b Invasive meningococcal disease surveillance: January to September 2018

Meningococcal disease occurs throughout the year in South Africa, appearing most frequently in the winter and spring months (Figure 4). Patients presenting with symptoms suggestive of meningitis/ bacteraemia, with or without a petechial rash, should receive prompt antibiotic therapy targeting meningococcal disease. Clinically suspected cases should be notified immediately for urgent public health action.

Up until week 39 of 2018, 92 cases have been reported to the GERMS-SA network, 72% (66/92) of which had isolates available for serogrouping. Serogroup B caused 44% (29/66) of disease, followed by W (24%, 16), Y (20%, 13) and C (12%, 8). The majority of cases occurred in Gauteng Province (33%, 30/92), followed by Eastern Cape (22%, 20/92) and Western Cape provinces (29%, 27/92). Of patients with known age, 52% (43/83) were less than 10 years old, 20 of which were infants.

Microbiology laboratories (both NHLS and private laboratories) are encouraged to submit ALL meningococcal isolates as soon as possible to the NICD for confirmation and serogrouping of the isolates; or to submit the actual CSF, blood and/or blood culture (for culture negative, but latex antigen positive and Gram-negative cocci seen on Gram stain) for PCR confirmation. Meningococcal disease is a category 1 notifiable medical condition (NMC) and any clinically suspected case should be reported immediately to the provincial Communicable Disease Control Coordinators to ensure appropriate contact tracing, responsible prescribing of chemoprophylaxis and case counting.

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

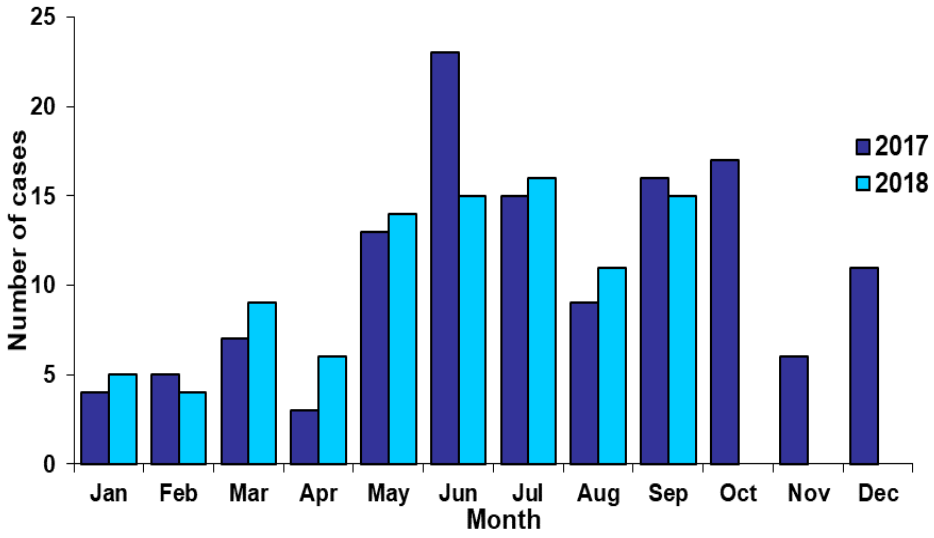

Figure 4. Number of *Neisseria meningitidis* cases reported to GERMS-SA by month, South Africa, 2017 and 2018 (until end week 39).

c Malaria seasonal advisory

Southern Africa is experiencing its annual malaria season and it is anticipated that there will be an increase in transmission due to increases in ambient temperature, rainfall and humidity. With the approach of the holiday season in December, it is important for travellers visiting any of the malaria areas within southern Africa or elsewhere to take appropriate precautions and maintain a high index of suspicion for symptoms of malaria on their return.

As shown in the revised malaria risk map in the September Communiqué (Vol. 17(9): 7-8) [http://www.nicd.ac.za/wp-content/uploads/2018/09/Malaria.pdf], the major areas of transmission of malaria in South Africa are the north-eastern parts of Limpopo Province (along the borders with Mozambique and Zimbabwe), the lowveld areas of Mpumalanga Province (including the Kruger National Park but excluding Nelspruit/Mbombela, White River, Sabie, and their immediate surrounds) and the far northern parts of KwaZulu-Natal Province. Personal protection against mosquito bites should be the focus of malaria prevention, together with use of chemoprophylaxis (preventive medication) in the indicated higher-risk areas. Chemoprophylaxis is now available in pharmacies without prescription. Regardless of antimalarial measures used, the occurrence of an acute fever and 'flu-like illness in the month after return from transmission areas must prompt an urgent malaria blood test and follow-up of results.

Regarding neighbouring countries:

1. Mozambique and Zambia have high malaria transmission throughout the country. The majority of malaria cases treated in South Africa have a history of travel to Mozambique.