

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

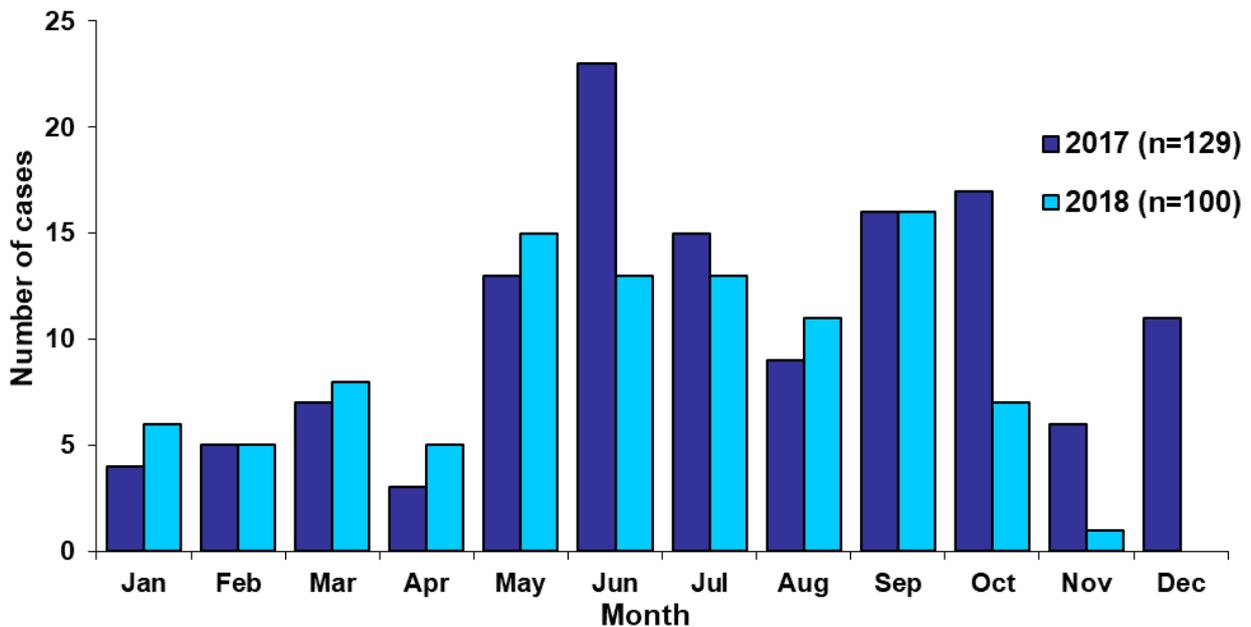


Figure 4. Number of invasive *Neisseria meningitidis* cases reported to GERMS-SA by month, South Africa, 2017 and 2018 (until end week 45)

c Malaria: seasonal increase in progress

Malaria cases in South Africa are increasing as expected during the summer months. As at the end of October 2018, more than 16 000 cases with 110 deaths have been reported. This is fewer than during the large upsurge in malaria seen in the 2017-2018 season, but still more than the average over the 10-year period 2007-2016, which was around 7 600 cases per year. During the holiday season, many people will be exposed because of their travel to higher transmission areas, both internally and outside the country borders, particularly in Mozambique (see updated malaria risk map, Figure 5).

There has been some recent expansion of low or very low malaria transmission to some districts previously regarded as non-malaria areas in South Africa, such as parts of the Waterberg District. People who are planning to travel are urged to take adequate measures to protect themselves from malaria. All people in malaria risk areas should reduce contact with mosquitoes by limiting outdoor activity after dark, covering up bare skin (not forgetting feet and ankles), using mosquito repellents, ensuring mosquito screens on windows are closed, and using bednets, fans or airconditioning, if available. Consid-

er antimalarial prophylaxis in higher risk areas – doxycycline and atovaquone-proguanil are available without prescription from pharmacies. Public sector travel clinics will also supply prophylaxis to travellers. It is important to understand that while these precautions will substantially reduce the chance of acquiring malaria, the risk is never completely abolished.

All travellers returning from malaria transmission areas, including very low risk ones, should get medical advice about 'flu-like' illness (headache, fever, chills, muscle and joint pain) that occurs up to four to six weeks after first possible exposure, in case it is malaria. Malaria risk map, FAQs and further information on prevention are available on the NICD website: www.nicd.ac.za

Source: Centre for Emerging Zoonotic and Parasitic Diseases, NICD-NHLS; johnf@nicd.ac.za