COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 2, 4-10 January 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

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

Opening date: 5 January 2015

In December 2014, Norway and the UK reported three cases of botulism affecting people who inject drugs within a short period of time. These cases raise the possibility that a batch of contaminated heroin is in circulation.

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

Opening date: 9 October 2014 Latest update: 19 December 2014

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

In week 01/2015, the intensity of influenza activity remained low in the majority of countries in Europe but the number of countries with increased activity continued to rise compared to previous weeks.

Medium influenza activity was reported by seven of the 35 reporting countries, while the proportion of influenza virus-positive sentinel specimens was 16% - at similar level with previous week (17%) – however with higher proportion positive (26%) in the Western parts of the WHO European Region.

The predominant influenza virus was type A, with A(H3N2) viruses predominating in primary care, among laboratory-confirmed hospitalised cases as well as other sources.

Non EU Threats

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 18 December 2014

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

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Since 2 January, and as of 8 January 2015, WHO has reported 801 additional cases in the affected countries and 369 additional deaths.

As of 8 January 2015, WHO has reported 21 007 confirmed, probable, and suspected cases of Ebola virus disease, with 8 274 deaths, in four affected countries (Guinea, Liberia, Mali, and Sierra Leone) and four previously affected countries (Nigeria, Senegal, Spain and the United States of America).

On 29 December 2014, Scotland reported the first imported case of EVD to the UK that was not a medical evacuation. The case is a healthcare worker who had returned from volunteering at an Ebola treatment centre in Sierra Leone. According to WHO all possible contacts of the case have been investigated and no high risk contacts have been identified.

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

Opening date: 24 September 2012 Latest update: 8 January 2015

Since April 2012, 968 cases of MERS-CoV have been reported by local health authorities worldwide, including 394 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 reported five new cases of MERS-CoV infection. Oman reported a case on 8 January 2015 which was the first case since December 2013.

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 8 January 2015

Dengue fever is one of the most prevalent vector-borne diseases, affecting an estimated 50 to 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 locally-acquired cases occurring in EU countries where the competent vectors are present. The dengue outbreak in the Autonomous Region of Madeira, Portugal, in October 2012 and the recent autochthonous dengue cases in the south of France further underline the importance of surveillance and vector control in other European countries.

➔Update of the week

There are ongoing outbreaks of dengue fever globally.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 8 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, eight new wild poliovirus type 1 (WPV1) cases have been reported to WHO, two cases from Afghanistan and six cases from Pakistan.

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 8 January 2015

An outbreak of chikungunya virus infection has been ongoing in the Caribbean since December 2013 and spread to North, Central and South America. There is a simultaneous outbreak of chikungunya in French Polynesia. In Europe, France reported autochthonous cases of chikungunya virus infection in 2014. This was the first time that locally-acquired transmission of chikungunya had been detected in France since 2010.

➔Update of the week

Since the last update on 5 December 2014, WHO PAHO has reported more than 100 000 new cases of chikungunya virus infection in the Pan-American region. Since the beginning of the outbreak in December 2013, there have been 169 deaths.

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II. Detailed reports

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

Opening date: 5 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 1 January 2015, NHS Greater Glasgow and Clyde's Public Health Protection Unit posted a press release saying that they were investigating two probable cases of botulism in drug-injecting heroin users. Both patients are from the Greater Glasgow and Clyde area and are receiving treatment in Glasgow hospitals. Both are in a serious condition. The cause of these infections is being investigated with the focus on intravenous drug use.

Web sources: NHS | Folkhelseinstitutet

ECDC assessment

Botulism in people who inject drugs (PWID) has been reported in recent years in several European countries and the US. 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 PWID 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 to recognising 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: 19 December 2014

Epidemiological summary

Influenza A(H3N2) viruses have been the predominant viruses detected across all surveillance systems. While there have been difficulties in characterising A(H3N2) viruses antigenically, as in the United States of America, the majority of the A(H3N2) viruses characterised genetically fall in genetic subgroups containing viruses that have drifted antigenically compared to the A(H3N2) virus used in the 2014–2015 northern hemisphere influenza vaccine. Although this may compromise the effectiveness of the A (H3N2) component of the vaccine, it is still important that people be vaccinated, particularly those in groups at risk of developing severe symptoms after influenza infection; see the WHO/Europe website and ECDC rapid risk assessment on drifted A(H3N2) viruses. The situation will be monitored carefully, and treatment guidelines must be disseminated to clinicians, including on use of antivirals.

The circulating influenza A(H3N2), A(H1N1)pdm09 and B viruses remain susceptible to the antivirals oseltamivir and zanamivir currently licensed in Europe.

No indication of increased mortality has been reported in the European project for monitoring excess mortality for public health action (EuroMOMO: http://www.euromomo.eu).

Web sources: Flu News Europe | ECDC Influenza |

ECDC assessment

The influenza season in Europe has started: the proportion of influenza virus-positive sentinel specimens has increased to over

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10% for the third consecutive week, despite the majority of countries still reporting low intensities of influenza activity.

Actions

ECDC and WHO produce the Flu News Europe bulletin weekly.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 18 December 2014

Epidemiological summary

Distribution of cases as of 8 January:

Countries with intense transmission:

- Guinea: 2 776 cases and 1 786 deaths (as of 5 January 2015).
- Liberia: 8 166 cases and 3 496 deaths (as of 3 January 2015).
- Sierra Leone: 10 030 cases and 2 977 deaths (as of 6 January 2015).

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

- The UK: one confirmed case on 29 December 2014.
- United States: four cases including one death. The last case tested negative on 11 November 2014 in New York.
- Mali: eight cases, six deaths.
- Nigeria, Senegal and Spain are declared free of EVD after having cases related to this current epidemic in West Africa.

Situation in specific West African countries

According to WHO, case incidence has declined to low levels in Liberia but it is still fluctuating in Guinea where EVD continues to spread geographically within the country, with a new affected prefecture, Fria, reporting two confirmed cases. In Sierra Leone the incidence seems to be stable, although transmission remains intense in the west of the country.

More than 90% 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. Each district is reported to have at least one contact-tracing team in place. Active case-finding teams are being mobilised as a complementary case-detection strategy in several areas.

The cumulative case-fatality rate in the three intense-transmission countries among all probable and confirmed cases for whom a definitive outcome is recorded is 71%. For those patients recorded as hospitalised, the case-fatality rate is 58% in Guinea and Liberia, and 60% in Sierra Leone.

Situation among healthcare workers

Up to the end of 4 January 2015, 838 healthcare workers (HCWs) are known to have been infected with EVD, 495 of whom have died. This is an increase of 160 infections since last week and it is due to additional cases reported from Sierra Leone that have occurred since the onset of the epidemic.
Distribution of cases: 154 HCWs in Guinea, 370 HCWs in Liberia, 296 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

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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. The patient was admitted to a hospital and placed into strict isolation on the morning of 29 December. Ebola virus disease was confirmed by RT-PCR later on the same day. The patient was transferred to London for treatment in isolation on 30 December.

Public Health England (PHE) has completed contact tracing following the confirmed case of Ebola in a healthcare worker returning from Sierra Leone. People contacted by Public Health England were made aware that a person on their flight was confirmed with Ebola after they returned to the UK, although the person would have been in the very early stages of disease and extremely unlikely to be infectious. The people sitting directly in the vicinity of the passenger (two rows adjacent, ahead and behind) were advised to take their temperature twice daily until 18 January 2015. If their temperature is 37.5°C or higher, or they begin to feel unwell in any way, they are advised to call a dedicated Public Health England contact immediately for advice.

No high-risk contacts have been identified in connection with the EVD case in the United Kingdom.

United States

On 5 January 2015, US CDC posted a press release announcing the end of enhanced airport entry screening for travellers from Mali to the United States and stating that "January 6 will mark two incubation cycles (21 days each) since the last patient in Mali had any contact with a person who was not wearing personal protective equipment (PPE)." The last Ebola patient in Mali tested negative on 5 December 2014, and there are currently no active cases.

Medical evacuations and repatriations from EVD-affected countries

Twenty-seven individuals have been evacuated or repatriated from the EVD-affected countries. As of 8 January, there have been 12 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 and one to the Netherlands). Two persons exposed to Ebola have been repatriated to the Netherlands and tested negative. One individual was evacuated to Switzerland and was confirmed not to have EVD in September.

Since 2 January 2015, four HCWs have been medically evacuated from West Africa after experiencing a high-risk exposure to *Ebolavirus,* one to the US, one to Sweden, one to Denmark and one to Germany. According to media the first test for the Swedish HCW was negative.

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 01/2015 **

* 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 01* 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 |WHO latest update |US press release | Medical evacuation - Sweden |

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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, EFSA-ECDC published a Scientific report assessing Risk related to household pets in contact with Ebola cases in humans.
On 18 November, ECDC published an updated rapid risk assessment.
On 10 September, ECDC published an EU case definition.
On 22 September 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 ECDC published risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU.
On 13 October, ECDC published Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures.
On 22 October 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 ECDC published Public health management of persons having had contact with Ebola virus disease cases in the EU.
On 29 October, ECDC published a training tool on the safe use of PPE and options for preparing for gatherings in the EU

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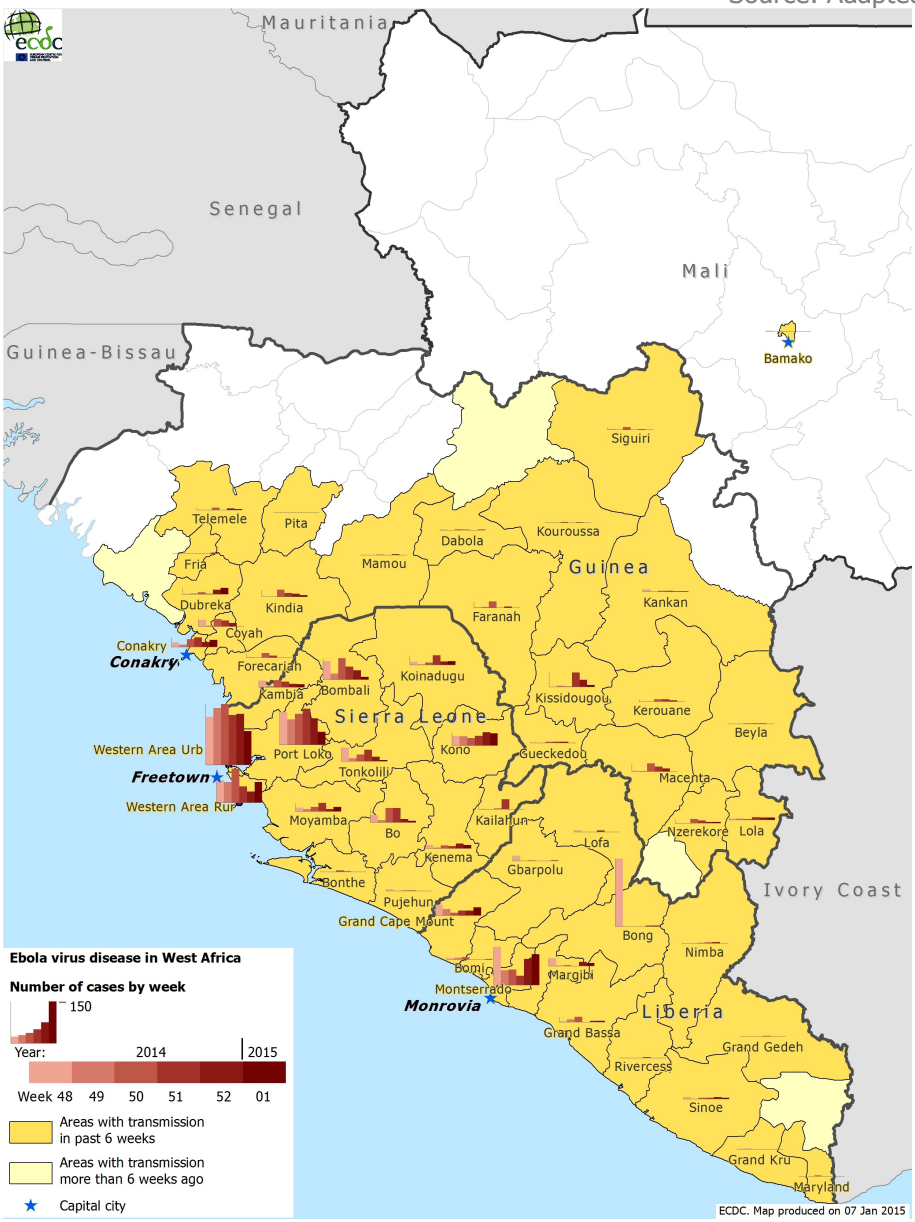
Distribution of cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia and Mali (as of week 01/2015)

Source: Adapted from national situation reports



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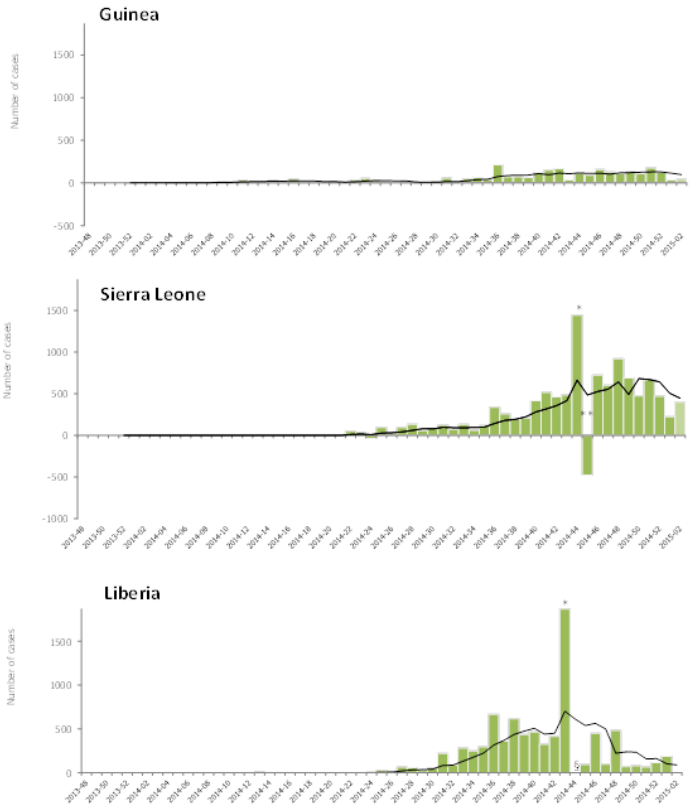
Distribution of cases of EVD by week of reporting in the three countries with widespread and intense transmission, as of week 02* 2015

Source: Adapted from WHO figures; *data for week 02 are incomplete



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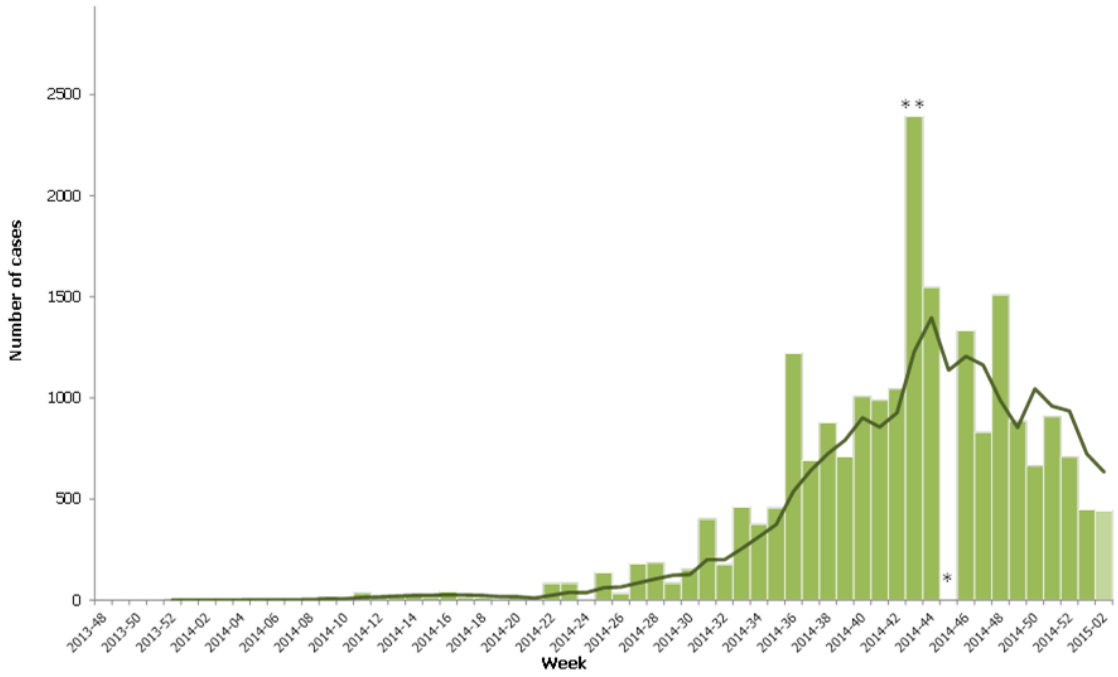
Distribution of reported cases of EVD by week of reporting in Guinea, Sierra Leone, Liberia, Mali, Nigeria and Senegal, weeks 48/2013 to 02*/2015

Source: Adapted from WHO figures; *data for week 02 are incomplete



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

Opening date: 24 September 2012 Latest update: 8 January 2015

Epidemiological summary

Since April 2012 and as of 8 January 2015, 968 cases of MERS-CoV have been reported by local health authorities worldwide, including 394 deaths. The distribution is as follows:

Confirmed cases and deaths by region:
Middle East
Saudi Arabia: 830 cases/358 deaths
United Arab Emirates: 73 cases/9 deaths
Qatar: 9 cases/4 deaths
Jordan: 19 cases/6 deaths
Oman: 3 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. Almost all of the recently reported secondary cases, many of whom are asymptomatic or have only mild symptoms, have been acquired in healthcare settings. There is therefore a continued risk of cases presenting in Europe following exposure in the Middle East. International surveillance for MERS-CoV cases is 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 16 October 2014.
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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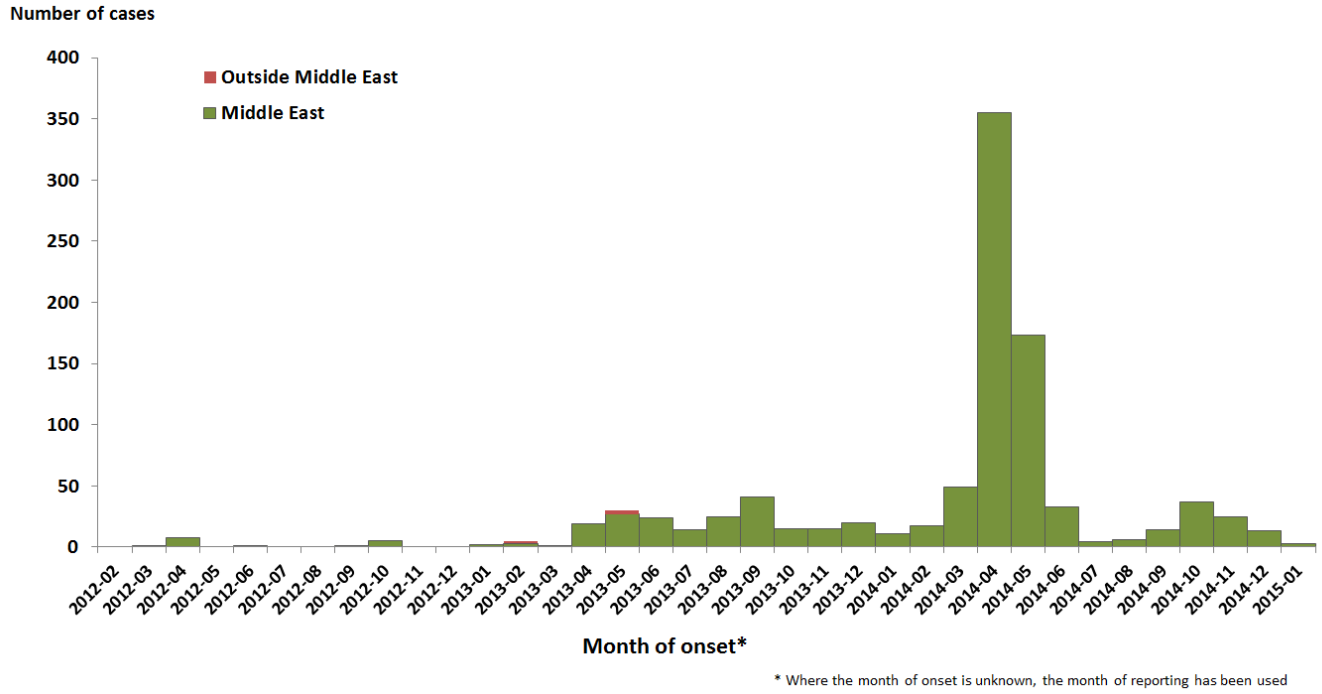
Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 08 January 2015 (n=968)

Source: ECDC



* Where the month of onset is unknown, the month of reporting has been used

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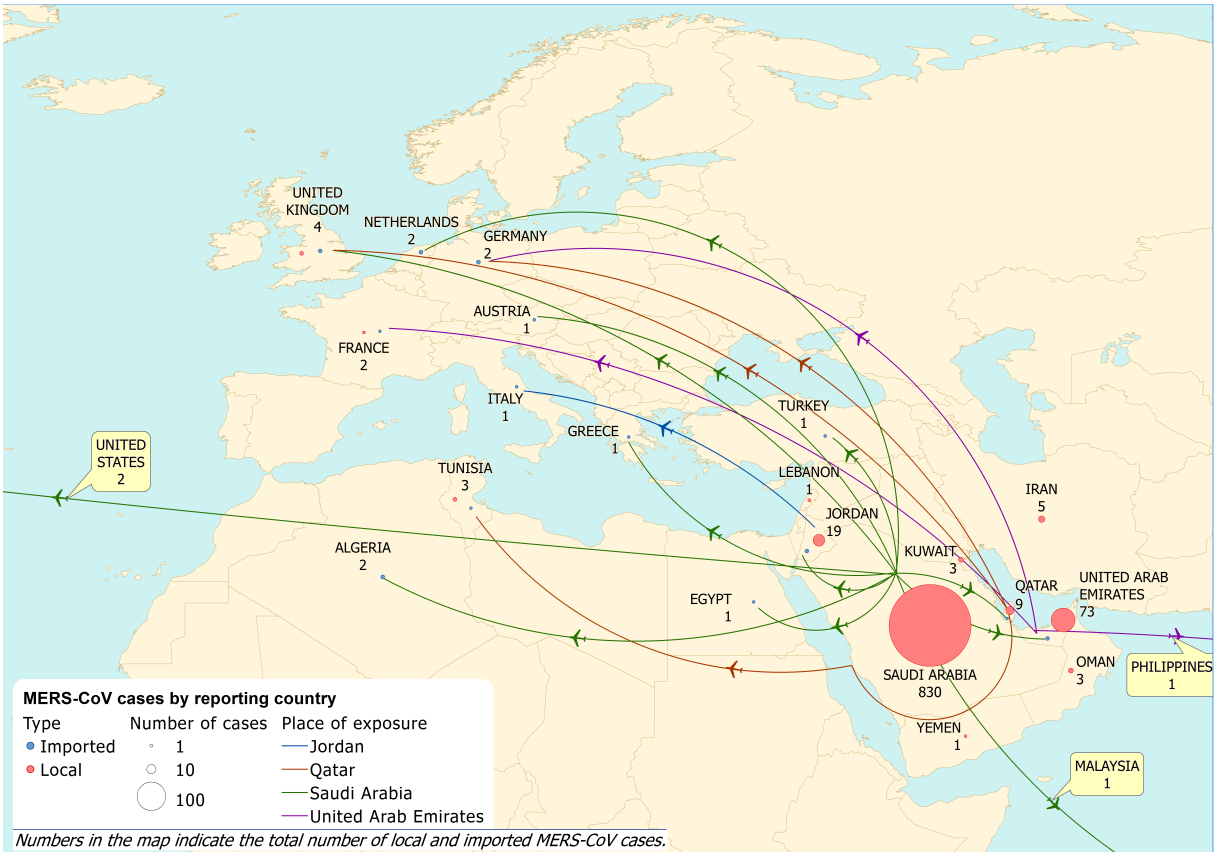
Geographical distribution of confirmed MERS-CoV cases and place of probable infection, worldwide, as of 08 January 2015 (n=968)

Source: ECDC



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

Dengue - Multistate (world) - Monitoring seasonal epidemics

Opening date: 20 April 2006 Latest update: 8 January 2015

Epidemiological summary

Europe: No new autochthonous cases detected since the last monthly update.

Asia: in **China**, the dengue outbreak in Guangdong province is nearing its end and was expected to be over by the end of December 2014. As of 15 December 2014, 45 171 laboratory-confirmed and clinical cases of dengue, including five deaths, had been reported from 20 cities. As of 20 December, the number of dengue cases in **Malaysia** was still higher than for the same time period in 2013. Dengue activity in **Singapore** shows a marked seasonal pattern with a gradual decline in cases from week 38-47. However, since week 48, the number of new cases has fluctuated with a slight increase in recent weeks. **Taiwan** reported more than 15 000 dengue cases in 2014 compared to less than 900 cases in 2013. However, the recent dengue trend has been decreasing. **Indonesia** recorded nearly 72 000 cases of dengue fever up to the middle of December 2014 which is less than during the same time period in 2013. However, certain areas reported notable increases in 2014, especially North Sumatra, Riau, West Kalimantan, North Kalimantan, North Sulawesi, Bali and Jakarta.

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Americas: in 2014, more than 1.1 million suspected cases of dengue fever were reported across the Americas, according to the latest update from the Pan American Health Organization (PAHO) on 29 December. This is a decrease compared to the previous year's numbers when nearly 2.4 million suspected cases were notified. **Brazil** recorded by far the most dengue cases in 2014 with 575 000 suspected and confirmed cases. Other countries reporting more than 100 000 cases include **Colombia** and **Mexico**. The number of dengue-related fatalities in the Americas was 641, approximately half the number of deaths reported in 2013.

In the **USA**, the number of new dengue infections dropped in 2014 to 389 cases compared to 543 cases in 2013. In the state of Florida, 80 imported and six locally-acquired dengue cases were reported, all from Miami-Dade County (as of 27 December 2014), according to the Florida Department of Health.

Pacific Islands and Australia: as of 16 December 2014, dengue activity is declining in most localities in the Pacific islands. A DENV-1 outbreak is still ongoing in **French Polynesia** with 13 new confirmed cases, including one DENV-3 case reported for the week ending 21 December 2014. Overall, the weekly number of cases has been decreasing, according to the Pacific Public Health Surveillance Network (PACNET). There is an ongoing dengue outbreak in **Tonga** with 400 suspected cases reported as of 16 December.

In **Australia**, the first dengue fever outbreak in 2015 has been reported in Queensland, Cairns. To date, there are two confirmed cases and a third suspected case is currently being investigated.

Web sources: ECDC Dengue | Healthmap Dengue | MedISys | ProMed Americas, Asia, Pacific | WPRO |

ECDC assessment

The recent autochthonous transmission of dengue fever in France highlights the risk of locally-acquired cases occurring in countries where the competent vectors are present.

Actions

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

ECDC monitors the dengue situation worldwide on a monthly basis.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

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

Epidemiological summary

Worldwide in 2014, 350 cases had been reported to WHO as of 24 December, compared with 416 for the same time period in 2013. In 2014, nine countries reported cases: Pakistan (297 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).

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.

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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.

Chikungunya- Multistate (world) - Monitoring global outbreaks

Opening date: 9 December 2013 Latest update: 8 January 2015

Epidemiological summary

Over one million suspected and confirmed cases of chikungunya virus infection have been reported in the Caribbean and the Americas since the beginning of the outbreak in December 2013. In the Pacific, there are ongoing outbreaks in French Polynesia, American Samoa, Samoa and Tokelau. In French Polynesia, as of 21 December 2014, 51 000 cases of chikungunya, including nine deaths, had been recorded since 10 October 2014, according to the Pacific Public Health Surveillance Network (PACNET).

Several EU/EFTA countries (France, Greece, Italy, the Netherlands, Spain, the UK and Switzerland) have reported imported cases of chikungunya infection in patients with a travel history to the affected areas.

Web sources: PAHO update| ECDC Chikungunya | CDC Factsheet | Medisys page |

ECDC assessment

Epidemiological data indicate that the outbreaks are still expanding both in the Caribbean, the Americas and the Pacific. The vector is endemic in both regions, where it also transmits dengue virus. Further spread of the outbreaks is to be expected. Continued vigilance is needed to detect imported cases of chikungunya in tourists returning to the EU from these regions. This requires awareness among clinicians, travel clinics and blood safety authorities.

Actions

ECDC published an updated Rapid Risk Assessment on 27 June 2014.

ECDC monitors the global chikungunya situation on a monthly basis.

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

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