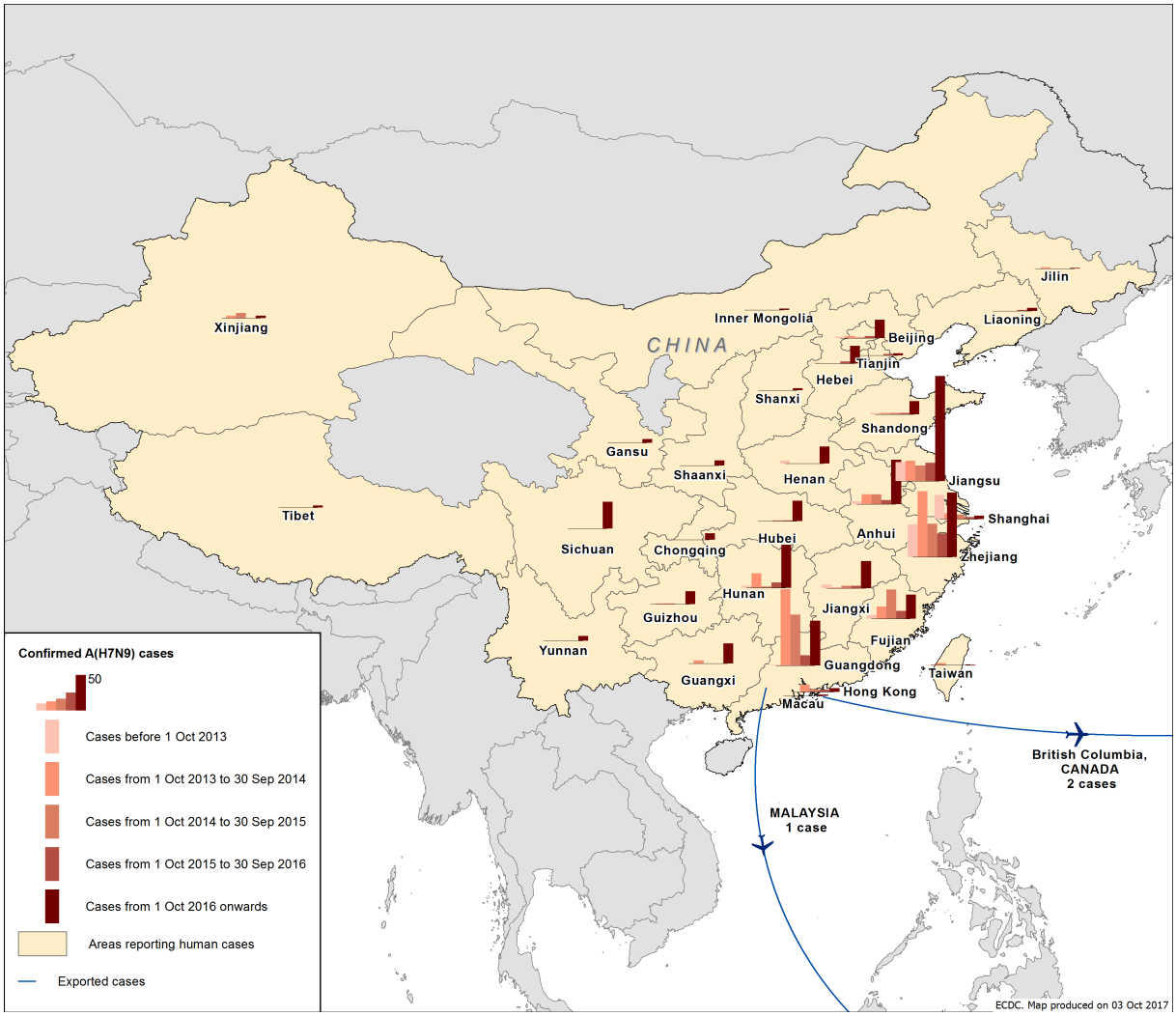
Distribution of confirmed cases of A(H7N9) by five seasons, February 2013 to 3 October 2017

ECDC



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

Opening date: 24 September 2012 Latest update: 3 November 2017

Epidemiological summary

Since April 2012 and as of 31 October 2017, 2 120 cases of MERS, including 792 deaths, have been reported by health authorities worldwide.

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

ECDC assessment

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

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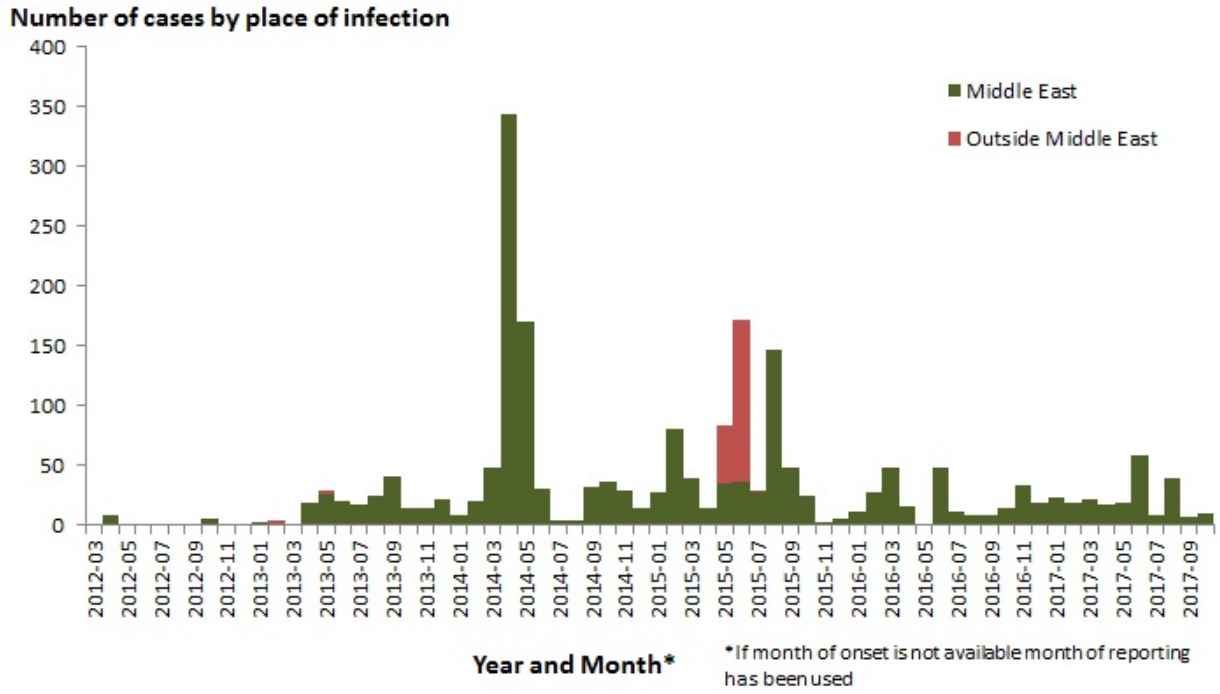
Actions

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

Distribution of confirmed cases of MERS-CoV by first available month and region, March 2012 to 31 October 2017



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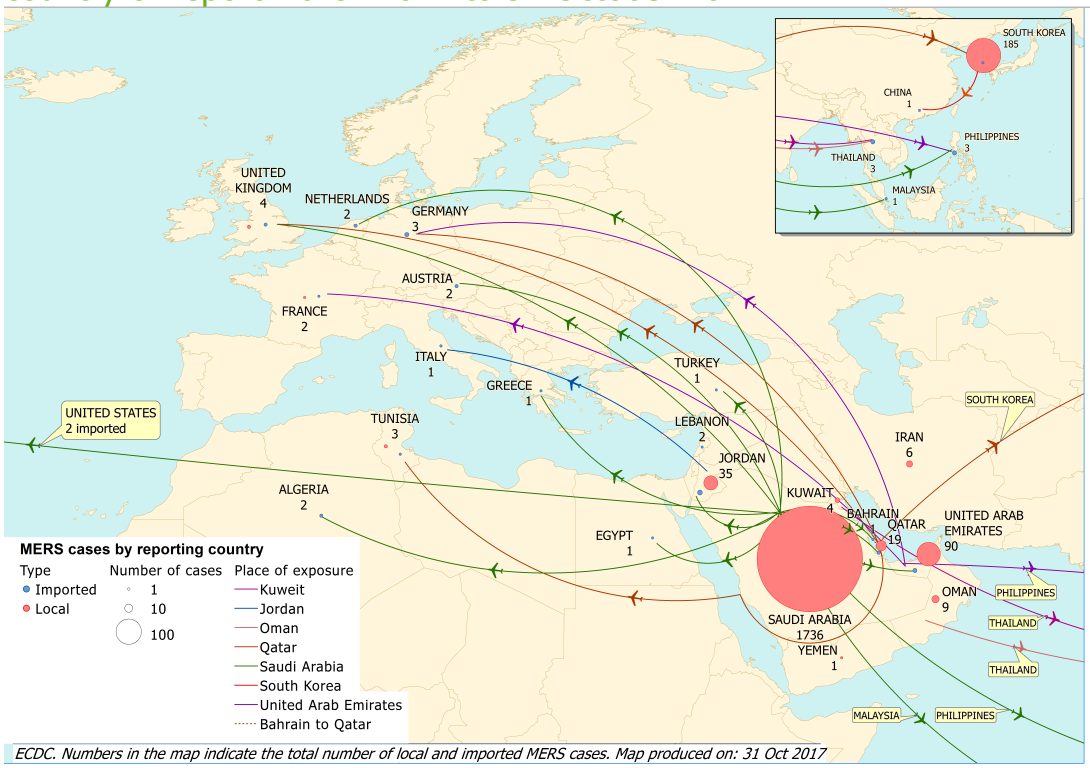
Distribution of confirmed cases of MERS-CoV by country of probable infection and country of report March 2012 to 31 October 2017



ECDC. Numbers in the map indicate the total number of local and imported MERS cases. Map produced on: 31 Oct 2017

Plague - Madagascar - 2017

Opening date: 15 September 2017 Latest update: 3 November 2017

Epidemiological summary

The outbreak began in August 2017 with the death from pneumonic plague of a 31-year-old man who had been travelling in a crowded minibus taxi toward the capital city of Antananarivo in the central highlands. The outbreak was initially recognised on 11 September by local authorities.

Between 1 August and 30 October 2017, WHO has reported 1 801 plague cases, including 127 deaths (CFR: 7.1%). Pneumonic plague accounts for 1 111 cases, bubonic plague for 261 cases, septicaemic plague for one case, and 428 cases remain unspecified. Regarding the 1 111 pneumonic plague cases, 257 have been confirmed, 374 are probable and 480 have been classified as suspected cases.

At least 71 healthcare workers have contracted plague since the beginning of the outbreak. The region of Analamanga, where the capital city of Antananarivo is located, is the most affected. The current pulmonary plague outbreak has affected major urban centres including the capital Antananarivo with three million inhabitants, and the port city of Toamasina with around 275 000 inhabitants on the east coast. In addition, sporadic cases of pneumonic plague without apparent epidemiological links with the initial cluster have been reported in several regions across the country. Overall, 16 of the 22 regions of Madagascar have been affected (51 of 114 districts).

On 10 October, the Ministry of Health of the Seychelles issued a statement about a case of plague in a returning traveller from Madagascar. The case was isolated and received antibiotic treatment. As of 17 October 2017, ten laboratory specimens have been collected from suspected and probable cases. All tested negative by PCR at the WHO Collaborating Centre for plague at the Institute Pasteur in Paris, France. Over 320 contact persons of the index case completed follow-up and monitoring on 13 October 2017, including 41 passengers and seven crew members from the flight to the Seychelles, 12 close family members, and 18 staff and patients from the health centre visited by the index case. All were provided with a prophylactic course of antibiotics to prevent the disease. Overall, 1 223 contacts were registered and followed-up. All contacts that were isolated in the hospital were discharged home, including the index case, and passive surveillance and antibiotic prophylaxis was discontinued for all contacts of the case.
Mauritius, another neighbouring country, identified two suspected plague cases according to local media that tested negative.
To date, no cases outside of Madagascar related to this outbreak have been confirmed for plague.

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ECDC links: Plague factsheet
Sources: WHO Africa, MoH Seychelles, media,

ECDC assessment

While plague outbreaks in Madagascar are not unexpected, the high proportion of pneumonic plague cases is of concern. The current outbreak is the largest in the last decade in Madagascar. The risk of further transmission in the country is considered very high until public health prevention and control measures are fully implemented with the support of the World Health Organization (WHO) and international partners working in the country. The risk of regional spread in the Indian Ocean region is considered moderate.

The risk to travellers from the EU or for importation to the EU is considered low. WHO considers the risk for international spread of plague to be very low and advises against any restrictions to travel and trade with Madagascar based on the information to date. There is no restriction of movement in and out of Antananarivo, where cases have occurred, in accordance with the recommendations of the Malagasy authorities. However, Malagasy authorities are placing sanitary controls on the entry and exit from different cities in order to reduce the risk of epidemic propagation.

According to WHO, prophylactic treatment is only recommended for persons who have been in close contact with plague cases, or who have experienced other high-risk exposure such as flea bites or direct contact with bodily fluids or tissue from infected animals.

Actions

ECDC published a rapid risk assessment on 9 October 2017 and an update on 13 October 2017. On 26 October 2017, ECDC downgraded the PHE level from PHE Level 1 maintenance phase to PHE Level 0 recovery phase.
ECDC has published the below documents:
- Case definition and algorithm for initial assessment and management of cases related to the outbreak of plague in Madagascar
- Information leaflet for travellers to Madagascar
- Guidance for healthcare workers on the use of personal protective equipment in the management of bubonic and pneumonic plague patients
- Guidance for the management of suspected pneumonic plague cases identified on aircraft and ships
- Guidance for the management of suspected bubonic plague cases identified on aircraft and ships

Travel-associated Legionnaires' disease – Dubai, UAE – 2016/2017

Opening date: 10 November 2016 Latest update: 3 November 2017

Epidemiological summary

As of 30 October 2017, 14 EU/EEA/EFTA countries have reported 79 TALD cases with onset of symptoms since 1 October 2016 and with travel history to Dubai within two to ten days prior to illness. Cases were reported by the UK (37), Sweden (8), Germany (7), the Netherlands (7), France (6), Denmark (5), Spain (2), Austria (1), Belgium (1), the Czech Republic (1), Hungary (1), Ireland (1), Italy (1) and Switzerland (1). Seventy cases are associated with commercial accommodation sites and nine with private accommodation sites. Sixteen cases spent time in another location in the UAE or in a country other than their home country during their incubation period. Two cases were reported as fatal. All cases are laboratory confirmed. Nine cases had their infection further characterised through sequence base typing: five strains are identified as *Legionella pneumophila* serogroup 1 sequence type 616 and one as *Legionella pneumophila* serogroup 1 sequence type 2382. Sequence type 616 is uncommon in Europe and has been associated with other cases of Legionnaires' disease returning from Dubai in previous years, while sequence type 2382 is the first such identification worldwide and appears to be closely-related to type 616 (personal communication, ELDSNet network). One strain has been characterised as *Legionella pneumophila* serogroup 2-14 sequence type 1327 and two strains have been characterised as *Legionella pneumophila* serogroup 13 sequence type 1327.

ECDC links: Legionnaires' disease web page | First update of Rapid Risk Assessment Increase of Legionnaires' disease in EU travellers returning from Dubai since October 2016 – 21 September 2017

ECDC assessment

ECDC observed a significant increase in the number of cases of TALD in EU travellers returning from Dubai over the period October 2016 to May 2017 that could not be accounted for by the increase in travel patterns from the EU. The return to the baseline level of TALD in the most recent months suggests that the measures implemented by the UAE were effective in

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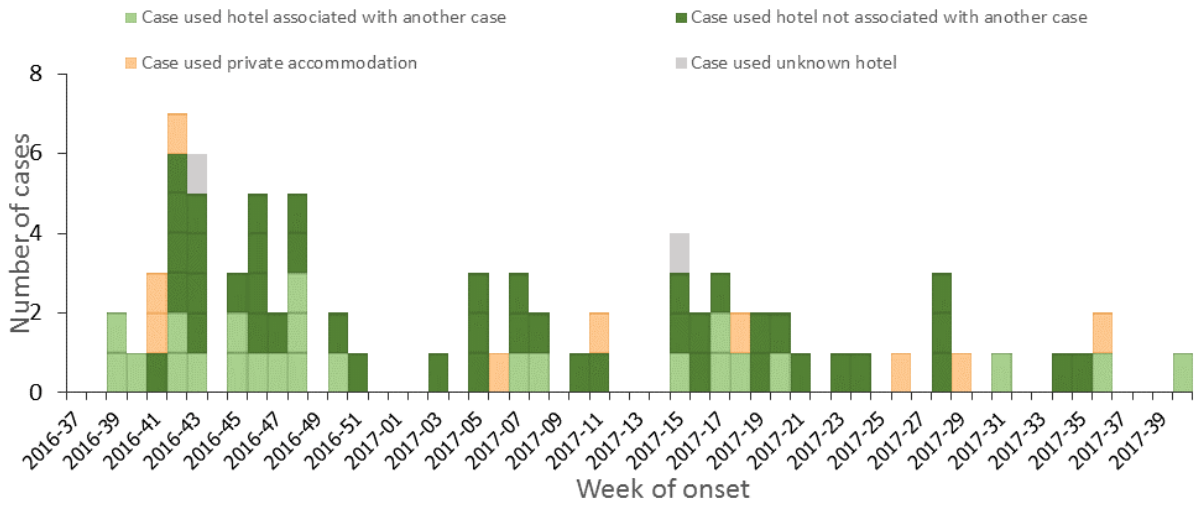
containing this outbreak. However, in the past, the months of October and November were associated with the highest seasonal numbers of TALD notifications over the last few years, particularly in 2016, and additional cases are expected in the coming months.

Actions

ECDC is monitoring this event through ELDSNet. ECDC is in contact with EU Member States, the ELDSNet network, World Health Organization and the United Arab Emirates to share information.
ECDC published the first update of the rapid risk assessment 'Increase of Legionnaires' disease in EU travellers returning from Dubai since October 2016' on 21 September 2017.

Distribution of travel-associated Legionnaires' disease cases with history of stay in Dubai, United Arab Emirates, by week of onset 37-2016 and 40-2017, EU/EFTA Member States

ELDSNet



Poliomyelitis – Multistate (World) – Monitoring global outbreaks

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Opening date: 8 September 2005 Latest update: 3 November 2017

Epidemiological summary

Since the last CDTR on 6 October 2017 and as of 25 October 2017, Afghanistan has reported two new cases of wild poliovirus type 1 (WPV1). Syria has reported six cases. The Democratic Republic of the Congo (DRC) reported one case of type 2 circulating vaccine-derived poliovirus (cVDPV2). As of 25 October 2017, thirteen wild poliovirus cases have been reported, eight cases from Afghanistan and five cases from Pakistan. In 2016, 37 cases were reported during the same period. In 2017, 63 circulating cVDPV2 cases have been reported so far, ten from the Democratic Republic of Congo and 53 from Syria. The onset of paralysis in the Syrian cases was between 3 March and 25 August 2017. Fifty of the cases are from Deir-Ez-Zour governorate (with the bulk of the cases from Mayadeen district), two cases are from Raqqa governorate (one from Talabyad district and one from the newly infected Thawra district), and one is from Homs governorate (Tadmour district). In 2016, only five VDPV2 cases were reported during the same period worldwide.

ECDC links: ECDC poliomyelitis web page | Information to travellers to polio-infected countries
Sources: WHO IHR Emergency Committee | Polio eradication: weekly update

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 cases. Importation of the infection as well as of polio cases in to the EU remains possible.

ECDC links: Rapid Risk Assessment on suspected polio cases in Syria and the risk to the EU/EEA | ECDC poliomyelitis web page

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.

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