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Department of Health
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Quarantine Services and International Health Surveillance System (QSIHSS)
Health Information Update

Source: WHO, Event Information Site for IHR National Focal
Event Updates: **22 October to 25 October 2018**

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2018-10-25	Saudi Arabia	Infectious	Coronavirus Infection	<p>Between 17 September and 15 October 2018, the National IHR Focal Point of The Kingdom of Saudi Arabia reported eight (8) additional cases of MERS-CoV infection, including three (3) deaths. Of the eight cases reported, three (listed as cases #1, 3 and 4) were hospital contacts from one hospital in Dammam and two (listed as cases #2 and 5) were household contacts in Riyadh.</p> <p>The details of the cases are reported below: Case reported on 19 September A 66-year-old male national, retired and living in Buraydah City, Al-Qassim Region. He developed respiratory symptoms on 14 September whilst having been admitted to hospital in Dammam on 8 June for his chronic conditions, whereupon a chest X-ray the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 17 September tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at Riyadh regional laboratory on 18 September. The patient had diabetes mellitus, hypertension, ischemic heart disease and end-stage renal disease as comorbid conditions. He had a history of hemodialysis. Investigation of history of exposure to the known risk factors in the 14 days prior to the onset of symptoms is ongoing. Unfortunately, he passed away on 19 September. Investigation of 9 household contacts was conducted and no further cases were identified. He was identified as a contact of the 57-year-old male MERS-CoV case reported to WHO on 29 September (see below)</p> Case reported on 24 September A 50-year-old male national, not working, living in Afif City, Riyadh Region. He developed fever, cough and shortness of breath on 15 September, and was admitted to hospital in Afif on 21 September, whereupon a chest X-ray, the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 22 September tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at Riyadh regional laboratory on 23 September. The patient had diabetes mellitus and hypertension as comorbid conditions. Investigation of history of exposure to the known risk factors in the 14 days prior to the onset of symptoms is ongoing. The patient who was in critical condition was admitted to the ICU and died on 27 September 2018. Investigation of 9 household contacts was conducted. The patient was a household contact of the 22-year-old male case reported to WHO on 3 October (see below).	Public Health Risk (PHR)

				<p style="text-align: center;"><u>Case reported on 29 September</u></p> <p>A 57-year-old male national, teacher living in AlAsiah City, Al Qassim Region. He developed fever, cough and shortness of breath on 26 September and was admitted to hospital in Dammam on 27 September, whereupon a chest X-ray the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 27 September tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at Riyadh regional laboratory on 28 September. The patient had diabetes mellitus, hypertension and chronic renal failure as comorbid conditions. He had a history of hemodialysis. He was a contact of the 66-year-old male MERS-CoV case reported to WHO on 19 September (see above). Unfortunately, he passed away on 29 September. Investigation of 10 household contacts and 32 healthcare workers was conducted and no further cases were identified.</p> <p style="text-align: center;"><u>Case reported on 29 September</u></p> <p>A 65-year-old male national, retired, living in Buraydah City, Al-Qassim Region. He developed fever, vomiting, abdominal pain and shortness of breath on 25 September and was admitted in a hospital in Dammam on 26 September, whereupon a chest X-ray the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 27 September tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at Riyadh regional laboratory on 28 September. The patient had diabetes mellitus and hypertension as comorbid conditions. As he had already been admitted in that hospital from 17 September to 24 September for laparoscopic cholecystectomy, an investigation of possible exposure is ongoing in it. Patient was discharged on 17 October 2018. Investigation of 15 household contacts and 13 healthcare workers was conducted and no further cases were identified.</p> <p style="text-align: center;"><u>Case reported on 3 October</u></p> <p>A 22-year-old male national, unemployed living in Afif City, Riyadh Region. He developed fever and cough on 30 September and was admitted to Afif general hospital in Riyadh on 1 October for pneumonia that was not confirmed by chest X-ray. A nasopharyngeal swab collected on 1 October tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at Riyadh regional laboratory on 2 October. The patient has no comorbid conditions. He was a household contact of the 50-year-old male MERS case reported to WHO on 24 September (see above). The patient is in stable condition at home isolation. Investigation of 9 household contacts was conducted and no further cases were identified.</p> <p style="text-align: center;"><u>Case reported on 4 October</u></p> <p>A 49-year-old male non-national, driver living in Najran City, Najran Region. He developed fever, cough and shortness of breath on 27 September and was admitted to hospital in Riyadh on 1</p>	
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				<p>from the Middle East, and that cases will continue to be exported to other countries by individuals who might acquire the infection after exposure to animals, animal products (for example, following contact with camels), or humans (for example, in a health care setting). WHO continues to monitor the epidemiological situation and conducts risk assessment based on the latest available information.</p> <p>The global number reflects the total number of laboratory-confirmed cases reported to WHO under IHR to date. The total number of deaths includes the deaths that WHO is aware of to date through follow-up with affected member states. Since 2012 until 15 October 2018, the total number of laboratory-confirmed MERS-CoV cases reported globally to WHO is 2,262, with 803 associated deaths.</p> <p>Based on the current situation and available information, WHO encourages all Member States to continue their surveillance for acute respiratory infections and to carefully review any unusual patterns. Infection prevention and control measures are critical to prevent the possible spread of MERS-CoV in health care facilities. It is not always possible to identify patients with MERS-CoV early because like other respiratory infections, the early symptoms of MERS-CoV are non-specific. Therefore, healthcare workers should always apply standard precautions consistently with all patients, regardless of their diagnosis. Droplet precautions should be added to the standard precautions when providing care to patients with symptoms of acute respiratory infection; contact precautions and eye protection should be added when caring for probable or confirmed cases of MERS-CoV infection; airborne precautions should be applied when performing aerosol generating procedures. MERS-CoV appears to cause more severe disease in people with diabetes, renal failure, chronic lung disease, and immunocompromised persons. Therefore, these people should avoid close contact with animals, particularly camels, when visiting farms, markets, or barn areas where the virus is known to be potentially circulating. General hygiene measures, such as regular hand washing before and after touching animals and avoiding contact with sick animals, should be adhered to. Food hygiene practices should be observed. People should avoid drinking raw camel milk or camel urine, or eating meat that has not been properly cooked.</p> <p>WHO does not advise special screening at points of entry with regard to this event nor does it currently recommend the application of any travel or trade restrictions.</p>
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2018-10-24	Niger (the)	Infectious	Poliomyelitis, acute paralytic, vaccine-associated	<p>Between July and September six cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) are reported from Niger, genetically linked to a cVDPV2 in Jigawa and Katsina States, Nigeria. The virus was isolated from children with acute flaccid paralysis (AFP) from Zinder region, located in the south of Niger and on the border with Nigeria, with dates of onset of paralysis ranging from 18 July until 16 of September, according to information available to date. AFP stool samples from Niger were tested at the Senegal laboratory for viral isolation and Intratypic differentiation. Isolates that need to be sequenced were sent to National Institute for Communicable Disease (NICD). Cases have been reported from Tanout, Dungass and Magaria districts.</p> <p>The first case, a 15-month-old, was notified by Tanout district (Region of Zinder, Niger). This case is linked to an environmental case notified in Jigawa (Nigeria). The second case, an 18-month-old from Katsina State, Nigeria, was brought for medical care to Magaria district, Niger, and was linked to a cVDPV2 case in Katsina, Nigeria. A third child, 26 months of age and notified in Dungass district with a link to an environmental case in Jigawa, Nigeria, has died. Three other cases have been confirmed in September from Magaria district, increasing the cases to six. All children affected so far are under five years of age. This outbreak has also affected Jigawa, Katsina, Yobe, Gombe, and Borno states in Nigeria.</p> <p>Nigeria is also reporting a separate cVDPV2 outbreak in Sokoto district since January 2018. Nigeria is one of only three countries in the world classified as endemic for wild poliovirus, along with Afghanistan and Pakistan. As part of the Lake Chad response, the last monovalent oral polio vaccine type 2 (mOPV2) round was implemented in Niger in January 2017. There is a large cohort lacking immunity against the type-2 poliovirus.</p> <p>The outbreak response plan is being finalized to include the outbreak zone most at risk and the exact scale and extent of the response is being determined. Two mOPV2 response vaccination campaigns will reach close to 3.2 million children under five years of age in four provinces in Niger (Agadez, Diffa, Maradi and Zinder). The first round will be from 24 to 27 October and the second is scheduled for the 7 to 11 November 2018. Acute flaccid paralysis surveillance and routine immunization across the country with focus on the infected provinces and the provinces at the international borders with Nigeria is being reinforced.</p> <p>WHO and its partners are continuing to support local public health authorities in conducting field investigation and risk assessment to more</p>	Public Health Risk (PHR)
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				<p>clearly assess risk of the identified cVDPV2 and to conduct additional response measures as appropriate and necessary. Active case search for additional AFP cases is continuing, and additional surveillance measures such as increasing the frequency and extent of environmental surveillance and community sampling of healthy individuals is being expanded. WHO is supporting the Ministry of Health to strengthen the risk communication and community engagement. WHO in collaboration with the Ministry of Health are working together to finalize with the deployment of the human resources needed at national and provincial levels.</p> <p><i>The emergence of cVDPV2 in Niger is a reminder that until polio is eradicated, polio-free countries will remain at risk of polio re-infection or re-emergence.</i> The detection of this cVDPV2 strain underscores the importance of maintaining high levels of routine polio vaccination coverage at all levels to minimize the risk and consequences of any poliovirus circulation. <i>As this outbreak is linked to an ongoing cVDPV2 outbreak in Nigeria, the risk of further international spread associated with this virus remains high.</i></p> <p>It is important that all countries, in particular those with frequent travel and contacts with polio-affected countries and areas, strengthen surveillance for AFP in order to rapidly detect any polio case, implement prevention measures, and speed-up the response if needed. <i>Countries should also maintain uniformly on all their territory high polio immunization coverage through routine vaccination to minimize the consequences of any new virus introduction or emergence.</i> <u>WHO's International Travel and Health recommends that all travelers to polio-affected areas be fully vaccinated against polio. Residents (and visitors for more than four weeks) from infected areas should receive an additional dose of oral polio vaccine (OPV) or inactivated polio vaccine (IPV) within four weeks to 12 months of travel. For travelers to Niger, IPV is recommended as it is effective against cVDPV2, whereas the type 2 component is no longer included in OPV.</u> All countries should report any polio case using the decision instrument in Annex 2 of the International Health Regulations (IHR). Countries affected by polio transmission should comply with the Temporary Recommendations issued by the Director General following advice from the IHR Emergency Committee concerning ongoing events and context involving transmission and international spread of poliovirus. These recommendations include that affected countries declare a national public health emergency, and encourage departing travelers to be vaccinated.</p>	
2018-10-	Israel	Zoonosis	Monkeypox	On 12 October 2018, Israel reported a laboratory confirmed human monkeypox	Public Health

22				<p>case that was detected in Israel. The patient is a 38-year-old Israeli man who was working in Nigeria. He returned to Israel on 23 September 2018. His symptom onset was on 30 September 2018 with fever, followed by a papulopustular rash that appeared on 2 October 2018. After consultation at a local hospital, skin lesion samples were taken for laboratory testing. Monkeypox was confirmed by electron microscopy and PCR at Israel Institute for Biological Research. Epidemiological investigation revealed that the patient had contact with dead rodents at his dwelling in Port Harcourt, Rivers State, Nigeria. The patient followed a benign clinical course and was subsequently discharged. Currently he is placed in home isolation. No additional suspected cases of monkeypox were found according to the Israeli authorities.</p> <p>The Ministry of Health Israel is conducting active contact tracing and risk assessment for this case. They have released a press statement about this event on 12 October 2018 in which information is provided about the case and measures taken to minimize the risk of any potential onward transmission.</p> <p>Monkeypox is a sylvatic zoonosis with incidental human infections that occur sporadically in remote parts of Central and West Africa. It is caused by the monkeypox virus (MPXV) and belongs to the <i>Orthopoxvirus</i> family. Genomic sequencing showed two MPXV clades to exist (Congo Basin and West African), consistent with observed differences in human pathogenicity and mortality in the two geographic areas. As opposed to the West African clade, the MPXV Congo Basin clade can be transmitted by contact and droplet exposure via exhaled large droplets, and MPXV infection by this clade can be fatal in humans. Otherwise the disease is self-limiting with symptoms usually resolving spontaneously within 14-21 days. MPXV infection in this case is more likely to be Western African clade, which is less virulent, although molecular characterization of the virus is pending. The animal reservoir of MPXV remains unknown, although is likely to be rodents. Contact with live and dead animals through hunting and bush meat consumption are presumed drivers of human infection. There is currently no vaccine specifically for MPXV, however smallpox vaccine provides cross-protection. Increased susceptibility of humans to monkeypox is thought to be related to waning immunity linked to cessation of routine smallpox immunization.</p> <p>This is the <i>first diagnosed human case of monkeypox infection in Israel</i>. Like two cases recently imported to the UK, this case is reported in a traveler arriving from Nigeria, where a multistate monkeypox outbreak is ongoing since September 2017. Authorities in Israel promptly initiated appropriate public health</p>	Risk
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				<p>measures, including home isolation of the case, contact tracing, daily follow-up of contacts, surveillance, and risk communication. Therefore, <i>the risk of onward spread in the country is low.</i></p> <p>Residents and travelers to endemic countries should avoid contact with sick, dead or live animals that could harbor MPXV (rodents, marsupials, primates) and should refrain from eating or handling bush meat. The importance of hand hygiene using soap and water or alcohol-based sanitizer should be emphasized. Any illness during travel or upon return should be reported to a health professional, including information about all recent travel and immunization history. There is no specific treatment or vaccine for the MPXV infection. Timely contact tracing, surveillance measures and raising awareness of imported emerging diseases among health care providers are essential to prevent secondary cases and effective management of MPXV outbreaks. Health-care workers caring for patients with suspected or confirmed MPXV infection should implement standard, contact and droplet infection control precautions. Samples taken from people and animals with suspected monkeypox virus infection should be handled by trained staff working in suitably equipped laboratories.</p> <p>WHO does not advise the application of any travel or trade restrictions on Israel or Nigeria regarding this event based on available information at this point in time.</p>
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*A **public health risk** is something that is (or is likely to be) hazardous to human **health** or could contribute to a disease or an infectious condition in humans.