COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 16, 14-20 April 2013

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

Hepatitis A - Multistate (Europe) - 2013 outbreak

Opening date: 9 April 2013 Latest update: 18 April 2013

An outbreak of hepatitis A infection has been reported in Denmark, Finland, Norway and Sweden over the last six months, with 68 cases as of 17 April 2013. Twenty-six of the cases were due to genotype 1b with identical RNA sequence. The source of the outbreak has not been identified but epidemiological investigations in the affected countries point towards frozen berries as the vehicle of infection.

➔Update of the week

As of 18 April, the number of cases reported in Denmark is 35 (11 with same RNA sequence), in Sweden 17 (8 with same RNA sequence), in Norway 6 (4 with same RNA sequence), and in Finland 10 (3 with same RNA sequence).

Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 11 April 2013

Measles, a highly transmissible vaccine-preventable disease, is still endemic in many countries of Europe due to a decrease in the uptake of immunisation. More than 30 000 cases were reported in EU Member States in each of 2010 and 2011. However, the number of outbreaks and reported cases in Member States decreased significantly in 2012. The 29 participating EU and EEA countries reported 8 032 cases of measles during the last 12-month period from February 2012 to January 2013. France, Italy, Romania, Spain and the United Kingdom accounted for 94% of all reported cases.

➔Update of the week

The earlier reported measles outbreaks in the north-east of England and in Wales are continuing.
A new outbreak was reported from Berlin, Germany.

Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 19 September 2012

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

During the week leading up to 19 April, no new outbreaks were detected.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu

Epidemic Intelligence duty email: support@ecdc.europa.eu

Influenza - Multistate (Europe) - Monitoring 2012-2013 season

Opening date: 2 December 2011 Latest update: 19 April 2013

Following the 2009 pandemic, influenza transmission in Europe has returned to its seasonal epidemic pattern, with peak activity seen during winter months. ECDC monitors influenza activity in Europe during the winter seasons and publishes the results on its website in the Weekly Influenza Surveillance Overview.

Weekly reporting on influenza surveillance in Europe for the 2012–2013 season started in week 40/2012 and will finish after week 20/2013. Active influenza transmission began around week 49/2012 with influenza-like illness/acute respiratory infection rates peaking in almost all countries between weeks 52/2012 and 8/2013.

➔Update of the week

This week, in all reporting countries, influenza activity has continued to decline or has already returned to baseline levels. After more than three months of active transmission, a long period compared to other years, the 2012–2013 influenza season is waning and getting closer to its end.

Non EU Threats

Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 11 April 2013

On 31 March 2013, the Chinese health authorities announced the identification of a novel avian influenza A(H7N9) virus in three seriously ill patients in Shanghai. The outbreak has since spread to six provinces: Shanghai, Jiangsu, Zhejiang, Anhui, Henan and Beijing. The source of infection and the mode of transmission are yet to be determined. Zoonotic transmission from poultry to humans is the most likely scenario. There is no epidemiological link between most of the cases and sustained human-to-human transmission has not been confirmed. There has been one cluster reported with two confirmed cases (husband and wife). This is the first time that possible human infection with avian influenza A(H7N9) virus has been identified.

➔Update of the week

Between 11 and 18 April 2013, 49 additional confirmed human cases of influenza A(H7N9) virus, including seven deaths, have been reported from six provinces in eastern China. Since the beginning of the outbreak, 87 confirmed cases, including 17 deaths, have been reported.

Novel Coronavirus - Multistate - Severe respiratory syndrome

Opening date: 24 September 2012 Latest update: 31 March 2013

From April 2012 to 28 March 2013, 17 laboratory-confirmed cases including eleven deaths from an acute respiratory disease caused by nCov have been notified. The new virus is genetically distinct from the coronavirus that caused the SARS outbreak. Cases have occurred in Saudi Arabia, Qatar, Jordan, United Arab Emirates and the United Kingdom. There have been three clusters of cases with evidence of human-to-human transmission, one in Jordan, one in Saudi Arabia and one in the United Kingdom, where the index case is believed to have been infected during a visit to Saudi Arabia. The reservoir of the novel coronavirus has not been established nor is it clear how transmission is sustained from one sporadic case to another.

➔Update of the week

No new cases have been reported since 25 March 2013.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 18 April 2013

Dengue fever is one of the most prevalent vector-borne diseases in the world, affecting an estimated 50-100 million people each year, mainly in the tropical regions of the world. The identification of sporadic autochthonous cases in non-endemic areas in recent years has already highlighted the risk of the occurrence of locally acquired cases in EU countries where the competent vectors are present. The detection of a dengue outbreak in the Autonomous Region of Madeira, Portugal, further underlines the importance of surveillance and vector control in other European countries.

➔Update of the week

The Autonomous Region of Madeira, Portugal, experienced an outbreak of dengue starting in October 2012 with a few sporadic cases still reported between week 1 and week 9 in 2013. So far in 2013, no autochthonous dengue cases have been reported in other European countries.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 18 April 2013

Polio, a crippling and potentially fatal vaccine-preventable disease mainly affecting children under five years of age, is close to being eradicated from the world after a significant global public health investment and effort. The WHO European Region is polio-free.

➔Update of the week

During the week leading up to 18 April 2013, one new polio case was reported to WHO.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
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II. Detailed reports

Hepatitis A - Multistate (Europe) - 2013 outbreak

Opening date: 9 April 2013 Latest update: 18 April 2013

Epidemiological summary

Between 1 October 2012 and 18 April 2013, Denmark, Finland, Norway and Sweden have reported 26 hepatitis A cases due to genotype 1b with identical RNA sequence. None of the cases have travel history outside the EU within the period of their potential exposure. There are 42 additional non-travel-related cases of hepatitis A reported in the four countries for whom the sequence is not known.

Epidemiological investigations in Denmark, Finland and Sweden revealed that all the patients had consumed berries, in particular frozen berries in smoothies. Strawberries were the food item with the strongest association with the disease. No hepatitis A virus (HAV) could be isolated from food samples so far. Food safety authorities and Public Health Authorities in the affected countries are actively collaborating to uncover the vehicle of infection and to prevent occurrences of additional cases.

Following epidemiological investigations, the food authorities in Denmark (14 March 2013), Finland (20 March 2013) and Sweden (11 April 2013) recommended that citizens should boil all frozen berries or berries of non-domestic origin before consumption.

On 12 April, the Norwegian Food Safety Authority and the Norwegian Institute of Public Health informed consumers on their official websites that the risk of contracting HAV through frozen imported berries can be reduced by boiling the berries prior to consumption.
Web sources: ECDC HAV factsheet |

ECDC assessment

The identification of the same HAV sequence in four different countries confirms that this is a multinational food-borne outbreak. The distribution of cases over time suggests a persistent common source. As the most recent cases had onset in April 2013, the outbreak is most likely still on-going.

Actions

ECDC and EFSA published a joint rapid outbreak assessment on 16 April.

Web sources: ECDC and EFSA joint rapid outbreak assessment.

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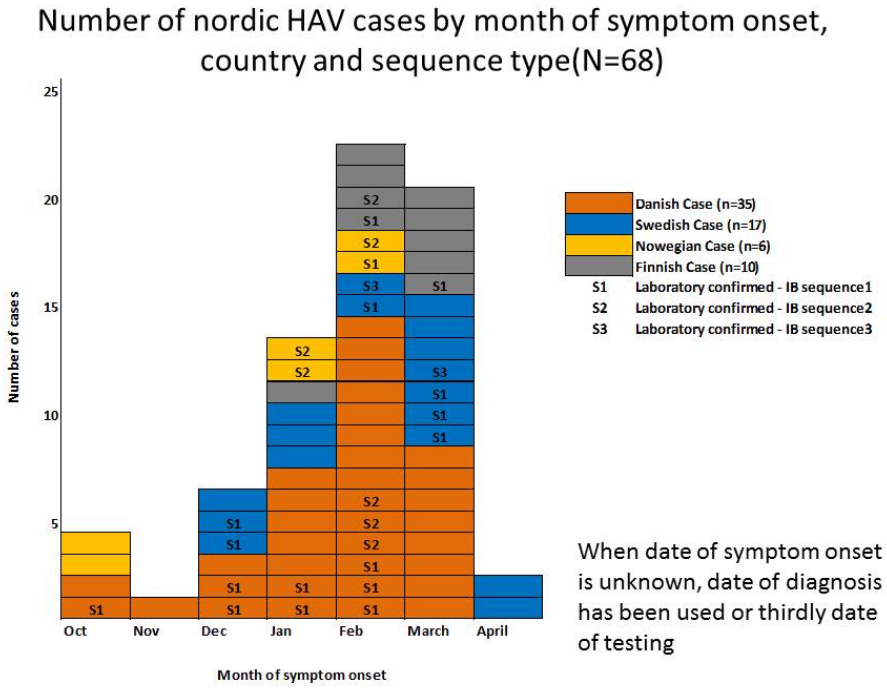
HAV cases in Nordic countries

ECDC



Measles - Multistate (EU) - Monitoring European outbreaks

Opening date: 9 February 2011 Latest update: 11 April 2013

Epidemiological summary

UK – Update

Wales

As of 17 April 2013, the measles outbreak in Wales has caused 765 cases with nearly 80 hospitalisations (an increase of 145 cases since last week). Almost 3 700 children have been immunised during the last two weeks at drop-in clinics and school immunisation sessions. Health authorities plan to immunise an additional 2 000 pupils with measles-mumps-rubella (MMR) vaccine in schools this week. The highest attack rate is seen in children aged 10-18 years who may not have been vaccinated because of concerns about the safety of MMR in the late 1990s. Most cases were reported in the Swansea area, but cases are seen throughout Wales.

North-east England

The measles outbreak in north-east England is also continuing with a more than 10% rise in suspected cases over a week. In all, 214 cases have been laboratory confirmed and another 220 suspected since numbers began to rise last September. Nearly a third of all cases have involved children aged 10-14 and nearly one in six of those affected have needed hospital treatment.

Germany – Outbreak in Berlin

Due to an increasing number of measles cases in Berlin, the Department for Health recommends that all adults born after 1970 review their measles immunisation status. There have been 43 cases so far since February 2013 compared with only five cases during the same period in 2012. Sixty percent of the patients are between 16 and 45 years old. Around half of the patients had to be hospitalised.

Web sources: ECDC measles and rubella monitoring | ECDC/Euronews documentary | WHO Epidemiological Briefs | MedISys Measles page | EUVAC-net ECDC | ECDC measles factsheet | Public Health Wales |

ECDC assessment

So far in 2013, the UK, Sweden, Denmark and Germany have reported outbreaks. In 2012, considerably fewer measles cases were reported in the EU than in 2011, primarily due to the dramatic decrease in the number of cases reported from France. There was no increase in the number of cases during the peak transmission season from February to June and there have

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
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been very few outbreaks detected by epidemic intelligence methods in 2012. There have been no measles-related deaths during the last 12 months, but seven cases were complicated by acute measles encephalitis. The reduction in notified cases in 2012 indicates that the incidence at EU/EEA level is back at the level before the 2010–2011 outbreaks, but does not signify a long-term downward trend in measles notifications.

Actions

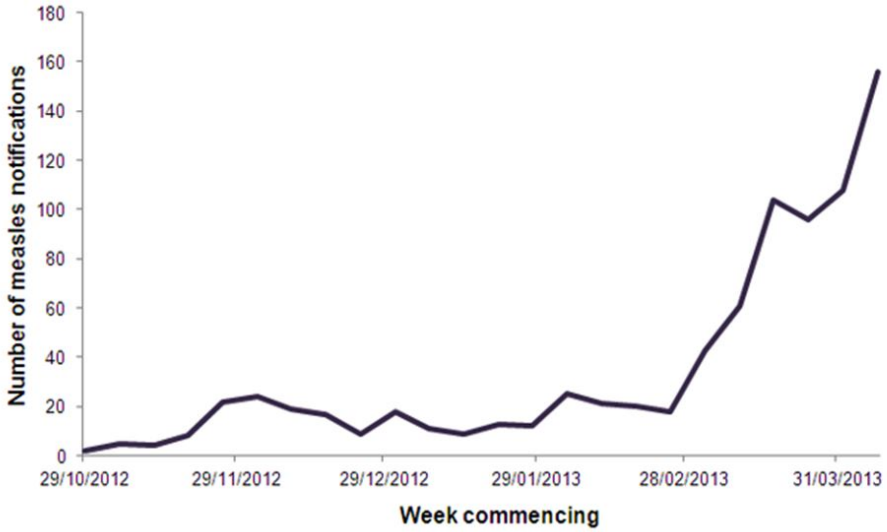
ECDC closely monitors measles transmission and outbreaks in the EU and neighbouring countries in Europe through enhanced surveillance and epidemic intelligence activities. The countries in the WHO European Region, which include all EU Member States, have committed to eliminating measles and rubella transmission by 2015. Elimination of measles requires consistent vaccination coverage above 95% with two doses of measles vaccine in all population groups, strong surveillance and effective outbreak control measures.

Measles Wales week 15

Public Health Wales

Notifications of measles in Wales by week

Chart of number of notifications by week: Week 44 2012 (week commencing 29/10/2012) - week 15 2013 (week commencing 08/04/2013)



Data until end of week 15 2013 (08/04/13 - 14/04/13)
Source: *CoSurv Notifications, Public Health Wales*
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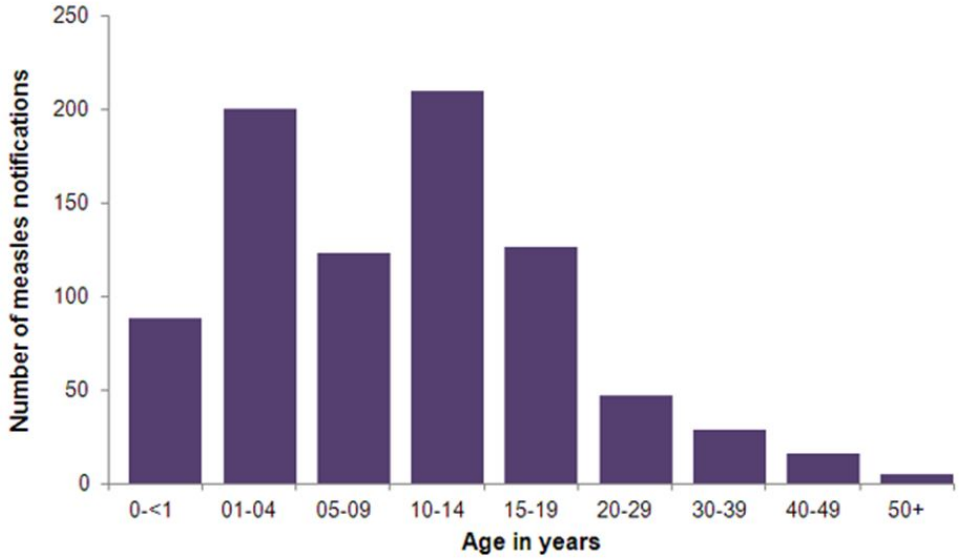
Notifications of measles in Wales by age

Public Health Wales

Notifications of measles in Wales by age

Chart of number of notifications by age during time period: 1 November 2012 - 12 noon 15 April 2013



data as at 12 noon, 15 April 2013
Source: *CoSurv Notifications, Public Health Wales*
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Rubella - Multistate (EU) - Monitoring European outbreaks

Opening date: 7 March 2012 Latest update: 19 September 2012

Epidemiological summary

No new outbreaks have been identified since the last update.

There were 26 129 cases of rubella reported during the last 12-month period by the 26 EU and EEA countries which contribute to the enhanced surveillance for rubella. Poland and Romania accounted for 99% of all reported rubella cases in the 12-month period.

Web sources: ECDC measles and rubella monitoring | WHO epidemiological brief summary tables | ECDC rubella factsheet

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. CRS surveillance plays an important role but tends to be biased towards the severe end of the spectrum as the rubella infection is known to cause a wide range of conditions from mild hearing impairment to complex malformations which are incompatible with life. Routine control of immunity during antenatal care is important for identifying susceptible women who can be immunised after giving birth and for surveillance of the size of the susceptible female population. The increase in the number of rubella cases reported in 2012 compared with 2011 and the potential for an increase in the number of babies born with CRS are of concern.

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 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.

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Influenza - Multistate (Europe) - Monitoring 2012-2013 season

Opening date: 2 December 2011 Latest update: 19 April 2013

Epidemiological summary

During week 15/2013, 25 of 28 reporting countries indicated low-intensity transmission. The proportion of influenza-positive sentinel specimens (34%) has continued to decrease since the peak observed in week 5/2013 (61%) in line with lower numbers of specimens being tested. Since week 40/2012, 47% of sentinel surveillance specimens testing positive for influenza virus have been type A, and 53% type B. Of the influenza A viruses subtyped, the proportion of A(H1)pdm09 viruses has been 64%. Forty-four hospitalised, laboratory-confirmed, influenza cases were reported by three countries.

Web source: ECDC Weekly Influenza Surveillance Overview |

ECDC assessment

In all reporting countries, influenza activity continued to decline or had already returned to baseline levels. After more than three months of active transmission, a long period compared to other years, the 2012–2013 influenza season is waning and getting closer to its end.

Actions

ECDC updated its influenza website for the start of the season and published its annual risk assessment for seasonal influenza 2012-2013 in early February based on data up to week 3/2013.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
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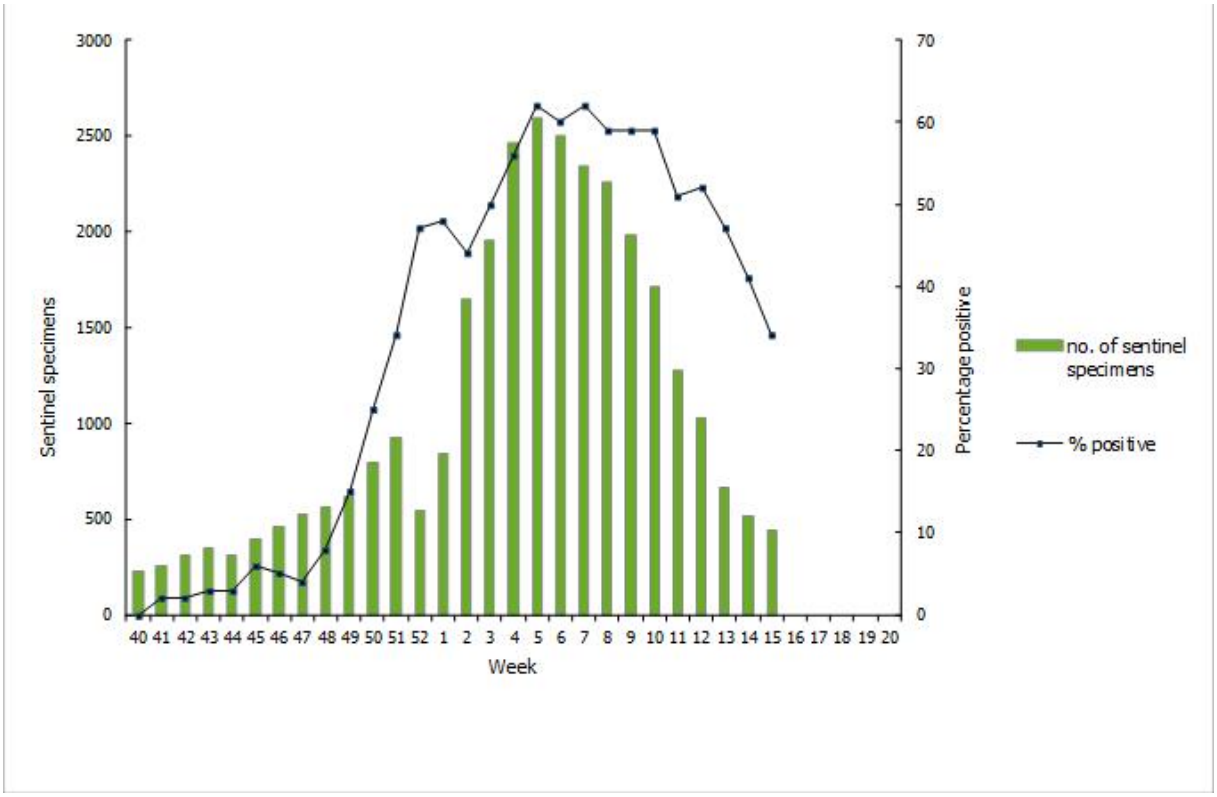
Proportion of sentinel specimens positive for influenza virus, weeks 40/2012-15/2013

ECDC WISO



Influenza A(H7N9) - China - Monitoring human cases

Opening date: 31 March 2013 Latest update: 11 April 2013

Epidemiological summary

The influenza A viruses from the first three cases were non-subtypeable and were sent to the WHO Influenza Collaborating Centre at the Chinese Centre for Disease Control and Prevention (CCDC). The genetic comparison indicated that these cases were caused by a novel reassortant avian influenza virus with avian origin genes from both A(H7N9) and A(H9N2). No similar viruses have been seen before and A(H7N9) differs from A(H7) and A(H9) viruses that have been seen previously in Europe. No vaccine is currently available for this subtype of the influenza virus. Preliminary test results suggest that the virus is susceptible to the neuraminidase inhibitors (oseltamivir and zanamivir).

Since 31 March 2013, 87 cases of human infection with influenza A(H7N9) have been reported from six provinces in eastern China with a combined population of about 330 million. Cases have been reported from Shanghai (32), Jiangsu (21), Zhejiang (27), Anhui (3), Henan (3) and Beijing (1). The known onset dates of disease have been between 19 February and 14 April 2013, and date of disease onset is currently unknown for sixteen patients. Most cases have developed severe respiratory disease. Seventeen patients have died (case-fatality ratio=20%). The median age is 64 years with a range between 4 and 89

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Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

years; 25 of them are females.

The Chinese health authorities are responding to this public health event with enhanced surveillance, epidemiological and laboratory investigation and contact tracing. The animal health sector has intensified investigations into the possible sources and reservoirs of the virus. The authorities reported to the World Organisation for Animal Health (OIE) that avian influenza A(H7N9) was detected in samples from pigeons, chickens and ducks, and in environmental samples from live bird markets ('wet markets') in Shanghai, Jiangsu, Anhui and Zhejiang provinces. Authorities have closed markets and culled poultry in affected areas.

The Ministry of Agriculture in China reports that 47 801 tests samples have been taken from live animal markets, farms and slaughter houses. Of those, only 39 samples were positive for the H7N9 avian influenza virus, of which 38 were from Shanghai, Anhui, Zhejiang and Jiangsu provinces. One positive sample was from a wild pigeon in Jiangsu province.

Web sources: Chinese CDC | WHO | WHO FAQ page | Centre for Health Protection Hong Kong | OIE | Chinese MOA |

ECDC assessment

The source and mode of transmission have not been confirmed. The outbreak is caused by a reassortant avian influenza virus with low pathogenicity for birds, hence it does not cause the signal 'die-offs' in poultry associated with highly pathogenic strains of avian influenza viruses. Genetic analyses of the isolates have shown changes which suggest that the H7N9 virus may have greater ability to infect mammalian species, including humans, than most other avian influenza viruses. Pathogenicity for humans appears to be high and higher age appears to be a risk factor for disease.

The most likely scenario is that of A(H7N9) spreading undetected in poultry populations and occasionally infecting humans who have close contact with poultry or poultry products but this will have to be validated as further data become available.

At this time there is no evidence of any human-to-human transmission. More than 1 000 close contacts of confirmed cases are reported to have been followed up without evidence of person-to-person transmission.
There is one family cluster with two confirmed cases for which human-to-human transmission cannot be ruled out but where common exposure is the most likely explanation. In addition, the virus has been detected in one asymptomatic four-year-old boy during surveillance of risk groups. The father of this boy is reported to have purchased poultry from the father of the first case in Beijing.

The rapid geographic spread and the increase of confirmed cases is likely to be the result of strengthened case finding and increased testing. Influenza A(H7N9) test kits have been distributed to over 400 laboratories across China and this increased ascertainment is expected to provide important epidemiological information.

An increasing incidence of sporadic cases and expansion of geographic spread in China and possibly neighbouring countries are expected over the coming weeks. Individual imported human cases to Europe cannot be ruled out and countries need to prepare for detecting and diagnosing such cases. Critical developments that would change this assessment would be evidence of sustained human-to-human transmission and detection of avian influenza A(H7N9) in bird populations in Europe.

Actions

ECDC is closely monitoring developments and is continuously re-assessing the situation in collaboration with WHO, the US CDC, the Chinese CDC and other partners. The ECDC emergency operations centre was activated to Public Health Event (PHE) level 1 on 15 April to support its internal activities.

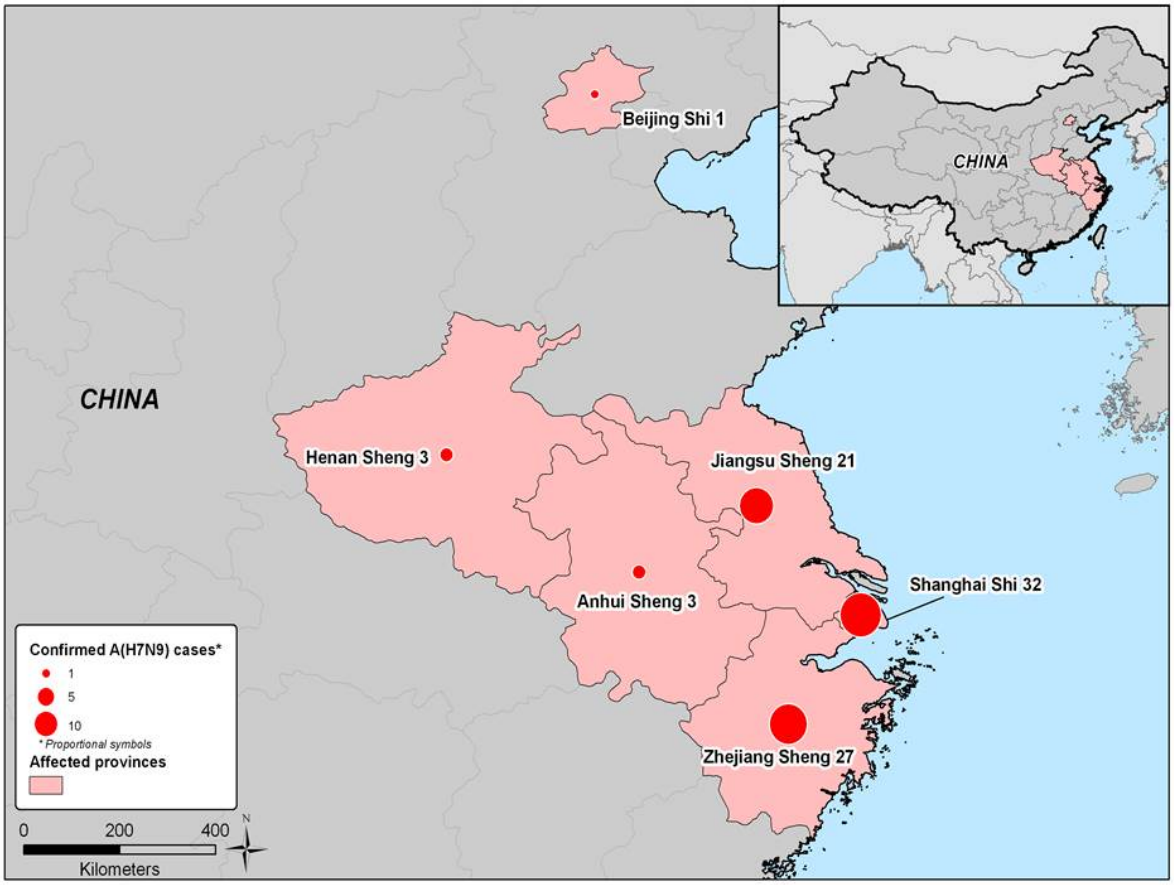
A senior ECDC expert is participating on the on-going expert mission in China jointly lead by WHO and Chinese health authorities.

This epidemiological update does not change the conclusions and recommendations of the updated rapid risk assessment published on 12 April 2013. ECDC posted an epidemiological update on 18 April (link to be added).

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Distribution of cumulative number of influenza A(H7N9) cases by province, China, 19 February-18 April 2013

Source:ECDC



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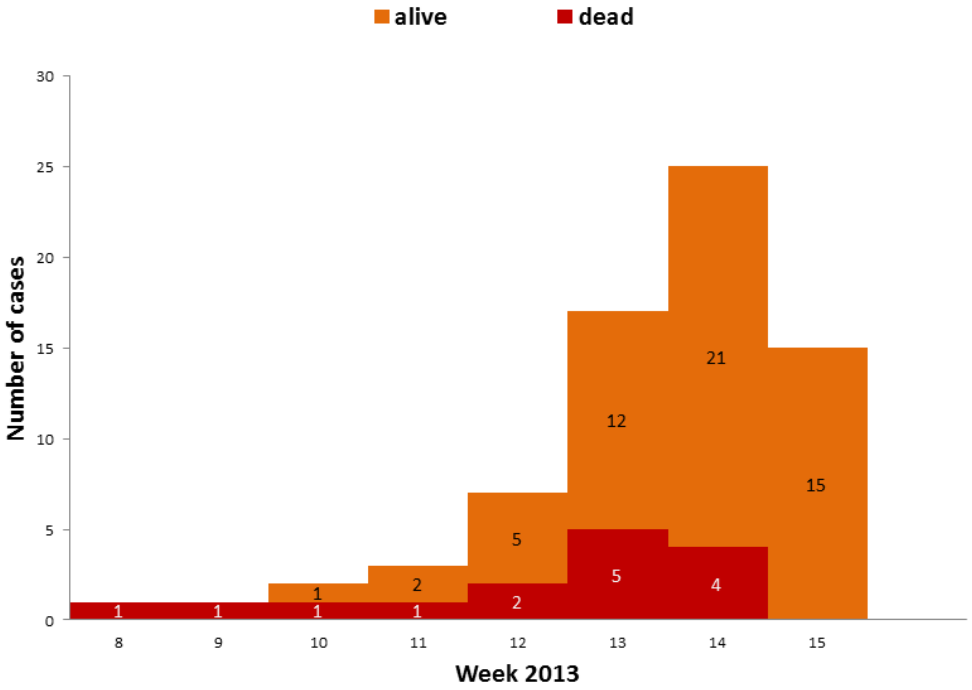
Distribution of influenza A(H7N9) cases by week of onset of symptoms, China, as of 18 April 2013 (n=71, no onset dates for 16 cases)

Source: ECDC



Novel Coronavirus - Multistate - Severe respiratory syndrome

Opening date: 24 September 2012 Latest update: 31 March 2013

Epidemiological summary

The first described case of novel coronavirus infection was a 60-year-old male resident of Saudi Arabia who died from severe pneumonia complicated by renal failure in June 2012. A previously unknown coronavirus isolated from this patient was identified and named Human Coronavirus-Erasmus Medical Centre (HCoV-EMC/2012). In September 2012, a second case was reported, a Qatari man, who was transferred for care to Europe. In November 2012, additional cases with similar symptomatology were diagnosed in Qatar and Saudi Arabia. These included a family cluster of three confirmed and one probable case. Subsequently, two fatal cases were confirmed retrospectively by testing stored samples from a cluster of 11 cases of lower respiratory infection linked to a hospital in Jordan in April 2012.

In February 2013, a cluster of novel coronavirus cases was reported from the United Kingdom where the index case had travelled to Pakistan and Saudi Arabia ten days before symptom onset and where contact tracing identified two secondary cases among family members without recent travel. One person died, the other had a self-limiting influenza-like illness which did not require

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Postal address: ECDC 171 83 Stockholm, Sweden
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hospitalisation. Three additional sporadic cases have been reported since February, all from Saudi Arabia and fatal.

A latest case, was reported on 25 March by Robert Koch Institute (RKI), Germany, the second imported case to be reported in this EU Member State. The patient, a 73 year old male with underlying clinical conditions, had been hospitalised in United Arab Emirates and transferred to a hospital in Germany (Munich) for specific clinical care where subsequent diagnosis of nCoV infection was confirmed. The patient died on 26 March.

This brings the number of cases to 17 globally, including eleven deaths.

Web sources: WHO| HPA press release 11 February |HPA press release 15 February |HPA update 19 February |ECDC updated RRA 19 February |WHO revised interim case definition 19 February | ECDC novel coronavirus website |WHO update 21 February 2013 |WHO update 6 March 2013 | WHO update 12 March 2013 |RKI risk assessment 26 March | WHO update 26 March

ECDC assessment

Research on the complete genome sequence of the novel coronavirus has characterised the virus as a new genotype that is closely related to bat coronaviruses. It is genetically distinct from SARS-CoV. The routes of transmission to humans and the virus reservoir have not been determined. This is a common problem with emerging zoonoses where there is often simultaneous possibilities including environmental, animal and human exposures.

The cluster of three cases in the UK is evidence of limited human-to-human transmission. However, several hundred contacts of the UK cluster and the case treated in Germany have now been actively followed up without evidence of novel coronavirus infection indicating that the risk of transmission remains low.

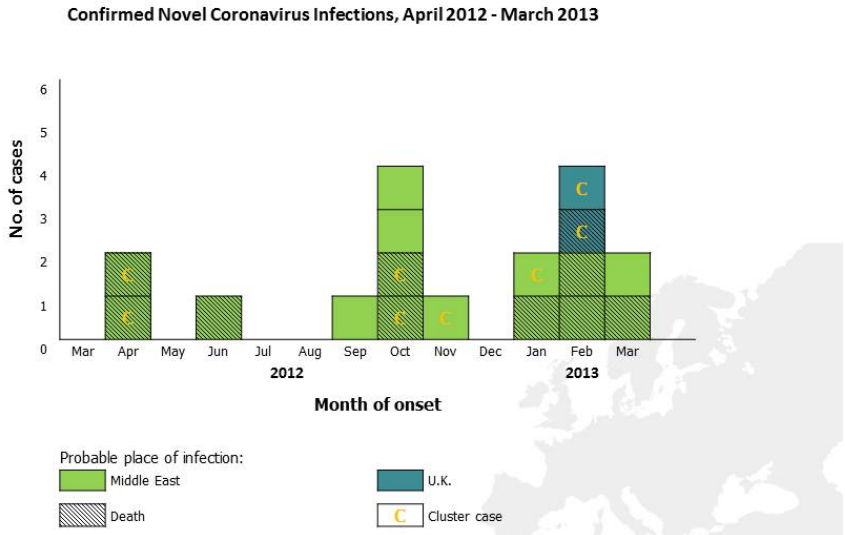
Actions

ECDC updated its rapid risk assessment, first published on 7 December 2012 and an epi-update on 27 March (Epidemiological update ECDC). The results of an ECDC coordinated survey on laboratory capacity for testing for the novel coronavirus in Europe were published in EuroSurveillance. On 18 March, WHO posted interim surveillance recommendations for human infection with novel coronavirus on their website.

ECDC is closely monitoring the situation in collaboration with WHO and the European Union Member States. If new sporadic cases of confirmed NCoV infection are reported, ECDC will communicate them through this report.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Confirmed Novel Coronavirus Infections, April 2012 - March 2013



Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 18 April 2013

Epidemiological summary

Europe: There have been no reports of confirmed autochthonous dengue cases in Europe in 2013, besides the dengue outbreak in Madeira.

Asia: There is no new update from WHO Western Pacific Region. According to the media, the number of dengue cases in Cambodia in the first quarter of 2013 is 10 percent higher than during the same period in 2012. In Singapore, the National Environment Agency (NEA) has warned that the number of dengue cases could double in the next five weeks before peak season arrives. Last week, they reported 492 cases which is the highest number of cases reported in a week since July 2007. DENV-1 has replaced DENV-2 as the predominant strain which the population has lower immunity against, according to the NEA.

The Caribbean: As of 9 April, Puerto Rico has reported more than 4 100 suspected dengue cases so far in 2013. Central and South America: High dengue activity is reported across most states in Mexico. Costa Rica, El Salvador and Honduras are all experiencing increased activity. In South America, an increasing trend of dengue cases is reported across Brazil, Paraguay, Ecuador, Colombia, and Peru.

Pacific: The dengue outbreak in the Solomon Islands is still on-going with a reported 1 700 cases recorded on the islands so far this year.

Africa: According to the media, health authorities in Luanda, Angola's capital city, have confirmed six cases of dengue fever. Two additional dengue cases have been reported this week in the French overseas department of La Reunion.

Web sources:
HealthMap | MedISys | ProMED Asia update| ProMED Americas update| WPRO | CDC |

ECDC assessment

ECDC monitors individual outbreaks, seasonal transmission patterns and inter-annual epidemic cycles of dengue through epidemic intelligence activities in order to identify significant changes in disease epidemiology. Of particular concern is the potential for the establishment of dengue transmission in Europe. Before the current outbreak in the Autonomous Region of Madeira, local transmission of dengue was reported for the first time in France and Croatia in 2010. Imported cases are detected in European countries, highlighting the risk of locally acquired cases occurring in countries where the competent vectors are present.

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Actions

ECDC has published a technical report on the climatic suitability for dengue transmission in continental Europe and guidance for invasive mosquitoes' surveillance.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 18 April 2013

Epidemiological summary

During the past week one new wild polio case was reported to WHO from Nigeria (WPV1 from Yobe, onset of paralysis on 5 March). Globally, 19 cases of polio have been reported so far in 2013 compared with 47 for the same period in 2012.

Web sources: Polio Eradication: weekly update | MedISys Poliomyelitis | ECDC Poliomyelitis factsheet | WHO EMRO

ECDC assessment

The WHO European Region so far remains polio-free.

The last polio cases in the European Union occurred in 2001 when three young Bulgarian children of Roma ethnicity developed flaccid paralysis caused by WPV. Investigations showed that the virus originated from India. The latest outbreak in the WHO European Region was in Tajikistan in 2010 when WPV1 imported from Pakistan caused an outbreak of 460 reported cases. The last indigenous WPV case in Europe was in Turkey in 1998. An outbreak in the Netherlands in a religious community opposed to vaccinations caused two deaths and 71 cases of paralysis in 1992.

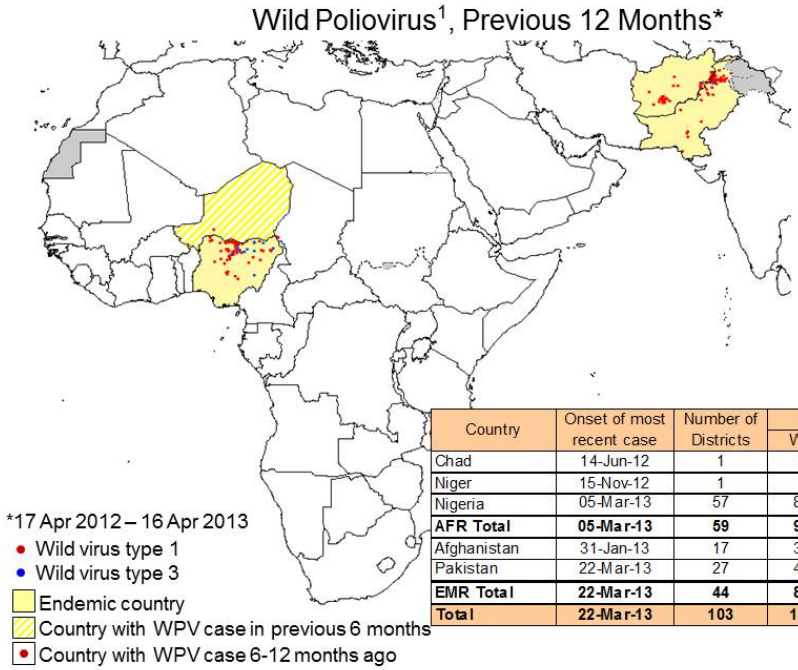
Actions

ECDC follows reports on polio cases worldwide through epidemic intelligence in order to highlight polio eradication efforts and identify events that increase the risk of re-introduction of wild poliovirus (WPV) into the EU.

European Centre for Disease Prevention and Control (ECDC)
Postal address: ECDC 171 83 Stockholm, Sweden
Visiting address: Tomtebodavägen 11a, Solna, Sweden
www.ecdc.europa.eu
Epidemic Intelligence duty email: support@ecdc.europa.eu

Polio Global Update

WHO



Country	Onset of most recent case	Number of Districts	Virus Type		TOTAL WPV
			W1	W3	
Chad	14-Jun-12	1	2		2
Niger	15-Nov-12	1	1		1
Nigeria	05-Mar-13	57	89	10	99
AFR Total	**05-Mar-13**	**59**	**92**	**10**	**102**
Afghanistan	31-Jan-13	17	32		32
Pakistan	22-Mar-13	27	48	1	49
EMR Total	**22-Mar-13**	**44**	**80**	**1**	**81**
Total	**22-Mar-13**	**103**	**172**	**11**	**183**

[1]Excludes viruses detected from environmental surveillance and vaccine derived polioviruses.
1 WPV1 in Gilgit Baltistan, date of onset 06 August 2012, does not appear on the map.

Data in WHO HQ as of 16 April 2013

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

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