COMMUNICABLE DISEASE THREATS REPORT

CDTR
Week 34, 16-22 August 2015

All users

This weekly bulletin provides updates on threats monitored by ECDC.

I. Executive summary

EU Threats

New! Case of chikungunya without travel history to endemic areas - Spain

Opening date: 20 August 2015 Latest update: 20 August 2015

On 3 August 2015, Spain notified the EU (through the EWRS tool) and WHO, about a case of chikungunya virus infection in a resident in the city of Gandia, Valencian Community of Valencia.

➔Update of the week

ECDC is producing a Rapid Risk Assessment on this event.

West Nile virus - Multistate (Europe) - Monitoring season 2015

Opening date: 2 June 2015 Latest update: 20 August 2015

West Nile fever (WNF) is a mosquito-borne disease which causes severe neurological symptoms in a small proportion of infected people. During the June-to-November transmission season, ECDC monitors the situation in EU Member States and neighbouring countries in order to inform blood safety authorities of WNF-affected areas and identify significant changes in the epidemiology of the disease.

➔Update of the week

During the past week, Italy reported four new cases from Cremona, Parma and Reggio nell'Emilia (two cases), three provinces already affected this year. Romania reported a second case of West Nile fever from the newly affected Sibiu County, an area also affected last year. Hungary reported its first case in the current transmission season from the newly affected Fejer County, an area previously affected in 2013.

In neighbouring countries, Israel reported two new cases from already affected districts, Tel Aviv and Central District. In addition, West Nile virus has been detected in mosquitoes in Lipetskaya and Voronezhskaya Oblasts, Russia.

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

Monitoring environmental suitability of Vibrio growth in the Baltic Sea – Summer 2015

Opening date: 6 July 2015 Latest update: 20 August 2015

ECDC has developed a model to map the environmental suitability for *Vibrio* growth in the Baltic Sea (ECDC E3 Geoportal).

➔Update of the week

As of 18 August, the environmental conditions for *Vibrio* growth for the next five days are considered suitable at a very low to low level on the east coast of Denmark around Aarhus and Flensburg, as well as the southern part of the Baltic Sea, particularly around Lubeck, Kiel, Szczecin, Gdansk, Klaipeda, the Gulf of Riga and around Sosnovy Bor.

Cases of meningococcal disease in scouts who returned from the 23rd World Scout Jamboree in Japan

Opening date: 14 August 2015 Latest update: 21 August 2015

On 13 August, Health Protection Scotland, UK, reported two confirmed cases of invasive meningococcal disease among Scottish scouts who had recently returned from the 23rd World Scout Jamboree in Japan. The Jamboree, held from 28 July to 8 August, was attended by over 33 000 scouts from 162 countries.
On 17 August 2015, the Swedish Public Health authorities reported the detection of one probable and two suspected cases of meningococcal infection in Swedish participants who had returned after attending the same event in Japan.

➔Update of the week

As of 20 August 2015, two EU countries, the UK and Sweden, have reported eight cases (five confirmed and three suspected cases) of invasive meningococcal disease in scouts and their contacts associated with this event. The meningococcal serogroup W strain has been identified as the causative agent in two of the cases in the UK. Preliminary typing suggests that the strain is indistinguishable from the strain that has been increasingly seen in England since 2009. Further microbiological and molecular studies are needed to prove that the cases are linked.

Non EU Threats

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 20 August 2015

Global public health efforts are ongoing to eradicate polio, a crippling and potentially fatal disease, by immunising every child until transmission of the virus has completely stopped and the world becomes polio-free. Polio was declared a Public Health Emergency of International Concern (PHEIC) on 5 May 2014 due to concerns regarding the increased circulation and international spread of wild poliovirus during 2014. On 6 May 2015, the Temporary Recommendations in relation to PHEIC were extended for another three months.

➔Update of the week

During the past week, no new cases of wild poliovirus type 1 (WPV1) and circulating vaccine-derived poliovirus (cVDPV) have been reported by WHO.

On 17 August, WHO announced that based on the sixth Emergency Committee meeting conclusions, the international spread of polio remains a Public Health Emergency of International Concern (PHEIC) and the Temporary Recommendations (as revised) are extended for three more months.
The Committee updated the criteria to assess the period of no new exportations and the period for detection of new cases or environment isolates of wild poliovirus. The criteria allow classifying countries in states no longer exporting and states no longer infected. According to these criteria, if there will be no further detection of wild poliovirus in the next 1-2 months, Nigeria and Somalia will meet the criteria for 'States no longer infected by wild poliovirus, but which remain vulnerable to international spread'. The countries that are in this group right now, Ethiopia, Syria, Iraq, Israel, Equatorial Guinea and Cameroon, are called to enhance regional cooperation and cross border coordination to ensure prompt detection of wild poliovirus alongside with enhancing surveillance quality and intensifying efforts to vaccinate vulnerable groups. The statement also highlights the critical importance of interrupting all poliovirus transmission, including outbreaks of vaccine-derived poliovirus for successful completion of polio eradication.

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

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 20 August 2015

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

➔Update of the week

As of 16 August 2015, WHO has reported 27 988 cases of Ebola virus disease related to the outbreak in West Africa, including 11 299 deaths.

According to the latest WHO situation report published on 19 August 2015, three confirmed cases of EVD were reported in the week up to 16 August, all reported from Guinea. For the first time since the beginning of the outbreak, a full week has passed with no confirmed cases reported from Sierra Leone. Liberia has reported no new cases.

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

Opening date: 24 September 2012 Latest update: 20 August 2015

Since April 2012 and as of 21 August 2015, 1 472 cases of MERS have been reported by local health authorities worldwide, including 557 deaths. The source of the virus remains unknown but the pattern of transmission and virological studies point 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 13 August, Saudi Arabia has reported 46 additional cases and seven deaths in previously reported cases. Among these cases, 45 are reported from Riyadh, including three healthcare workers.

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

II. Detailed reports

New! Case of chikungunya without travel history to endemic areas - Spain

Opening date: 20 August 2015 Latest update: 20 August 2015

Epidemiological summary

On 3 August 2015, Spain notified the EU (through EWRS), and WHO, about a case of chikungunya virus infection in a resident of the city of Gandia, in the Autonomous Community of Valencia. The patient is a 60-year-old male with no history of travel outside the EU in the previous three months. The case was travelling in France from 4 July, developed symptoms on 7 July and sought medical care on 8 July while still in France. Following his return to Spain, the patient was hospitalised in Girona (Autonomous Community of Catalunya) on 11 July and discharged on 16 July. Back in Gandia, the patient, who works on vector control activities, contacted local health authorities presenting his illness as a possible case of Chikungunya because he was still suffering from arthralgia. The patient's blood samples were collected on 23 July. On 31 July, ELISA tests were positive for chikungunya IgM. A second sample was collected on 19 August and IgG seroconversion was identified.

During his probable incubation period (26 June to 6 July 2015) and while symptomatic before hospitalisation on 11 July, the patient stayed in the Valencian Community in Spain (most of the time), and the Languedoc-Roussillon region and Vosges department in France. *Aedes albopictus* is known to be present in the Valencia Community and the Languedoc-Roussillon region.

ECDC assessment

The chikungunya case without travel history to endemic areas reported by Spain is not an unexpected event. Europe is vulnerable to the transmission of chikungunya virus as exemplified by the chikungunya outbreak in Italy in 2007 and sporadic autochthonous cases reported in France in 2010 and 2014. In the Valencia Community, the competent vector *Aedes albopictus* has been present since 2013. In addition, imported chikungunya cases have been reported from the Gandia commune, the climate is conducive for chikungunya transmission and this case spent most of his period at risk in Gandia. The infection of this case in France is most unlikely based on the short stay during the period at risk and the investigations carried out in the places in France visited by the patient.

Actions

ECDC is producing a Rapid Risk Assessment.

West Nile virus - Multistate (Europe) - Monitoring season 2015

Opening date: 2 June 2015 Latest update: 20 August 2015

Epidemiological summary

Since the beginning of the 2015 transmission season and as of 20 August, 13 human cases of WNF have been reported in EU Member States: Italy (8), Romania (2), Bulgaria (1), Hungary (1) and Austria (1). Ten cases have been detected in neighbouring countries: Israel (9) and Serbia (1).

Web sources: ECDC West Nile fever | ECDC West Nile fever risk assessment tool | ECDC West Nile fever maps | WHO fact sheet

ECDC assessment

WNF in humans is a notifiable disease in the EU. The implementation of control measures is considered important for ensuring blood safety by the national health authorities when human cases of WNF fever occur. According to the EU Blood Directive, efforts should be made to defer blood donations from affected areas with ongoing virus transmission unless donations are tested using individual nucleic acid amplification testing (NAAT).

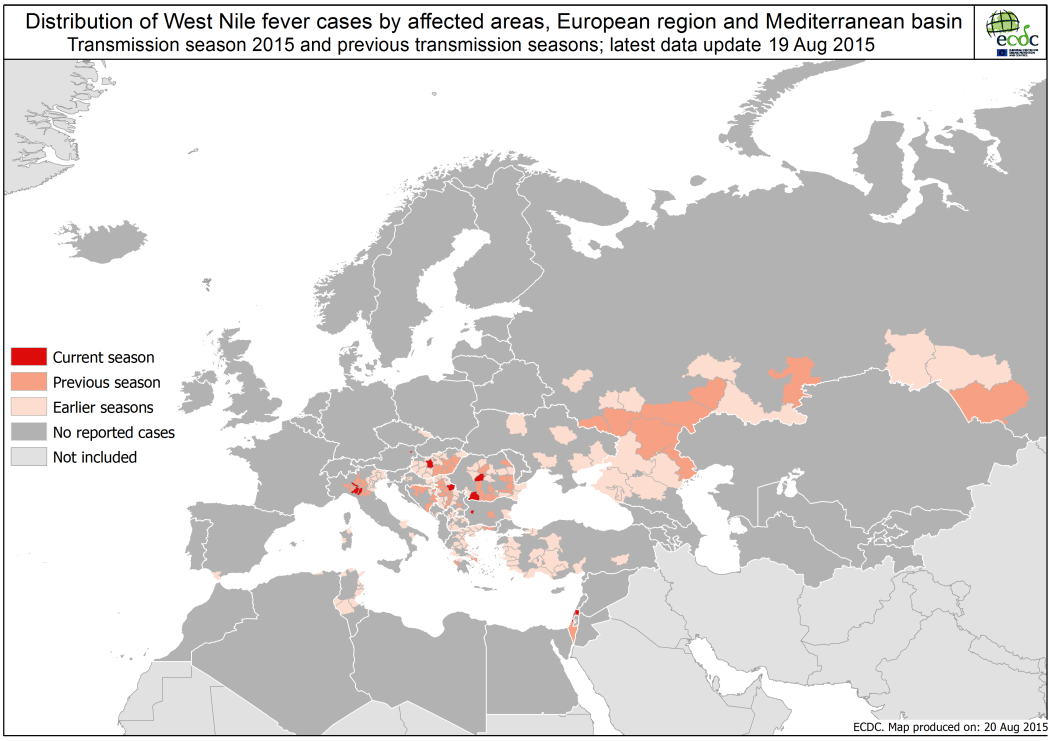
Actions

ECDC produces weekly WNF maps during the transmission season (June to November) to inform blood safety authorities of WNF

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

affected areas.

Source: ECDC



Monitoring environmental suitability of Vibrio growth in the Baltic Sea – Summer 2015

Opening date: 6 July 2015 Latest update: 20 August 2015

Epidemiological summary

In late June 2015, the *Vibrio* suitability tool on the ECDC E3 Geoportal helped ECDC to ascertain favourable environmental factors for *Vibrio* growth.
On 3 July 2015, ECDC launched an Urgent Inquiry (UI) in EPIS-FWD after detecting elevated sea surface temperatures (according to the National Oceanic and Atmospheric Administration, NOAA) in the Baltic Sea (as of 2 July 2015).

ECDC assessment

Elevated sea surface temperatures in marine environments with low salt content provide ideal environmental growth conditions for certain *Vibrio* species. These conditions can be found during the summer months in estuaries and enclosed water bodies with moderate salinity. In contrast, open ocean environments do not offer appropriate growth conditions for these bacteria due to the high salt content, low temperatures, and limited nutrient content. These *Vibrio* species, particularly *V. parahaemolyticus, V. vulnificus* and non-toxigenic *V. cholera,* can cause vibriosis infections.
Vibriosis in humans caused by these species in the Baltic region have occurred in the past during hot summer months, particularly when the sea surface temperature has been elevated. The most common clinical manifestations are gastroenteritis (with nausea, vomiting, and diarrhoea), wound infections (exposure of a cut, wound, or abrasion to contaminated seawater), primary septicaemia, and otitis externa (swimmer's ear). Risk factors for illness include consumption of shellfish, particularly raw oysters, and contact with natural bodies of water, especially marine or estuarine waters.

Actions

ECDC launched an UI in EPIS-FWD to inform the FWD network about the elevated surface water temperatures measured in the Baltic Sea, which create a favourable environment for the growth of *Vibrio* bacteria. ECDC will monitor this threat on a weekly basis during the summer of 2015 and report on increased environmental suitability for growth of *Vibrio* bacteria.

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

The *Vibrio* suitability tool is available on the ECDC E3 Geoportal. Please note that this model has been calibrated to the Baltic region in northern Europe and might not be compatible with other regional settings prior to validation.

Cases of meningococcal disease in scouts who returned from the 23rd World Scout Jamboree in Japan

Opening date: 14 August 2015 Latest update: 21 August 2015

Epidemiological summary

On 13 August, Health Protection Scotland, UK, reported two confirmed cases of invasive meningococcal disease among Scottish scouts who had recently returned from the 23rd World Scout Jamboree held in Japan, the Yamaguchi Prefecture. The Jamboree, held from 28 July to 8 August, was attended by over 33 000 scouts from 162 countries around the world.
On 14 August, a third confirmed case was reported in a returning scout; all three cases were in the same scout group and they all returned on 8th August. The three cases were admitted to hospital in Scotland, treated with antibiotics and are all recovering well. Two have been confirmed as having capsular group W meningococcal disease. Preliminary typing suggests that the strain is indistinguishable from the strain that has been increasingly seen in England since 2009.
On 18 August, a secondary case of meningococcal infection was reported in a household contact (parent) of a scout from the north of Scotland unit bringing the total of cases in Scotland to four.

On 17 August 2015, the Swedish Public Health authorities reported the detection of one probable and two suspected cases of meningococcal infection in Swedish participants who had returned home on 9th August after attending the same event in Japan. On 18 August, the probabale case was confirmed through PCR with *N. meningitidis* infection while one of the two suspected cases showed negative PCR results. A further suspected case, with positive throat culture, was reported on 18 August in a returning scout who sought hospital care on 16 August and who recovered well.

So far there is no information if the Swedish cases had any contact with the Scottish scouts. The Swedish authorities sent letters to all returning scouts (1 900) and their parents advising to seek medical care if they show any signs of meningitis infection and in order to receive chemoprophylaxis.

ECDC assessment

This is not an unexpected event at mass gatherings. It is not uncommon for young people to be asymptomatic carriers of meningococci, and because the majority of invasive meningococcal disease cases result from recent transmission following close contact with an asymptomatic carrier, it is likely that one or several scouts attending the Jamboree were indeed carriers. It has not yet been established if the Swedish and Scottish cases have interacted and possibly shared a close contact. However, the number and frequency of close contacts between participants at a Jamboree is expected to be high. Further microbiological and molecular studies may provide evidence of direct or indirect transmission between the cases.
ECDC published a rapid risk assessment on the situation.

Poliomyelitis - Multistate (world) - Monitoring global outbreaks

Opening date: 8 September 2005 Latest update: 20 August 2015

Epidemiological summary

Worldwide in 2015, 36 wild poliovirus type 1 (WPV1) cases have been reported to WHO so far, compared with 145 for the same period in 2014. Since the beginning of the year, two countries have reported cases: Pakistan (29 cases) and Afghanistan (7 cases).

In 2015, ten cases (nine in Madagascar and one in Nigeria) of circulating vaccine-derived poliovirus (cVDPV) have been reported to WHO so far, compared with 31 for the same period in 2014. The cases in Madagascar are genetically linked to a case reported in September 2014, indicating prolonged and widespread circulation of the virus.

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

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

ECDC assessment

Europe is polio-free. The last locally acquired wild-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 wild poliovirus in several countries and the documented exportation of wild poliovirus to other countries support the fact that there is a potential risk of wild poliovirus 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 both.

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? |

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 re-introduced 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.

Ebola Virus Disease Epidemic - West Africa - 2014 - 2015

Opening date: 22 March 2014 Latest update: 20 August 2015

Epidemiological summary

Distribution of cases as of 16 August 2015:

Countries with intense transmission:

- **Guinea:** 3 786 cases, of which 3 332 were confirmed; 2 524 deaths.
- **Sierra Leone:** 13 494 cases, of which 8 697 were confirmed; 3 955 deaths.
- **Liberia:** 10 672 cases, of which 3 157 are confirmed as of 13 August. Six confirmed cases including 2 deaths have been reported since the end of June 2015 when the country was declared Ebola free.

Countries that have reported an initial case or localised transmission:

- Nigeria, Senegal, the USA, Spain, Mali, the UK and Italy.

Situation in West African countries
In **Guinea**, WHO reported three new confirmed cases (two in Conakry and one in Forecariah) in the week up to 16 August, compared to two cases during the previous week. All the cases were registered contacts of previous confirmed ones. According to WHO there are 796 contacts in three prefectures (Conakry, Forecariah and Coyah) under follow-up. WHO reported that all contacts previously under observation in the prefecture of Kindia have now completed the 21-day follow-up period.

In **Sierra Leone**, WHO reported no new confirmed cases in the week up to 16 August, compared with one during the previous week. WHO reported that in three districts (Tonkolili, Western Area Urban and Western Area Rural) there are 72 contacts still under follow-up.
WHO posted a news release on 17 August acknowledging the first week with no new cases in Sierra Leone. The Ebola response in Sierra Leone is now down to a single chain of transmission, which started in Freetown and sparked a cluster of cases in Tonkolili. Forty-three people remain quarantined in Tonkolili until the end of this week and another 38 people remain in quarantine in Freetown until 29 August.

In **Liberia**, no new cases were reported from Liberia in the week up to 16 August.

Situation among healthcare workers
No new healthcare worker infections were reported during the week up to 16 August. Since the start of the outbreak, 880 confirmed healthcare worker infections have been reported from Guinea, Liberia, and Sierra Leone; 512 deaths were reported.

Outside of the three most affected countries, 2 Ebola-infected healthcare workers were reported in Mali, 11 in Nigeria, 1 in Spain

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

(infected while caring for an evacuated EVD patient), 2 in the UK (both infected in Sierra Leone), 6 in the USA (2 infected in Sierra Leone, 2 in Liberia, and 2 infected while caring for a confirmed case in Texas) and 1 in Italy (infected in Sierra Leone).

Medical evacuations and repatriations from EVD-affected countries
Since the beginning of the epidemic and as of 21 August 2015, 65 individuals were evacuated or repatriated worldwide from the EVD-affected countries. Of these, 38 individuals were evacuated or repatriated to Europe. Thirteen were medical evacuations of confirmed EVD-infected patients to: Germany (3), Spain (2), France (2), UK (2), Norway (1), Italy (1), the Netherlands (1) and Switzerland (1). Twenty-five asymptomatic persons were repatriated to Europe as a result of exposure to Ebola in West Africa: UK (13), Denmark (4), Sweden (3), the Netherlands (2), Germany (1), Spain (1) and Switzerland (1).
Twenty-seven persons were evacuated to the United States.
No new medical evacuations have taken place since 18 March 2015.

Images
- Epicurve 1: the epicurve shows the confirmed cases in the three most affected countries. In order to better represent the tail of the epidemic, only the data for 2015 are shown.
- Epicurve 2: the epicurve shows the confirmed cases in Guinea, Sierra Leone and Liberia. In order to better represent the tail of the epidemic, only the data for 2015 are shown.
- Map: this map is based on country situation reports and shows only confirmed cases of EVD in the past six weeks.

Web sources: ECDC Ebola page | ECDC Ebola and Marburg fact sheet | WHO situation summary | WHO Roadmap | WHO Ebola Factsheet | CDC | News release from WHO about the situation in Sierra Leone

ECDC assessment

This is the largest-ever documented epidemic of EVD, both in terms of numbers and geographical spread. The 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 risk of importing EVD into the EU and the risk of transmission within the EU following an importation remains low or very low as a result of the range of risk reduction measures that have been put in place by the Member States and by the affected countries in West Africa. However, continued vigilance is essential. 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.

According to WHO, case incidence has held at three confirmed cases per week for three consecutive weeks and only Guinea and Sierra Leone reported cases. WHO maintains that a significant risk of further transmission and an increase in case incidence in the near and medium term still remains. In addition to the large number of contacts under observation (800), some high-risk contacts have been lost to follow-up both in Conakry and Freetown.
The introduction of an EVD case into unaffected countries remains a risk as long as cases exist in any country. With adequate preparedness, however, such an introduction can be contained through a timely and effective response.

Actions

As of 21 August 2015, ECDC has deployed 91 experts (on a rotating basis) from within and outside the EU in response to the Ebola outbreak. This includes an ECDC-mobilised contingent of experts to Guinea. Furthermore, additional experts are already confirmed for deployment to Guinea over the next few months.

ECDC is looking for additional French-speaking experts with field epidemiology experience from EU Member States to join the ECDC-coordinated contingent in response to the Ebola outbreak in Guinea. For further information, please contact Valeria Pelosi at valeria.pelosi@ecdc.europa.eu with copy to support@ecdc.europa.eu.

An epidemiological update is published weekly on the EVD ECDC page.

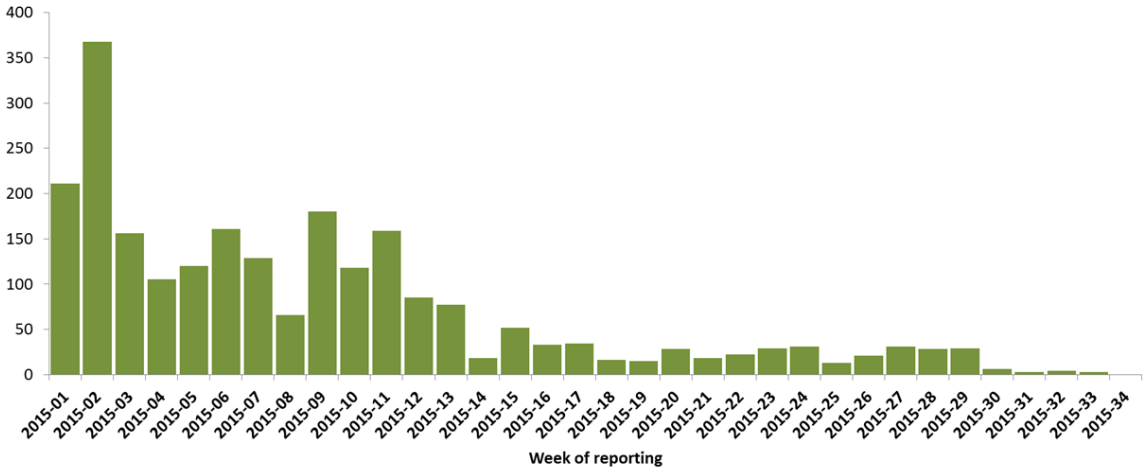
The latest (12th) update of the rapid risk assessment was published on 1 July 2015.
On 31 July 2015, ECDC published Positive preliminary results of an Ebola vaccine efficacy trial in Guinea.
On 22 January 2015, ECDC published Infection prevention and control measures for Ebola virus disease. Management of healthcare workers returning from Ebola-affected areas.
On 4 December 2014, EFSA and ECDC published a Scientific report assessing Risk related to household pets in contact with Ebola cases in humans.
On 29 October 2014, ECDC published a training tool on the safe use of PPE and options for preparing for gatherings in the EU.
On 23 October 2014, ECDC published Public health management of persons having had contact with Ebola virus disease cases in

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

the EU.
On 22 October 2014, ECDC published Assessing and planning medical evacuation flights to Europe for patients with Ebola virus disease and people exposed to Ebola virus.
On 13 October 2014, ECDC published Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures.
On 6 October 2014, ECDC published risk of transmission of Ebola virus via donated blood and other substances of human origin in the EU.
On 22 September 2014, ECDC published assessment and planning for medical evacuation by air to the EU of patients with Ebola virus disease and people exposed to Ebola virus.
On 10 September 2014, ECDC published an EU case definition.

Distribution of confirmed cases of EVD by week of reporting in Guinea, Sierra Leone and Liberia (weeks 01/2015 to 34/2015)

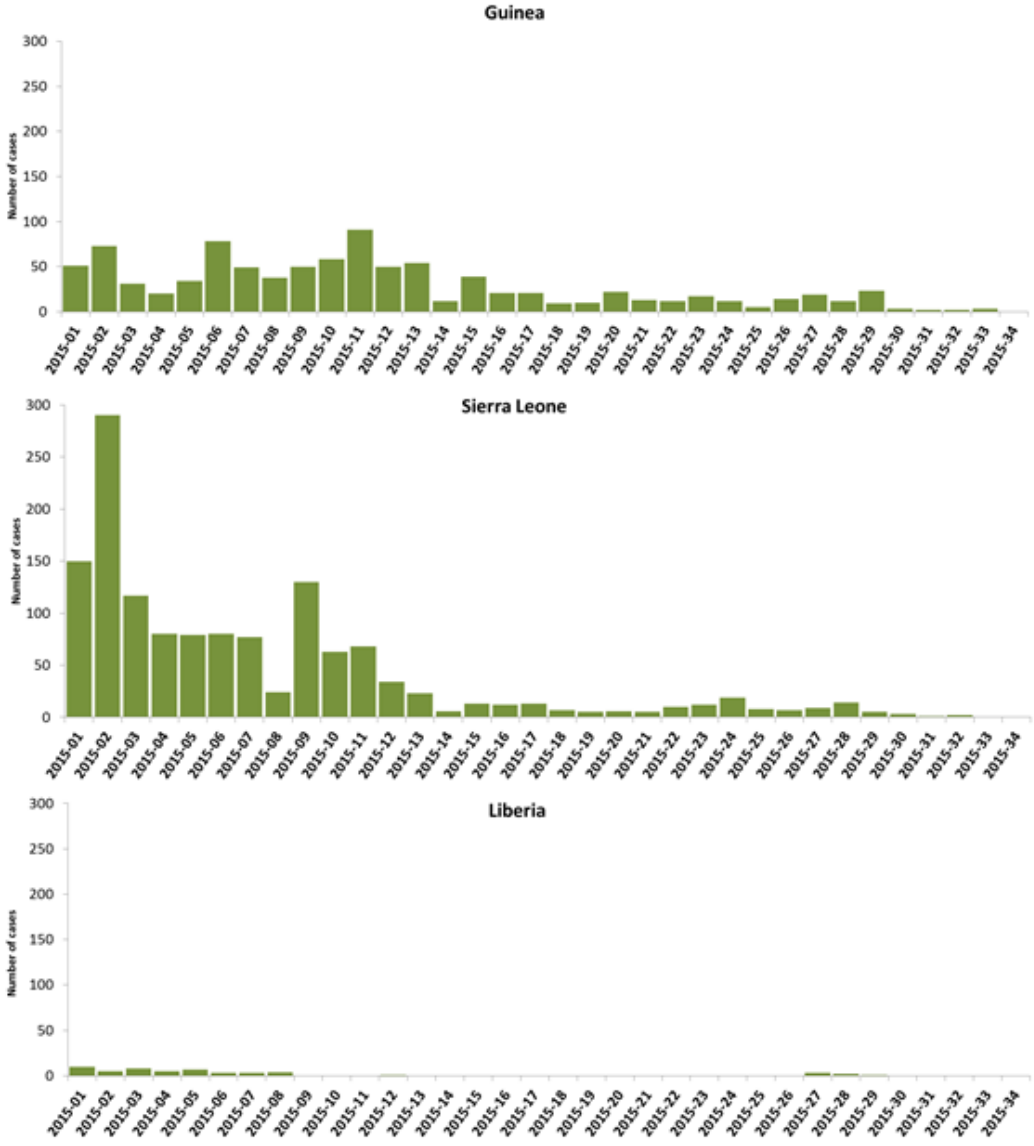
Adapted from WHO figures; *data for week 34/2015 are incomplete



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 confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (weeks 01/2015 to 34/2015)

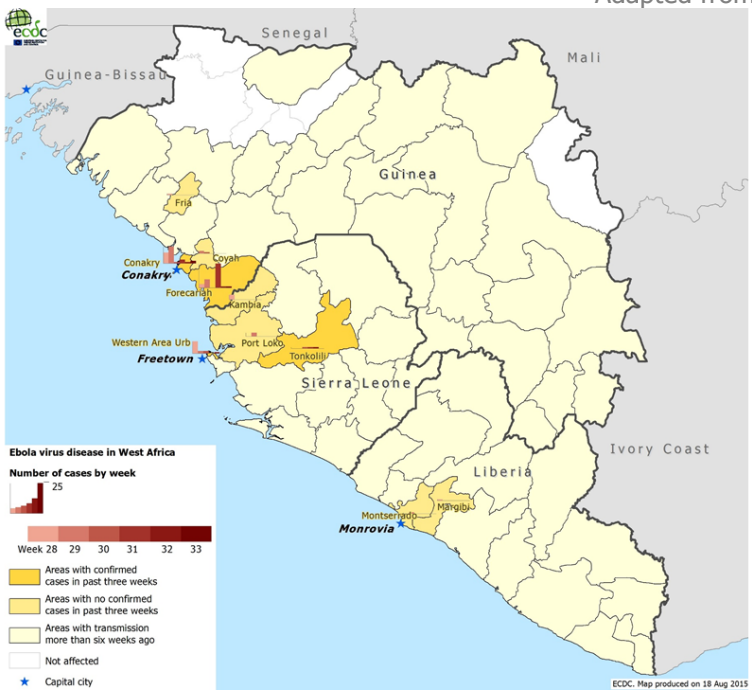
Adapted from WHO figures; *data for week 34/2015 are incomplete



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 confirmed cases of EVD by week of reporting in Guinea and Sierra Leone (as of week 33/2015)

Adapted from national situation reports



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

Opening date: 24 September 2012 Latest update: 20 August 2015

Epidemiological summary

Since April 2012 and as of 20 August, 1 472 cases of MERS-CoV have been reported by local health authorities worldwide, including 557 deaths.

Saudi Arabia: Since the last publication of the RRA on 31 July 2015 (data until 20 July 2015), Saudi Arabia reported 80 MERS cases. Among them, 75 (94%) were reported in Riyadh city. According to the Ministry of Health, most of these cases are linked to an outbreak occurring in King Abdul-Aziz Medical City. However, the Ministry mentioned other cases occurring in other health facilities, including private ones.

The distribution is as follows:
Confirmed cases and deaths by region:

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

Middle East
Saudi Arabia: 1 128 cases/481 deaths
United Arab Emirates: 81 cases/11 deaths
Qatar: 13 cases/5 deaths
Jordan: 19 cases/6 deaths
Oman: 6 cases/3 deaths
Kuwait: 3 cases/1 death
Egypt: 1 case/0 deaths
Yemen: 1 case/1 death
Lebanon: 1 case/0 deaths
Iran: 6 cases/2 deaths

Europe
Turkey: 1 case/1 death
UK: 4 cases/3 deaths
Germany: 3 cases/2 deaths
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: 3 cases/0 deaths
South Korea: 185 cases/36 deaths
China: 1 case/0 deaths
Thailand: 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 | Saudi Arabia statement |ECDC factsheet for professionals

ECDC assessment

According to ECDC experts, the MERS outbreak poses a low risk to the EU. Efforts to contain the nosocomial clusters in the affected countries are vital to prevent wider transmission. Although sustained human-to-human community transmission is unlikely, secondary transmission to unprotected close contacts, especially in healthcare settings, remains possible, as documented in South Korea.

Countries should advise travellers returning from all countries affected by MERS to seek medical attention if they develop a respiratory illness with fever and cough during the two weeks after their return and to disclose their recent travel history to the healthcare provider. The travellers, especially those with pre-existing medical conditions, should be reminded of the importance of good hand and food hygiene, and to avoid contact with sick people. In addition, travellers to the Arabian Peninsula should avoid close contact with camels, visiting farms and consuming unpasteurised camel milk, urine or improperly cooked meat.

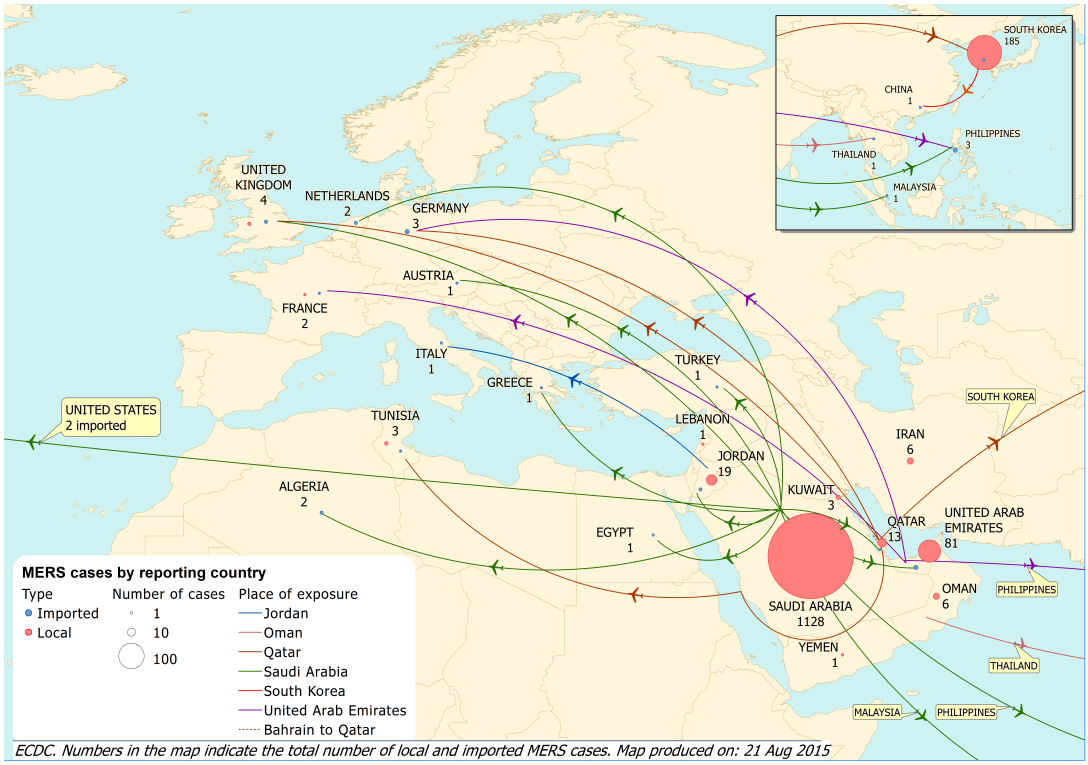
Actions

ECDC published a rapid risk assessment on 31 July 2015 and an epi-update on 19 August 2015.

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 confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 21 August 2015 (n=1 472)

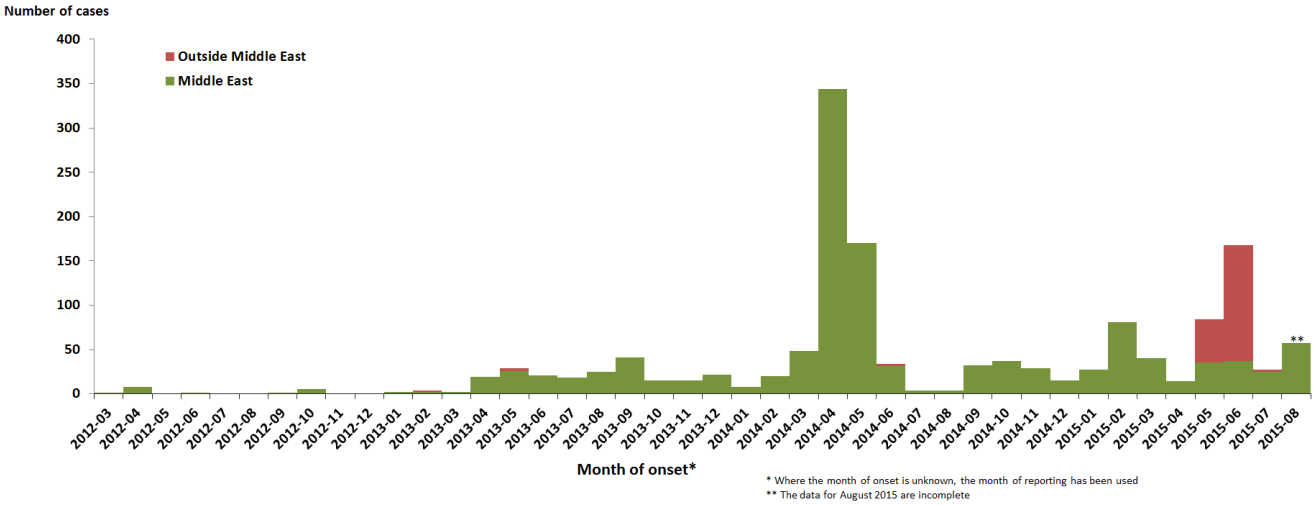
ECDC



ECDC. Numbers in the map indicate the total number of local and imported MERS cases. Map produced on: 21 Aug 2015

Distribution of confirmed cases of MERS-CoV by first available date and place of probable infection, March 2012 – 21 August 2015 (n=1 472)

ECDC



* Where the month of onset is unknown, the month of reporting has been used
** The data for August 2015 are incomplete

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

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

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