Chikungunya in Italy

An outbreak of chikungunya virus infection in the Emilia Romagna Region of Italy has been reported by The Italian Ministry of Health. The index case is thought to be an Indian national who traveled to Kerala in India, and developed symptoms on 23 June 2007. The first Italian case was reported on 4 July. The outbreak in Italy peaked between 17 and 19 August, and active surveillance has continued since.

The most recent report on ProMED-mail (21 September 2007) states that as of 13 September, 254 cases of potential chikungunya infection had been identified, 78 of which had been confirmed by laboratory tests (ProMED-mail archive number 20070918.3102). Among these confirmed cases, the most recent date of onset was 4 September. Chikungunya virus has also been isolated from *Aedes albopictus* mosquitoes from the affected areas.

It appears that most of the first 135 cases originated from two small villages (Castiglione di Ravenna and Castiglione di Cervia) in the Province of Ravenna, Italy. All other cases seem to have been exposed elsewhere within the Ravenna Province (http://www.hpa.org.uk/infections/topics_az/chikungunya/italy.htm). Typical clinical presentation has consisted of a febrile illness (>38°C), with arthralgia and lethargy. Overall, clinical symptoms have been generally mild, and most patients have made a full recovery over a few weeks. One death due to chikungunya virus infection has been reported in Italy in an 83 year old male who had underlying medical conditions. Previous experience suggests that 5—10% of patients may go on to suffer from chronic joint pain, stiffness and swelling.

A large outbreak of chikungunya fever, involving over a million cases, was reported from India in 2006 (http://www.who.int/csr/don/2006_10_17/en/index.html). Other large-scale outbreaks have recently occurred in countries in east and central Africa, and the Indian Ocean countries, including Comoros, Gabon, Madagascar, the Maldives, Mauritius, Mayotte, La Reunion (France) and the Seychelles. Representatives from French institutions involved in the La Reunion outbreak investigation, together with the European Centre for Disease Prevention and Control (ECDC) and the WHO Regional Office for Europe are currently visiting Italy, to help with the investigations and advise on control measures. These are likely to centre on intense vector control activities. There is no vaccine available to protect against Chikungunya virus.

Ebola Haemorrhagic Fever in Congo DR

The latest update from the WHO (http://www.who.int/csr/don/2007_10_03a/en/index.html), also reported on ProMED-mail (ProMED-mail archive number 20071003.3270), states that there were 76 suspected cases of Ebola haemorrhagic fever from the province of Kasai Occidental, Congo DR, as of 2 October 2007. A total of 25 of these cases have tested positive for Ebola virus, and there are a further 187 contacts under medical observation. These contacts will continue to be monitored until each individual has reached the end of the potential incubation period, and remains asymptomatic.

Strong clinical and epidemiological evidence supports the proposal that the outbreak in Congo is slowing down. However, efforts are still focussed on the identification and isolation of all suspect cases, to try to break the chain of transmission. The outbreak is only considered ‘controlled’ when two consecutive incubation periods have elapsed (42 days) following the identification and isolation of the last confirmed case.

Acute Respiratory Distress Syndrome in Persons with Tick-borne Relapsing Fever: United States

The U.S. Centers for Disease Control and Prevention reported (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5641a1.htm) that cases of tick-borne relapsing fever (TBRF) with acute respiratory distress syndrome (ARDS) had occurred in the western U.S. states of Nevada,
Washington, and California. A subsequent epidemiologic investigation of relapsing fever from Nevada and California from 1995–2004 and the state of Washington from 1996–2005 indicated "that ARDS might occur more frequently in patients with TBRF than previously recognized and can occur in persons without predisposing conditions. All cases of TBRF-associated ARDS identified in this review occurred after 2001, but further surveillance will be needed to determine whether the risk for ARDS in TBRF is increasing. Increases might be related to changes in medical practice, use of newer antimicrobials, or possibly the emergence of a more virulent strain." The retrospective study identified a total of "65 cases of TBRF among persons who reported living in or visiting the Lake Tahoe area during the usual incubation period of 2–18 days before illness onset", two of whom had ARDS and 46 TBRF cases reported in Washington during 1996–2005, three of whom had ARDS.