

Overseas briefs

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Avian influenza, human — East Asia

Viet Nam

Source: BBC News online, 20 March 2004 (edited)

A 12-year-old boy has died from avian influenza virus infection in Viet Nam, taking this year's death toll in East Asia to 24. Viet Nam has been the worst-hit country, with 16 deaths now reported, whereas eight people have died in Thailand. It is not clear whether this child was a previous laboratory-confirmed case of avian influenza A (H5N1) virus infection or is a new case only diagnosed at death. Prior to this report, the number of confirmed cases was 34; 12 in Thailand and 22 in Viet Nam.

Thailand

Source: World Health Organisation (WHO), CSR, Disease Outbreak News, 17 March 2004 (edited)

The Ministry of Public Health in Thailand has confirmed another case of human infection with avian influenza A (H5N1) virus. The case, which was fatal, was a 39-year-old woman from Ayudhaya Province. She developed symptoms on 1 March 2004, was hospitalised on 3 March, and died on 12 March 2004. To date, Thailand has reported 12 confirmed cases, eight of them fatal.

Avian influenza A (H7) virus, human — Canada

Source: World Health Organization (WHO), CSR, Disease Outbreaks News, 5 April 2004 (edited)

The first human case of avian influenza A (H7) virus infection in British Columbia arose in a person who was involved in the culling of infected birds on 13–14 March 2004. On 13 March 2004, he may have been accidentally exposed in the eye. On 16 March, he reported conjunctivitis and nasal discharge. Treatment with oseltamivir — an antiviral drug active against influenza A viruses — began on 18 March. On 30 March, Health Canada concluded that this case was caused by avian influenza A (H7) virus and informed the World Health Organization (WHO) on 31 March. The patient has recovered fully.

On 2 April 2004, WHO was informed by Health Canada of a second poultry worker in British Columbia infected with avian influenza A (H7) virus infection. This worker developed conjunctivitis on 25 March after close contact with infected birds. He was treated with oseltamivir and his symptoms resolved.

Based on this epidemiological information provided by Health Canada, WHO today raised the global pandemic preparedness level from 0.1 to 0.2 for the Canadian outbreak. Global pandemic preparedness levels are dictated by the epidemiological situation for each local event. Level 0.2 means that more than one human case caused by a new subtype of influenza virus has been identified in the local event.

Preparedness levels have been organised into a matrix established by WHO in 1999 (WHO Influenza Pandemic Preparedness Plan). When a preparedness level is raised to 0.2, affected countries are advised to step up their surveillance in people exposed to affected poultry, to organise special investigations to better understand the new virus, to advise people at risk to wear protected clothing, and to consider the use of antivirals and normal human influenza vaccine.

Severe acute respiratory syndrome — world-wide

Source: Centers for Disease Control, Traveller's Health, 10 February 2004 (edited)

The Centers for Disease Control and Prevention (CDC) have been working closely with the World Health Organization (WHO) and other international partners to track cases of severe acute respiratory syndrome (SARS). Since 16 December 2003, the Chinese Ministry of Health has reported four cases of SARS (three confirmed and one probable). All four cases are from Guangdong, the same province where the first case of SARS in 2003 was confirmed in a 32-year-old man and where the first cases of SARS were identified in November 2002. All four patients have recovered from their illness and have been discharged from the hospital. None of their contacts have developed SARS-like illness. The source of infection of the four patients is not known; however, SARS coronavirus (SARS-CoV), the virus that causes SARS, has been collected from cages that housed civet cats in the restaurant where one of the patients worked. The Chinese Ministry of Health continues to work in close collaboration with WHO to broaden the investigation and enhance surveillance throughout China.

BSE update 2004

Source: *BSE in Europe, updated 29 March 2004* (edited)

During 2003, decreased incidence of recorded BSE cases, compared to 2002, was seen in most countries. The exceptions were Portugal, Spain, Japan, Poland, and the Czech Republic.

The number of BSE cases in Germany seems to be increasing in 2004 after a steep decline during 2003. In the first quarter of 2004, Germany counted 14 cases; in the same period of 2003 the number of confirmed cases was only seven. Since the previous update (23 February 2004), one new case each was observed in Japan and Slovenia. Poland has observed two new cases: according to an AFP report of 27 March 2004, a 13th BSE case was discovered there 'during a routine test at a slaughterhouse'. This new case is not included in the above table.

For additional information, the reader is referred to the Office International des Epizooties table, last updated on 24 March 2004, available from: http://www.oie.int/eng/info/en_esbmonde.htm.

CJD (new var.), blood supply — United Kingdom

Source: *Eurosurveillance Weekly, 2004;8, 18 March 2004* (edited)

On 16 March 2004, the Department of Health in England announced that people who have received a blood transfusion in the United Kingdom (UK) since 1 January 1980 will no longer be able to donate blood. This additional donor selection criterion will be implemented by all four of the UK Blood Services (UKBS), including the National Blood Service, on 5 April 2004.

BSE confirmed cases update, 23 February 2004

Country	2001	2002	2003	2004	Total since 1987
UK	1,175	1,104	611	57	182,528
Austria	1	0	0	0	1
Belgium	46	38	15	6	124
Canada	0	0	1	0	1
Czech Republic	2	2	4	1	9
Denmark	6	3	2	0	13
Finland	1	0	0	0	1
France	274	239	137	20	906
Germany	125	106	54	14	312
Greece	1	0	0	0	1
Ireland	246	333	182	47	1,391
Israel	0	1	0	0	1
Italy	50	36	31	1	120
Japan	3	2	4	2 (1)	11
Liechtenstein	0	0	0	0	2
Luxembourg	0	1	0	0	2
Netherlands	20	24	19	4	75
Portugal	110	86	133	17	879
Poland	0	4	5	3	12
Slovakia	5	6	2	1	14
Slovenia	1	1	1	1	4
Spain	82	127	167	26	421
Switzerland	42	24	21	0	453
United States	0	0	1*	0	1

* The data from some countries may include exceptional imported cases or exclude exported cases which were found positive in the countries of destination.

This additional precautionary measure to safeguard the blood supply is being taken in the light of the first possible transmission of variant Creutzfeldt-Jakob disease by blood transfusion, which was reported in December 2003. The transfusion occurred in 1996; the blood donor was well at the time but developed symptoms of vCJD in 1999 and died the following year. The recipient was diagnosed with vCJD in 2003.

This is a highly precautionary approach, and the benefit of receiving a blood transfusion when needed far outweighs any possible risk of contracting vCJD. To date there has been only one possible case of vCJD being transmitted by blood, yet the UKBS issue over 2.5 million units of blood every year.

As of 1 March 2004 there have been 146 definite and probable cases of vCJD in the UK, one case each in the Republic of Ireland, Italy, the United States of America, Canada, and Hong Kong, and six cases in France. The eventual number of individuals within the UK population likely to develop vCJD remains uncertain; estimates range from the current numbers up to 540. It is not known how many current or past blood or tissue donors may develop vCJD in the future.

Hepatitis C virus, blood supply — South Korea

Source: Reuters Health online, 29 March 2004 (edited)

South Korea's Red Cross mishandled donor information and circulated blood donated by hepatitis virus carriers, infecting nine people, government auditors said. The Board of Audit and Inspection (BAI) called on the Korea National Red Cross to punish officials responsible for shipping blood donated by hepatitis virus carriers to hospitals and pharmaceutical companies for five years up until January 2004.

A BAI audit conducted at the end of 2003 found that 76,677 units of blood received from donors who had been infected with hepatitis C virus had been distributed for transfusions or research by the Red Cross, a board official said. The South Korean branch of the international agency also put into circulation 228 units of blood donated by 99 people who had been suspected of carrying human immunodeficiency virus, but who later tested negative for the virus, the official said. Nine people were found to have been infected with hepatitis during February 2004 after receiving blood transfusions from the Red Cross.

Cholera update

Mali

Source: Afrol News, Africa, 5 March 2004 (edited)

The cholera epidemic along River Niger in Mali is increasing, according to local media. More than 2,000 cholera cases have been reported and some 117 Malians have died. Cholera started spreading in August 2003 in Mali. It was associated with the release of sewage into River Niger from the outskirts of Bamako, the Malian capital. In the following months, the water-borne disease was reported in several cities and towns several hundreds of kilometres down-river. According to the World Health Organization, there is a total number of 13 clusters affected by the current cholera outbreak. The widespread nature of the epidemic makes it difficult to control.

Togo

Source: Afrol News, Africa, 1 March 2004 (edited)

A cholera epidemic in the Togolese capital, Lome, has so far caused 661 cases and 37 deaths, according to the Togolese Red Cross. While the epidemic is still on the increase, the Red Cross is heading information and awareness work to prevent a greater disaster in the city of 700,000 inhabitants. There is fear of the epidemic escalating as the rains are increasing.

Together with local health authorities and the WHO, Red Cross volunteers are now conducting a mass awareness campaign through radio and public institutions such as schools. Other activities to control the spread of the epidemic include active case surveillance and referring infected persons to special clinics established to treat cholera patients.

Mozambique

Source: WHO Disease Outbreak, 23 March 2004 (edited)

The Ministry of Health of Mozambique has reported a total of 15,237 cases and 85 deaths between 20 December 2003 and 18 March 2004 in seven provinces. Maputo city is the worst-affected area with 9,522 cases and 37 deaths. The Ministry of Health declared a cholera emergency on 9 January 2004. WHO and other agencies, including UNICEF, Médecins sans Frontières, World Food Programme, the United States Agency for International Development, and the Italian Government are supporting local health authorities in containing the outbreak.

South Africa (Eastern Cape)

Source: SABC News, 24 March 2004 (edited)

Thirteen people in the Eastern Cape have died from cholera and more than 100 had to be treated in hospital for the disease after a recent outbreak. The provincial government has promised the affected communities emergency medical resources to stop the spread of the disease. The disease has claimed many lives over the past three years in rural Transkei, due to a lack of clean water and sanitation.

Zambia

Source: AllAfrica.com, 27 March 2004 (edited)

Cholera has broken out in Lusaka at State Lodge, the police camp housing staff and families of presidential security staff at the presidential lodge, with four people currently undergoing treatment at various cholera centres. The cause of the outbreak was due to a sewer pipe that burst and contaminated the drinking water in the police camp.

Anthrax, cattle — Australia (Victoria)

From: Chief Veterinary Officer, Department of Primary Industries Victoria 16 March 2004 (edited)

Anthrax has been confirmed as the cause of death of seven cattle that died over a four-day period (10–14 March 2004) on a farm (Farm 1) in the Goulburn Valley. A single case occurred on an adjacent farm (Farm 2) during the same period. There have been earthworks between both farms associated with water drainage channels that may account for the incident. The incident has occurred in an area where anthrax has occurred previously and where occasional cases are not unexpected. Farm 1 has never recorded a case; Farm 2 had a case back in 1997.

The following response actions have been taken in accordance with Victorian and national protocols for anthrax control (starting immediately from the time anthrax was suspected):

- (i) Quarantine has been applied to both farms; the quarantine will remain in place until 42 days after vaccination or 21 days after the last case, whichever is the later date.
- (ii) All carcasses have been incinerated on-site.
- (iii) All cattle on both farms were vaccinated on 11 March 2004, and
- (iv) local agencies and key industry contacts have been advised of the situation.

No cattle have been moved from either property during the past 20 days, so there is no need to trace cattle movements and no implications for meat safety. Both properties are outblocks used to hold young heifers prior to first calving. These were not milking cattle; there are no implications for milk or dairy products. Action taken thus far means there are no public health implications or issues in relation to the safety of livestock, meat, or dairy products from the area.

Smallpox vaccination, secondary/tertiary transfer

Source: MMWR Morb Mortal Wkly Rep 2004;53:103–105, 13 February (edited)

In December 2002, the Department of Defense (DoD) began vaccinating military personnel as part of the pre-event vaccination program.¹ Because vaccinia virus is present on the skin at the site of vaccination, it can spread to other parts of the body (autoinoculation) or to contacts of vaccinees (contact transfer).

To prevent autoinoculation and contact transfer, DoD gave vaccinees printed information that focused on handwashing, covering the vaccination site, and limiting contact with infants.^{1,2} This report describes cases of contact transfer of vaccinia virus among vaccinated military personnel since December 2002; findings indicate that contact transfer of vaccinia virus is rare. Continued efforts are needed to educate vaccinees about the importance of proper vaccination-site care in preventing contact transmission, especially in household settings.

DoD conducts surveillance for vaccine-associated adverse events by using automated immunisation registries, military communication channels, and the Vaccine Adverse Events Reporting System. Contact transfer cases are defined as those in which vaccinia virus is confirmed by viral culture or polymerase chain reaction (PCR) assays. Other cases are classified as suspected on the basis of lesion description and reported linkage to a vaccinated person three to nine days before lesion development.

During the period December 2002 to January 2004, a total of 578,286 military personnel were vaccinated; 508,546 (88%) were male, and 407,923 (71%) were primary vaccinees (received smallpox vaccination for the first time). The median age of vaccinees was 29 years (range: 17 to 76). Among vaccinees, cases of suspected contact transfer of vaccinia were identified among 30 persons: 12 spouses, eight adult intimate contacts, eight adult friends, and two children in the same household. The sources of suspected contact transfer were all male service members who were primary vaccinees. Except for six male sports partners, all infected contacts were female.

Vaccinia virus was confirmed in 18 (60%) of the 30 cases by viral culture or PCR. Sixteen of the 18 confirmed cases involved uncomplicated infections of the skin; two involved the eye.³ None resulted in eczema vaccinatum or progressive vaccinia. Twelve of the 18 confirmed cases were among spouses or adult intimate contacts. The observed rate of contact transfer was 5.2 per 100,000 vaccinees overall or 7.4 per 100,000 primary vaccinees.

Among 27,700 smallpox-vaccinated DoD health-care workers, no transmission of vaccinia from a vaccinated health-care worker to an unvaccinated patient or from a vaccinated patient to an unvaccinated health-care worker has been identified.

Two of the 18 confirmed cases of transfer of vaccinia virus resulted from tertiary transfer. One involved a service member, his wife, and their breast-fed infant; the other involved serial transmission among male sports partners.

References

1. Grabenstein JD, Winkenwerder W Jr. US military smallpox vaccination program experience. *JAMA* 2003;289:3278–8322.
2. Centers for Disease Control and Prevention. Recommendations for using smallpox vaccine in prevent vaccination program: supplemental recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Healthcare Infection Control Practices Advisory Committee (HICPAC). *MMWR CDC Recomm Rep* 2003;52:RR–7.
3. Centers for Disease Control and Prevention. Smallpox vaccination and adverse events: guidance for clinicians. *MMWR CDC Recomm Rep* 2003;52:RR–4.

Dengue/DHF update 2004

Indonesia

Source: *The Jakarta Post, Samarinda, East Kalimantan, 24 March 2004 (edited)*

The East Kalimantan provincial government imposed a state of emergency in the province, as the number of people with dengue fever had reached an alarming level. As of 19 March 2004, a total of 1,028 people in the province had been hospitalised with dengue fever since January; 18 of them have died. In the same period in 2003, 1,951 people contracted dengue fever, 31 of them died.

Venezuela

Source: *Ministry of Health, Venezuela, 23 March 2004 (edited)*

In the first nine weeks of 2004 there were 8,848 cases of dengue, with a peak of 1,211 cases in the third epidemiological week 18–25 January 2004. There was a total of 634 dengue haemorrhagic fever cases reported (7% of total) and three deaths. The population under 15 years represented 50 per cent of total cases. The most affected age group was 15–24 years with 23.11 per cent of cases. The accumulated morbidity rate was 32.2 per 100,000 population. Circulating serotypes were DEN–1, DEN–2, DEN–3 and DEN–4.

El Salvador

Source: *Diario El Mundo, El Salvador, 17 March 2004 (edited)*

El Salvador's Ministry of Health reported laboratory confirmation of 37 dengue fever cases. This represents a considerable increase compared with the two previous years.

In 2004, 455 cases of dengue have been reported (in 2003 for the same period there were only 269 cases). There are now more cases than in 2002, a year which was considered as epidemic for dengue fever in El Salvador. Dengue haemorrhagic fever case numbers are still low. This year only 19 cases have been reported, compared with 24 in 2003. The current national larval index is 5.9 per cent, although there are places with up to 18 per cent.

The incidence rate is high in comparison with the last epidemic year (2002). Current incidence rate is 7.1 per 100 000 population. In 2002 this figure was 5.6 per 100,000 population.

Viet Nam

Source: *AFP, 18 March 2004 (edited)*

Health authorities in Vietnam expressed concern over the growing number of people infected with dengue fever, the mosquito-borne disease that has killed seven people this year in the country. The Hanoi-based Institute of Hygiene and Epidemiology reported that 4,199 people had been infected since the beginning of 2004, a 90 per cent increase compared to the same period of 2003. The worst-affected areas were in the southern Mekong Delta region, where moist and humid conditions provide ideal breeding conditions for mosquitoes. The region accounted for over 90 per cent of the cases and all the deaths.