Overseas briefs

This material has been summarised from information provided by the World Health Organization (http://www.who.int) and by ProMED-mail (http://www.promedmail.org).

For the period 1 July to 30 September 2006

Avian influenza

From July to the end of September this year, WHO has reported 23 cases including 18 deaths from human influenza A (H5N1) in four countries: China, Indonesia, Iraq and Thailand.

Since the beginning of the outbreak in November 2003 to 30 September 2006, WHO has reported a worldwide total of 251 confirmed human H5N1 cases (with 148 deaths) in 10 countries.

China

The Chinese Ministry of Health confirmed two fatal H5N1 cases, one retrospectively, during the current reporting period.

The retrospective case is likely to be the index case of human H5N1 infection in mainland China in the current outbreak. The case, which dates back to November 2003, occurred in a 24-year-old man from the military who was based in Beijing. He developed symptoms on 25 November and died on 3 December 2003. As a result of the lengthy delay in diagnosing the cause of death, no history of poultry exposure was taken and the source of his H5N1 infection remains uncertain.

The second case occurred in a 62-year-old man from north-western China. The farmer developed symptoms on 19 June and died on 12 July 2006. No exposure history could be ascertained.

Confirmation of these two cases bought China's total confirmed human cases to 21 including 14 deaths since the beginning of the outbreak.

Indonesia

Human H5N1 cases continue to occur in Indonesia and there is no evidence of a decrease in the incidence of poultry H5N1 outbreaks with almost all Provinces reporting poultry outbreaks this year.

Between July and September 2006, the Indonesian Ministry of Health reported 17 confirmed H5N1 cases including 13 deaths. Confirmation brought Indonesia's total human cases to 68, including 52 deaths, since the beginning of the outbreak.

During August, a cluster of human H5N1 cases were reported in the remote sub-district of Cikelet, West Java Province. Prior to late June 2006, no mass poultry deaths were known to have occurred in the area. However, shortly after the purchase of chickens from an outside market and subsequent integration into local flocks, large numbers of chickens began dying in an outbreak that continued throughout July and into August. Three human cases from the area were confirmed positive for H5N1, two of whom died.

Additional deaths from respiratory illnesses were known to have occurred in July and August but no samples were taken. An investigation found no evidence of human-to-human transmission or that the virus was spreading more easily from birds to humans.

As a result of a change in the WHO H5N1 case definitions during the reporting period, WHO retrospectively confirmed three cases.

The first case from Banten Province occurred in an 8-year-old girl who developed symptoms on 24 June 2005 and died on 14 July 2005. She was part of a family cluster reported to WHO in July 2005 in which her father and sister also died.

The second case occurred in a 45-year-old male from Central Java Province. He developed symptoms on 25 November 2005 after exposure to diseased poultry but subsequently recovered.

The third case occurred in a 27-year-old male from West Sumatra Province. The case was identified during contact tracing of the man's sister who was confirmed H5N1 positive in May 2006. He developed mild symptoms after caring for his sister during her hospital stay.

The remaining 11 confirmed cases that occurred during this period, 10 of which were fatal, were localised to four provinces: East Java (n = 2), Jakarta (n = 4), West Java (n = 4) and South Sulawasi (n = 1). The non-fatal case occurred in a 6-year-old girl from West Java Province.

Iraq

The Iraqi Ministry of Health retrospectively confirmed the country's third case of avian influenza for the year on 19 September 2006. The case was a 3-year-old

boy who was hospitalised in Baghdad on 15 March 2006. He has since fully recovered. The other two fatal cases in Iraq occurred in January 2006.

Thailand

The Thai Ministry of Public Health reported three fatal cases between July and September this year, the only cases reported in 2006.

The first case was a 17-year-old man from Phichit Province in the country's north. He developed symptoms on 15 July, was hospitalised on 20 July and died on 24 July. This case had a history of previously handling poultry prior to his illness and at the same time as a confirmed H5N1 poultry outbreak in the province.

The second case occurred in a 27-year-old man from the central Uthai Thani Province. He developed symptoms on 24 July, was hospitalised on 30 July and died on 3 August. He also had exposure to dying household chickens.

The third case occurred in a 59-year-old farmer from Nong Bua Lam Phu Province in the north-east. He developed symptoms on 14 July, was hospitalised on 24 July and died on 10 August. Poultry outbreaks had been noted in the area. This patient was treated with oseltamivir while hospitalised. Repeated tests on upper respiratory tract samples (most after antiviral treatment) were negative for all influenza viruses by polymerase chain reaction. The H5N1 virus was isolated from lung samples taken at autopsy. This brings the confirmed cases in Thailand to 25 including 17 deaths.

Poultry outbreaks were confirmed in two Thai Provinces in late July, the first since November 2005.

[Source: WHO updates: 4, 14, 20 and 26 July; 7, 8, 9, 14, 17, 21, and 23 August; 8, 14, 19, 25, 27 and 28 September]

Chikungunya

WHO has reported 151 districts in 8 states/provinces in India have been affected by chikungunya fever from February to 10 October. More than 1.25 million suspect cases have been reported throughout the country. The outbreak is concentrated towards the south with 752,245 and 258,998 cases from the Karnataka and Maharashtra Provinces respectively. In some areas, reported attack rates have reached 45 per cent.

[Source: WHO update: 17 October]

Cholera and acute watery diarrhoeal syndrome

There was a sharp increase in cholera cases reported to the WHO in 2005 and this increased activity continues. During the reporting period, cholera outbreaks have occurred in 17 African countries: Angola, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Kenya, Liberia, Mauritania, Niger, Nigeria, Senegal, Sudan, Togo, Tanzania, Uganda, and Zimbabwe.

All of these countries reported cholera outbreaks during 2005 with the exception of Angola and Sudan (neither had these countries reported outbreaks of acute watery diarrhoeal syndrome in 2005). However, neighbouring countries such the Democratic Republic of the Congo, have reported large cholera outbreaks in 2005 which are still continuing. Between 1 March and 17 September 2006, 9,565 cases including 196 deaths were reported in the Democratic Republic of the Congo.

Angola has reported 7,041 cases and 261 deaths between 24 June and 27 September 2006. The cumulative total as at 7 September was 53,537 cases and 2,187 deaths since 13 February [case fatality rate (CFR) = 4.0%]. This is the country's worst outbreak of water-borne disease in 20 years.

Sudan has reported 25,344 cases and 768 deaths between 28 January and 24 September 2006. The majority of the cases were from the first half of the year with 3,879 cases including 105 deaths reported between 19 July and 24 September. The last previously reported outbreak in Sudan occurred in 1996 with 1,800 cases. WHO has stated that the Sudanese outbreak was probably the cause of the current outbreak in Ethiopia, especially as the first Ethiopian cases occurred in Gambella in western Ethiopia (which borders Sudan) in April 2006.

As of 28 September, the Ethiopian Ministry of Health has reported a total of 22,101 cases and 219 deaths since the beginning of the outbreak (CFR = 1.0%). Five of Ethiopia's nine regions are affected with 79 per cent of the cases occurring in the Oromiya region. Ongoing flooding is a problem with the severely affected Amhara region reporting a CFR of 10 per cent. *Vibrio cholerae* 01 serotype Inaba has been confirmed in some areas.

Côte d'Ivoire has reported 372 cases including 8 deaths between 2 January and 23 July 2006 in contrast to 2005 when 39 cases including six deaths were reported for the entire year.

[Source: WHO Weekly Epidemiological Report, 4 August – 20 October; WHO update: 4 October]

Crimean-Congo haemorrhagic fever

Turkey experienced its largest-ever outbreak of Crimean-Congo haemorrhagic fever (CCHF) with 242 laboratory confirmed cases, including 20 deaths (CFR = 8.3%) between 1 January and 4 August 2006. From the period of 1 July to 4 August, 92 cases and nine deaths were reported. One of the fatal cases was a health care worker who acquired the infection while treating cases.

CCHF was initially characterised in the Crimea in 1944 however Turkey did not report its first cases until 2002. During 2005, Turkey reported 41 cases including one death in Yozgat Province. The most recent outbreak was reported in the Black Sea and Central Anatolia regions with six provinces affected. CCHF generally emerges in the summer months and is spread to humans via an infected tick bite although human-to-human transmission can also occur via exposure to blood of an infected patient.

The Southern Federal District of Russia also reported a rise in CCHF cases this year with 192 cases including five deaths reported throughout the area. During the 2005 outbreak, 127 cases including four deaths were reported in the same region.

[Source: WHO update: 8 August; ProMED, 20050729.2210, 29 July 2005; ProMED, 20060810.2242,10August;ProMED20060822.2359, 22 August]

Lassa fever

On 21 July 2006, Germany reported a case of Lassa fever imported from Sierra Leone in a 68-year-old man. The man, a Sierra Leone resident, became ill on 5 July and flew to Germany on 10 July. Although the risk of transmission to fellow passengers was low, the case initiated an international contact tracing exercise. No secondary cases have been reported. (The last reported imported case into Europe was three years ago in a soldier from the United Kingdom who had been serving in Sierra Leone.) [Lassa fever is considered endemic in West Africa from Nigeria to Senegal.]

Liberia, which neighbours Sierra Leone, experienced a Lassa fever outbreak between late May and September 2006 with 20 suspected/confirmed cases, including seven deaths. The cases occurred in the northern Nimba County, which shares borders with Côte d'Ivoire and Guinea.

[Source: WHO update: 25 July; ProMED, 20060724.2045, 24 July, ProMED, 20061001.2812, 1 October]

Pneumonic plague

A suspected pneumonic plague outbreak is occurring in Oriental province, in the north-eastern part of the Democratic Republic of the Congo. The outbreak began in mid-May 2006 and at 29 September was ongoing. Local authorities had reported 1,174 suspect cases including 50 deaths. Preliminary results from rapid diagnostic tests in the area found three of eight samples positive for pneumonic plague but final laboratory confirmation is still pending.

[Source: WHO update: 14 June, 13 October, 7 November]

Poliomyelitis – world update

As at 12 September 2006, four countries remain polio-endemic – Afghanistan, India, Nigeria and Pakistan. In addition to these countries, 12 countries have reported polio cases in 2006 due to importations – Kenya, Cameroon, Somalia, Yemen, Indonesia, Bangladesh, Ethiopia, Angola, Namibia, Niger, Nepal and the Democratic Republic of the Congo.

Endemic countries

In 2006, polio cases in northern Nigeria account for two-thirds of all global cases (803 of 1,228 cases). Five northern states account for 80 per cent of Nigeria's cases. Immunization Plus Days were held in September, with additional rounds planned for November and December in an effort to increase polio vaccination coverage of every child.

As at 3 October, India had reported 353 polio cases. Approximately half of the cases are concentrated in and around the Moradabad district in western Uttar Pradesh. The neighbouring state of Bihar has reported 20 cases. During 2005, only 66 confirmed cases were reported across the entire country. There is no indication that the current outbreak is being contained and the risk of further spread remains high. Polio originating from this area has been detected in a number of previously polio-free counties including Angola, Namibia, Democratic Republic of the Congo, Bangladesh and Nepal.

As at 12 September 2006, Pakistan has reported 17 cases since the beginning of the year, compared to 15 cases for the same period in 2005. Afghanistan has reported 26 cases, compared to four cases for the same period in 2005. Pakistan and Afghanistan continue to synchronise immunisation activities to increase coverage in the shared corridor of transmission.

Importation countries

Of the 12 countries that have had imported polio cases in 2006, eight countries have reported the date of onset of their most recent case between July and September 2006.

In Niger, 11 cases have been reported for the year to date with the date of onset of the most recent case being 23 August 2006. For the same period last year, six cases had been reported.

In Bangladesh, 15 cases have been reported for the year to date with date of onset of the most recent case, 22 August 2006. For the same period last year, no cases were reported. Bangladesh had not reported any cases of polio since 2000.

Cameroon has reported one case for the year with the date of onset of 22 August 2006 (compared to 1 case for the same period last year). Genetic testing is being undertaken on the case to determine the origin of the virus (Cameroon or Nigeria).

The Democratic Republic of the Congo has reported eight cases for the year with the date of onset of the most recent case on 13 August 2006. For the same period last year, no cases were reported. The Democratic Republic of the Congo has experienced two separate individual importations from Angola.

Nepal has reported two cases for the year with the date of onset of the most recent case on 1 August 2006 (compared to 1 case for the same period last year).

Ethiopia became re-infected with polio in December 2004. Since the beginning of 2006 15 cases have been reported. The onset date of the most recent case was 18 July 2006. Cases have been reported from four of Ethiopia's 11 regions.

Somalia became re-infected in 2005 after being polio-free for almost three years. Since the beginning of 2006 32 cases have been reported. The onset date of the most recent case was 5 September. Cases have been reported in 14 of Somalia's 19 regions.

Kenya had been polio-free for 22 years, reported its first polio case in September 2006. This was an imported case from neighbouring Somalia. The 3-year-old girl born in Kenya was living in a Somali refugee camp in the North Eastern Province bordering Somalia. Genetic sequencing indicates a virus of Nigerian origin, imported from Kismayo, Somalia.

Somalia, Ethiopia and Kenya simultaneously vaccinated more than 3.5 million children aged under five years in September 2006 in an effort to restrict polio transmission. Additional efforts have been made to engage nomadic leaders as half of the confirmed Somali cases this year are from nomadic populations.

[Source: Global Polio Eradication Initiative – monthly updates 4 July, 8 August and 12 September; ProMED, 20060912.2587, 12 September; 20061003.2830, 3 October; WHO update: 8 September, 19 October]

Tuberculosis – extreme drug resistance

South Africa is reporting the increasing spread of extreme-drug resistant tuberculosis (XDR-TB) with HIV-infected patients particularly vulnerable. Between January and March 2006, 53 people were identified with suspected XDR-TB, 52 of whom have since died. Since then, 106 cases have been reported (81 deaths) up to 4 September. The National Health Laboratory Services confirmed the new XDR-TB strain which was first identified in KwaZulu-Natal Province earlier this year, is now circulating through all nine South African Provinces.

[Source: ProMED 20060904.2518, 4 September; 20061019.3003, 19 October; WHO Weekly Epidemiological Record, 13 October]