



COMMUNICABLE DISEASES COMMUNIQUÉ

ABSTRACTS FROM VOLUME 5 NO.1: January 2006

Viral haemorrhagic fevers

Crimean-Congo haemorrhagic fever (CCHF) was confirmed in a 52-year-old woman who lives in the Petrusburg area in the Free State Province, on a cattle farm situated between Bloemfontein and Kimberley. The patient presented with acute onset of fever, arthralgia, epigastric pain and vomiting. There was a history of a *Hyalomma* tick being removed from her leg nine days before the onset of illness. Laboratory testing demonstrated marked thrombocytopenia and increased hepatic transaminases. The diagnosis of CCHF was confirmed by the Special Pathogens Unit at the National Institute for Communicable Diseases in Johannesburg by detection of CCHF viral nucleic acid using RT-PCR on specimens taken on day 8 of illness. Despite intensive care, the patient died. No secondary cases have been reported in contacts to date. This is the first laboratory confirmed case of CCHF from South Africa in 2006.

CCHF may be acquired in one of three ways; through the bite of an infected *Hyalomma* tick, contact with the blood or tissues of an infected animal, or through contact with the blood or tissues of an infected patient. The incubation period may range from 1- 13 days, but is generally less than a week. Typically CCHF resulting from a bite by an infected tick has a very short incubation period - usually 1-3 days. In this respect, the history of tick exposure 9 days prior to the onset of illness in this patient as a source of CCHF virus infection would be unusual. However, the patient lived in an area where *Hyalomma* ticks are prevalent and she might have been subsequently exposed to an infected tick.

The diagnosis of CCHF should be considered in any patient presenting with the following history, clinical and laboratory findings: an acute febrile illness *plus* a history of rural dwelling or animal (livestock or game) or tick contact *plus* fever, bleeding, thrombocytopenia and liver dysfunction. These patients should be isolated appropriately and the specific diagnostic tests requested for laboratory confirmation at the Special Pathogens Unit at the NICD.

Source: *Special Pathogens Unit, NICD*

Waterborne Disease Risks in SA: Cholera alert

There is currently an outbreak of cholera in southern Zimbabwe. In addition, heavy rains and the ongoing limited access to safe water and adequate sanitation in many of South Africa's provinces raise the possibility of waterborne disease outbreaks. Health care workers and laboratories should be on the alert for possible cases.

Specimens should be collected from any patient suspected of having cholera *and/or* meeting the following clinical case definition: *Any patient ≥ 5 years of age presenting with severe dehydration or death from acute watery diarrhoea.* Many patients will not present with the classic rice water stool. For suspected cholera, a stool or a rectal swab should be collected. Stool specimens should be placed in Cary-Blair transport medium (available from the laboratory) if a delay of ≥ 2 hours will occur before processing. Rectal swabs must always be placed in Cary-Blair transport medium regardless of the time to processing. Specimens should then be refrigerated and transported in a cool box with ice packs.

Early communication with the laboratory and communicable disease personnel is essential when cholera is suspected. This will ensure appropriate specimen processing and early public health intervention. The mainstay of individual patient management for cholera is early and aggressive rehydration.

Source: *Epidemiology Unit NICD*

Other topics dealt with in the January edition: Food poisoning in the Eastern Cape

ABSTRACTS FROM VOLUME 5 NO.2 : February 2006

Global update on avian influenza

Nigeria has recently confirmed the presence of highly pathogenic avian influenza H5N1 in poultry. As of February 8th 2006, infection appeared to be limited to a large commercial poultry farm in Kaduna State. However, poultry deaths were reported in the neighbouring Kano province. Many homes in Nigeria have free range poultry and close contact with poultry is inevitable. There are no human cases of H5N1 in Nigeria to date. However many individuals have had extensive unprotected contact with infected poultry prior to confirmation of H5N1 and surveillance for human infection is essential. Public information campaigns will be used to inform individuals of the risk of acquiring infection measures to avoid this. As of February 9th 2006, human infections with H5N1 have been confirmed in 7 countries including Cambodia, China, Indonesia, Thailand, Viet Nam, Turkey and Iraq. There have been 166 confirmed cases and 88 deaths

South Africa remains avian influenza free and there is ongoing surveillance of both wild waterfowl and domestic poultry. The risk of infection in travellers from South Africa to H5N1 affected countries is very low unless they have close contact with infected poultry or poultry contaminated environments. There is a recommended screening procedure in SA for returning travellers suspected of infection with H5N1 which includes both clinical and epidemiological criteria.

The NICD has the diagnostic capacity to test suspected cases who meet the screening criteria.

Source: *World Health Organisation (WHO) Geneva, World Organisation for Animal Health*

Other topics dealt with in the February edition:

- **Rabies** case study in Limpopo
- Outbreak of **furuncular myiasis** due to *Cordylobia anthropophaga*, the tumbu fly
- **Diarrhoeal outbreak** in the Northern Cape
- **Screening procedure for suspected cases of avian influenza (H5N1) in South Africa**

The risk of infection in returning travellers from currently affected countries is very low. All cases that meet the criteria in these guidelines should be discussed with the NICD. For updates on countries currently reporting outbreaks in wild/domestic fowl: http://www.oie.int/eng/en_index.htm

The complete version of this newsletter is available at: <http://www.nicd.ac.za/communique.htm>
To subscribe to the electronic newsletter please e-mail your request to: Mrs Liz Millington: lizm@nicd.ac.za
Correspondence to: Mrs Liz Millington lizm@nicd.ac.za or Private Bag X4, Sandringham, 2131

This communiqué is published by the National Institute for Communicable Diseases (NICD) on a monthly basis for the purpose of providing up-to-date information on communicable diseases in South Africa. Much of the information is therefore preliminary and should not be cited or utilised for publication elsewhere. Permission has been granted to publish this newsletter in SA Family Practice. © NICD a division of the NHLS.