vomiting and a rash on the legs. The second case was a 32-year-old male from Somerset West who travelled to Central America and the Philippines at the end of 2018. The patient presented with headache, fever and a maculopapular rash on the arms and legs. The third case was a 27-year-old male from Durban, who travelled to Vietnam in January 2019 and presented with a fever, severe bone pain and rigors.

Physicians should be alert to returning travellers presenting with fever, rash, arthralgia, myalgia and headache at this time of the year. There is no specific treatment for dengue fever apart from symptomatic management. Mosquito control and prevention of bites are essential in reducing dengue virus infection.

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

2 ENTERIC DISEASES

a An update on cholera and typhoid fever

Update on the cholera and typhoid outbreaks in Zimbabwe

On 6 September 2018, a cholera outbreak was declared in Harare by the Ministry of Health of Zimbabwe. As at 16 January 2019, the cumulative number of cholera cases was 10 680 including 68 deaths. There has been an overall decline in the number of new cases reported per week across the country since the end of December 2018.

There has been a resurgence of typhoid fever in Harare since mid-September 2018. As at 09 December 2018, a cumulative total of 5 159 cases (including 15 deaths) was reported. The weekly incidence reportedly peaked in week 41 (week ending 14 October 2018) and has since been declining gradually.

Cholera in South Africa

Cholera is not endemic in South Africa. Infrequent, sporadic cholera cases are reported and are typically imported (travel-related). The notable exception is the 2008-2009 cholera outbreak which began as a spill-over from neighbouring Zimbabwe. During 2018, five laboratory-confirmed cases of cholera were reported in the country, including imported cases from Zimbabwe. Cases were detailed in previous NICD Communiqués: February 2018, Vol.17(2), October 2018, Vol.17(10), November 2018, Vol.17(11) - can be accessed on the NICD website: http://www.nicd.ac.za/index.php/publications/nicd-nhls-communicable-diseases-communique/archives.

Typhoid fever in South Africa

Typhoid fever remains endemic in South Africa. Typhoid outbreaks occurred in 2005-2006, but since then the number of culture-confirmed typhoid fever cases annually has remained stable at <150 cases per year. Most cases are typically sporadic, but small clusters and localised outbreaks do occur. Although imported travel-related cases are reported, the majority of cases are locally acquired, reflecting ongoing, albeit low-level, transmission. A recent imported case serves as a reminder to be alert for the disease in travellers from areas with high transmission or current outbreaks. A 19-year-old male who lives in Bulawayo, Zimbabwe, travelled to South Africa for elective orthopaedic surgery. He was admitted on 17 December 2018, but surgery was delayed due to persistent pyrexia (>40°C) with no overt source. Salmonella Typhi (S. Typhi) was isolated from blood cultures collected five days after admission. He received appropriate antibiotic treatment and was discharged on 10 January 2019. No other imported typhoid fever cases linked to the Zimbabwean outbreak have been identified. For the year 2019 to date, two laboratory-confirmed cases (both locally acquired) have been reported.

Alert for healthcare workers

Heightened awareness for possible cholera and typhoid fever cases must be maintained whilst the outbreaks continue in Zimbabwe, and especially so given the current social unrest and economic crisis, which could disrupt outbreak control activities and result in increased travel to South Africa. All suspected cases of cholera and typhoid fever should be investigated and notified immediately to the relevant stakeholders.

Cholera: cholera should be excluded in any patient who develops acute watery diarrhoea with or without vomiting. Stool samples (or rectal swab samples where stool sample collection is problematic) must be collected and submitted with a specific request for cholera testing, in addition to routine MCS requests. If a delay in testing or transport of specimens is anticipated, specimens should be submitted in Cary-Blair transport media. Guidance on sample collection can be found at: http://www.nicd.ac.za/assets/files/Suspected%20cholera_guidelines%20(2_2).pdf. Mild-to-moderate cholera cases may be treated with oral rehydration fluid. Severe cases require admission and intravenous fluid administration. Antibiotic treatment is recommended for patients with moderate to severe dehydration, as it reduces disease severity and the risk of further transmission. Azithromycin is recommended for cases linked to the current Zimbabwean outbreak.

Typhoid fever: Unfortunately, typhoid fever often presents with non-specific features and may mimic many other febrile diseases. Clinical features are protean, and include fever, white-coated tongue, gastrointestinal symptoms (abdominal pain,
nausea/vomiting, constipation, diarrhoea), hepatomegaly, splenomegaly, anaemia, neutrophilia or leukopenia, thrombocytopenia, headache, cough, relative bradycardia, and a rash ('rose spots'). The diagnostic test of choice for typhoid fever is blood culture. Serology (Widal test) is NOT recommended because of frequent false-positive and false-negative results and poor standardisation of test methods. Further guidance on investigation and management of typhoid fever can be found at: http://www.nicd.ac.za/assets/files/Guidelines_typhoid_20160125.pdf.

Source: Centre for Enteric Diseases, NICD-NHLS; (junot@nicd.ac.za)

3 INTERNATIONAL OUTBREAKS OF IMPORTANCE

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

The Ministry of Health (MoH), WHO and partners continue to respond to the ongoing Ebola virus disease (EVD) outbreak in the Democratic Republic of the Congo (DRC). As of 22 January 2019, 713 EVD cases (664 confirmed and 49 probable), including 439 deaths (390 confirmed and 49 probable) have been reported. Thus far, 247 people have been discharged from Ebola Treatment Centres (ETCs). Among cases with a reported age and sex, 59% (420/710) of cases were female, and 30% (214/708) were aged less than 18 years, including 108 infants and children under 5 years. Sixty-one healthcare workers have been infected to date.

The number of reported cases increased during recent weeks, most notably from the Katwa health zone, where response teams have faced pockets of community mistrust. The outbreak has also extended southwards to Kayina health zone, a high security risk area. Teams are working actively to build community trust and scale up response activities around these new clusters. During the periods of 2 – 22 January 2019, 102 new cases have been reported from 13 health zones, including: Katwa (62), Butembo (12), Oicha (6), Kayina (5), Beni (2), Manguredjipa (3), Kyondo (3), Kalungata (2), Komanda (1), Musienene (2), Biema (2), Mabalako (1), and Vuhovi (1). As of 14 January 2019 a total of 60 460 individuals has been vaccinated since the start of the outbreak. Contact tracing is continuing and 39 000 contacts have been registered and 4 634 contacts remain under surveillance.

Public health response
The MoH of the DRC continues to strengthen response measures, with support from WHO and partners. Priorities include coordination, surveillance, contact tracing, laboratory capacity, infection prevention and control, clinical management of patients, vaccination, risk communication and community engagement, psychosocial support, safe and dignified burials, cross-border surveillance, and preparedness activities in neighbouring provinces and countries. Infection prevention and control practices in healthcare facilities, especially antenatal clinics, need to be further strengthened. Stringent hand hygiene is essential. Contact tracing activities continue with over 39 000 contacts registered by 16 January 2019. The field team is intensifying community engagement and case investigation to ensure 100% of high-risk contacts are identified timeously and followed up daily. As of 13 January 2019, more than 26 million travellers have been screened. Between 10-14 January 2019, 9 alerts were notified, investigated and validated.

WHO risk assessment
This outbreak of EVD is affecting north-eastern provinces of the Democratic Republic of the Congo, which borders Uganda, Rwanda and South Sudan. Potential risk for transmission of EVD at the national and regional levels includes travelling between the affected areas, the rest of the country, and neighbouring countries including the displacement of Congolese refugees. Additionally, the security situation in North Kivu and Ituri at times limits the implementation of response activities. As the risk of national and regional spread is very high, neighbouring provinces and countries are advised to enhance surveillance and preparedness activities. Based on this context, on 28 September 2018, the public health risk assessment was revised from high to be very high at the national and regional levels, and low globally. WHO continues to advise against any restriction of travel to, and trade with, the Democratic Republic of the Congo based on currently available information.

Situation in South Africa
As at 29 January 2019, 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