In this bulletin:

MERS-CoV Update: imported case with secondary transmission in South Korea

Dear colleagues,

Although it has been just over one week since our last bulletin, we would like to highlight a recent MERS-CoV cluster in South Korea that underscores several key aspects of emerging pathogen response, including travel history, prompt and rigorous infection control, and contact follow-up.

Last week, South Korea notified the WHO of a laboratory-confirmed case of MERS-CoV, the first travel-related case to be reported in that country. Subsequent contact tracing investigations have so far identified at least six additional laboratory-confirmed cases, including among family and healthcare-associated contacts.

The index case, an adult male in his 60s, had recently returned from travel in the Middle Eastern region. The case had no history of exposure to known risk factors for MERS-CoV in the 14 days prior to detection, but did report travel in countries where MERS-CoV is known to be circulating (i.e. United Arab Emirates, Saudi Arabia and Qatar).

Since this initial report, six secondary laboratory-confirmed cases have been reported: the wife of the index case, two patients epidemiologically linked through shared hospital exposure to the index case, two healthcare workers who provided care to the index case, and the daughter of the third case who visited her father while in hospital with the index case. One additional suspect case, a contact of the third confirmed case, traveled to China while febrile and is currently under investigation.

Reminiscent of the SARS experience in 2003, this cluster highlights the potential for onward indigenous spread, particularly nosocomial infection, among countries receiving imported cases. To mitigate this risk, clinicians are reminded to elicit a travel history and to immediately implement respiratory precautions for suspected cases of severe acute respiratory illness (SARI) in a patient with links to affected areas in the 14 days prior to symptom onset (i.e. residence, travel history, or contact with someone with such history). Facilities should be mindful of the protection for other patients and visitors, in addition to healthcare workers, to minimize nosocomial transmission and risk. Cases should be managed in respiratory isolation with contact and droplet precautions; airborne precautions are warranted in the event of aerosol-generating procedures or conditions and/or where the index of suspicion may be raised (e.g. because of contact with a confirmed case/cluster or comorbidity or other clinical features that may influence transmission risk).

In the event of a SARI case, please notify your local health authority/Medical Health Officer so that appropriate follow-up may be undertaken and consult a virologist or microbiologist at the BC Public Health Microbiology & Reference Laboratory (PHMRL) to arrange advance notification and direct shipping of diagnostic specimens.

Sincerely,

Influenza and Emerging Respiratory Pathogens Team
BC Centre for Disease Control