

4 INTERNATIONAL OUTBREAKS OF IMPORTANCE

a Ebola virus disease outbreak, Democratic Republic of Congo (DRC)

The Ebola virus disease (EVD) outbreak in North Kivu and Ituri provinces, Democratic Republic of the Congo is on-going. As of 19 November 2018, a total of 373 EVD cases, including 326 confirmed and 47 probable cases, has been reported. The number of deaths reported to date is 217 with a case fatality rate of 52% among all confirmed cases. Seventy-two cases are suspected and still under investigation.

Vaccination campaigns with approved experimental vaccines began on 8 August 2018. Since then, 32 626 people have been vaccinated, including 16 210 in Beni. However, the country has faced setbacks in its fight to contain the outbreak when a MONUSCO base in the Boikene district of Beni was attacked by an armed group on the evening of Friday, 16 November 2018. The clash lasted several hours and took place a few meters away from the Ebola emergency operations centre and hotels housing several response teams. Vaccination was suspended and the operations centre was closed. The WHO has indicated that the treatment centre has re-opened on Sunday 18 November 2018 and remains operational. Contact-tracing is still of concern due to insecurity and persistent community resistance.

WHO risk assessment

Given the volatile security situation, sporadic incidents of community reluctance, refusal or resistance, continued reporting of confirmed cases, and the risk of spread to neighbouring countries, an International Health Regulations (IHR) Emergency Committee (EC) on the EVD outbreak in North Kivu was convened. The EC advised that the EVD outbreak does not constitute a public health emergency of international concern. The EC did, however, express their deep concern emphasising the need to intensify response activities and strengthen vigilance whilst noting the challenging security situation and providing a series of public health recommendations to further strengthen the response.

Situation in South Africa

As at 28 November 2018, there have been no EVD cases in South Africa associated with the current outbreak in the DRC. In addition, there are no suspected cases of EVD in South Africa at present.

Source: Division of Public Health Surveillance and Response, NICD-NHLS (outbreak@nicd.ac.za); WHO: www.who.int

5 SEASONAL DISEASES

a Influenza

The 2018 influenza season, started in week 18 (first week of May), peaked in mid-July and ended in week 41 (week ending 14 October), although sporadic detections of influenza B continue to be made. Over the previous 13 years the season on average, has started in mid-May (range mid-April to end June), peaked in mid-July (range early June – end August), ended at the end of September (range, end July to mid-October) and lasted an average of 19 weeks (range 12-25).

Since the start of the season, 679 influenza detections have been made from specimens of patients attending Viral Watch sites. Of these, 383 (56.4%) have been identified as influenza A(H1N1)pdm09, 20 (3.0%) as A(H3N2), and 273 (40.2%) as influenza B. Three influenza A detections were untyped due to low viral load. The season was dominated by influenza A(H1N1)pdm09 until mid-July, after which influenza B accounted for the majority of detections.

In the other two NICD influenza surveillance programmes (influenza-like illness at primary healthcare clinics and national syndromic surveillance for pneumonia), influenza was detected in 367/3 135 (12%) specimens received since the on-

set of the season. The majority were influenza A (H1N1)pdm09 (202/367, 55%), and 166/367 (45%) were identified as influenza B. Similar to the Viral Watch, the proportion of specimens positive for influenza B increased markedly from mid-July.

Although the season has ended, it is not unusual to find cases of influenza at this time of the year. Persons with influenza-like symptoms (fever, cough and generalised body pains) are encouraged to practice good cough etiquette, hand hygiene and stay away from school or work until they are no longer symptomatic.

Source: Centre for Respiratory Diseases and Meningitis, NICD-NHLS; cherylc@nicd.ac.za

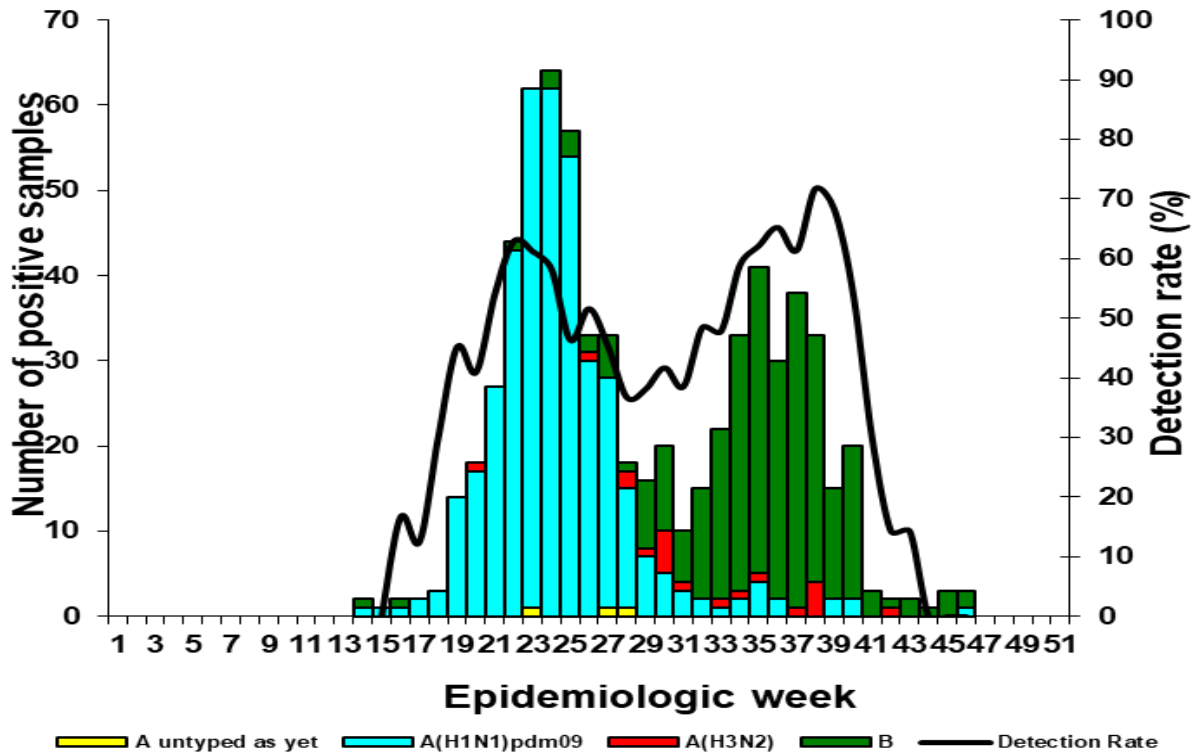


Figure 3. Viral Watch 2018: Number of positive samples by influenza types and subtypes and detection rate*
 * Only reported for weeks with >10 specimens submitted. Patients known to have acquired influenza abroad or from contact with travellers are not included in the epidemiological curve.

b Invasive meningococcal disease surveillance: January to November 2018

Up until the end of week 45 in 2018, 100 cases of invasive meningococcal disease (IMD) have been reported through the GERMS-SA surveillance programme. Half of the patients were male, and 46/91 (51%) with known age were less than ten years old. Sixty-seven percent of IMD cases were diagnosed from cerebrospinal fluid, whilst the remainder were confirmed from blood specimens (33/100). Of those with isolates or specimens available for serogrouping (75/100), disease was caused by a diversity of serogroups (B (n=36, 48%), C (n=9, 12%), W (n=16, 21%) and Y (n=14, 19%)).

As seen previously, the majority of disease occurred in the Western Cape (31 cases), Gauteng (30) and Eastern Cape (22) provinces. Most cases occurred from May to September with slightly lower numbers reported during October 2018. This pattern is consistent with previous years (Figure 4).

Although the meningococcal peak season has passed, cases continue to occur throughout the year. Clinicians should remain vigilant and consider a diagnosis of meningococcaemia or meningococcal meningitis when patients present with acute onset of severe illness, fever and/or a non-blanching pete-

chial rash. Appropriate antibiotic treatment targeting meningococcal disease should be initiated promptly, even while awaiting laboratory confirmation of the aetiology. As meningococcal disease is a category 1 notifiable medical condition (NMC), all **clinically suspected** cases of meningococcal disease should be notified immediately to the provincial Communicable Disease Control Coordinators to ensure appropriate contact tracing, responsible prescribing of chemoprophylaxis, and case counting.

As part of ongoing surveillance, Centre for Respiratory Diseases and Meningitis (CRDM) at the NICD offers free meningococcal isolate confirmation and serogrouping, and *Neisseria meningitidis* detection by PCR of culture-negative/autopsy cases. For more information, please contact the CRDM laboratory at the NICD, 011 555 0327.

Source: Centre for Respiratory Diseases and Meningitis, NICD-NHLS; annev@nicd.ac.za