SEASONAL DISEASES

Respiratory syncytial virus (RSV) 2021

The proportion of RSV detections in the pneumonia surveillance programme has remained below threshold since mid-April [using the Moving Epidemic Method (MEM), a sequential analysis using the R Language, to calculate the duration, start and end of the annual epidemic]. However, the detection rate in children under the age of five had been in low threshold, excluding one week when fewer specimens than usual were received. It has, however, since mid-March remained below the 10-year mean detection rate (Figure 3).

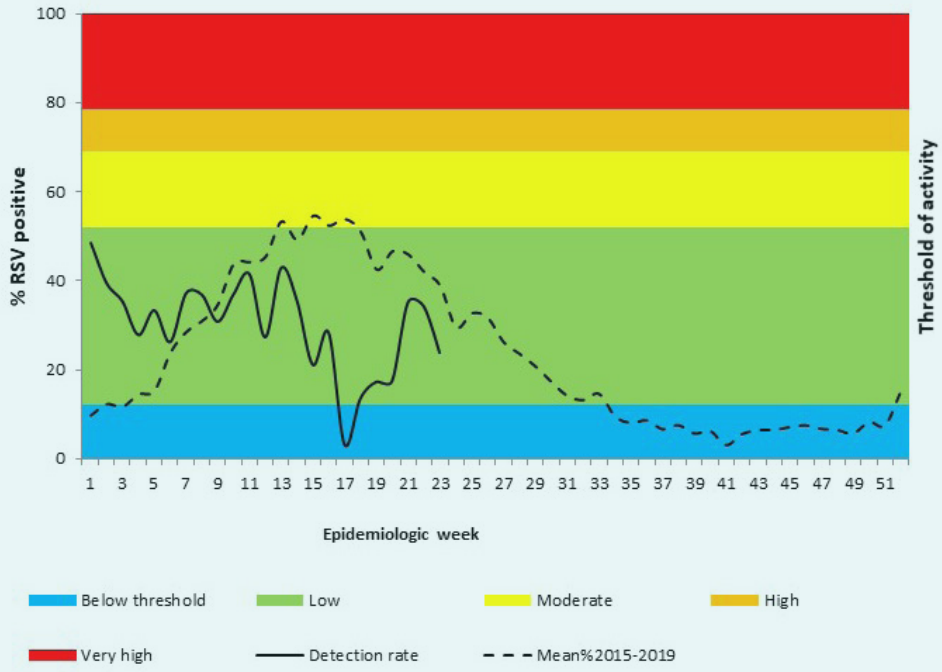

Figure 3. ILI surveillance (Viral Watch) percentage respiratory syncytial virus detections and epidemic thresholds**

*Threshold based on 2013-2019 data; ** Threshold based on 2010-2019

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

Invasive meningococcal disease in South Africa, 2021

In 2021, as of end of May, 17 cases of laboratory-confirmed invasive meningococcal disease (IMD) have been reported through the GERMS-SA surveillance network. Over a similar period in 2020, 25 cases were reported. IMD cases in 2021 are all sporadic with no outbreaks or clusters detected. Invasive disease numbers are down, possibly due to the continued mandatory mask-wearing in public and limited social interaction due to the COVID-19 pandemic, thus reducing the respiratory transmission of meningococci.

Most cases (53%) occurred in children: 29% (5/17) in <5 years of age; 6% (1/17) in 6-9 years, and 18% (3/17) in 10-14 years of age. Almost all IMD cases were males (88%, 15/17). The majority of cases were from the Western Cape (41%, 7/17), followed by Gauteng (29%, 5/17), Eastern Cape (24%, 4/17) and North West provinces (5%, 1/17). To date, seven of 17 reported cases were serogrouped: five were serogroup B and two were serogroup W. Throughout 2020, serogroup B predominated, followed by W.

The winter months typically signify an increase in invasive meningococcal disease, possibly due to crowding and poor ventilation indoors, as well as climatic changes. Clinicians should be vigilant at this time as non-specific early symptoms of IMD (headache, fever, myalgia) are often followed by rapid disease progression if antibiotics are not started timeously. Intravenous (IV) ceftriaxone is the preferred empiric therapy, followed by IV penicillin once antimicrobial susceptibility has been confirmed. Meningococcal disease is a category 1 notifiable medical condition (NMC) and any clinically suspected or laboratory-confirmed 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