衞生防護中心
Centre for Health Protection

# Scientific Committee on Emerging and Zoonotic Diseases

## Consensus Summary on Middle East Respiratory Syndrome (Updated on 26 August 2013)

As of 26 Aug 2013, more than 100 cases of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) have been identified in the Middle East (Kingdom of Saudi Arabia (KSA), Jordan, Qatar and the United Arab Emirates), Europe (United Kingdom, France, Italy and Germany) and North Africa (Tunisia) since its first report in September 2012. Over 80% of the cases were reported since April 2013, with the identification of some mild and asymptomatic cases, possibly related to improvement in case finding in recent months.

2. So far, all cases have either occurred in the Middle East or have had direct links to a primary case infected in the Middle East.

3. People of all age groups were affected although males of middle age or older were overrepresented. Majority of the cases had reported co-morbidities. Patients usually presented with acute febrile respiratory symptoms but immunocompromised individuals may have atypical presentations. Co-infection is also observed in some cases. The case fatality ratio remained high at around 50%. Based on the accumulating information about incubation period, the longest incubation period is about 14 days.

4. MERS is an emerging infection whose animal source has yet to be identified.

5. The currently observed pattern of disease occurrence could be consistent with ongoing transmission in an animal reservoir with sporadic spillover into humans resulting in non-sustained clusters, unrecognized sustained transmission among humans with occasional severe cases cannot be excluded.

6. Person-to-person transmission has occurred in many clusters, either in a household, work environment, or health care setting. With the exception of the health facility associated cluster in Eastern KSA, the number of confirmed secondary cases per cluster has remained low. To date, evidence does not support sustained human-to-human transmission and the pandemic potential of MERS-CoV is considered as low.

7. Although the International Health Regulations Emergency Committee of the World Health Organization (WHO) has not yet classified MERS as a Public Health Emergency of International Concern, there exists risk of sporadic importation resulting in clusters of infections locally. The risk may increase during mass pilgrimages.

8. People travelling to the Middle East need to be aware of the presence of MERS-CoV in this area and of the risk of infection. They should avoid contact with animals. People with underlying illnesses should seek medical consultation before travelling. Travellers who develop symptoms during travel or up to 14 days after their return are encouraged to seek medical attention and to inform their doctors of their travel history.

9. Surveillance for MERS is crucial. Health care professionals should continue to maintain vigilance for cases of MERS-CoV infection and notify any suspected cases to the Centre for Health Protection. They should look out for atypical presentation in people with underlying medical conditions. Lower respiratory specimens such as sputum, endotracheal aspirate, or bronchoalveolar lavage should be used whenever possible for diagnosis. Health care facilities dealing with patients suspected of being infected with MERS-CoV should exercise strict infection control measures.

10. The Committee recommends:

- Continue intensive surveillance for MERS;
- Strengthen health education for travellers to the Middle East;
- Maintain close liaison with WHO and international health authorities to monitor the latest development; and
- Health care facilities to maintain stringent infection control measures.

Centre for Health Protection
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