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Communicable Diseases Watch



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- Two local cases of psittacosis
- A sporadic case of *Streptococcus suis* infection
- DH participated in WHO's IHR Exercise Crystal 2026

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Feature in focus

Updates on Local Situation of Mpox in Hong Kong

Reported by Dr LAU Kin-lun, Kenny, Medical and Health Officer, and Dr MAK Ling-fung, Kenneth, Senior Medical and Health Officer, Communicable Disease Surveillance and Intelligence Section, Communicable Disease Branch, CHP



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Key Points

- Globally, over 190,000 confirmed mpox cases have been reported since 2022. Numbers have fallen significantly from the 2022 peak, yet recent data shows a rise in global case number.
- Hong Kong has recorded 32 cases in 2026 so far, with a sharp upsurge since August concentrated among men who have sex with men engaging in high-risk sexual contacts, often with strangers met via dating apps.
- Vaccination is effective in protecting against infection and severe disease. Local data showed pre-exposure prophylaxis vaccination shortened disease duration and prevented desssimation of the skin lesions to other body parts. The Department of Health is providing free walk-in mpox vaccination services for high-risk groups.
- The overall risk to the general public remains low, as transmission is limited to high-risk community.

Background

Mpox (also known as monkeypox) is an infectious disease caused by the monkeypox virus (MPXV), which consists of two distinct clades: clade I (subclades Ia and Ib) and clade II (subclades IIa and IIb). The first human case of mpox was reported in 1970 in the Democratic Republic of the Congo.

Mpox can spread from person to person through close contact. Since the start of the global outbreak in 2022, sexual transmission within sexual networks has been the primary driver of sustained global transmission of mpox. Outside Africa, non-sexual transmission (such as through household contact or in community settings) was extremely rare. Sexual contact remains the most efficient mode of transmission because of the extensive skin-to-skin and mucosal contact involved. Transmission through respiratory droplets or aerosols is unlikely and generally requires prolonged face-to-face contact. Notably, mpox does not spread through casual social contact.

Mpox is characterised by a painful rash, and other commonly associated symptoms include enlarged lymph nodes, fever, headache, muscle ache, back pain and lethargy. While ocular, genital and inguinal lesions are well described, clinical features newly recognised since the 2022 global outbreak - including proctitis, balanitis, urethritis, and colonic involvement - are most likely related to contact transmission among men who have sex with men (MSM).

In most healthy adults, mpox is typically self-limiting. However, severe disease including secondary infections and death can occur in people with advanced human immunodeficiency virus (HIV) infection or other immunocompromising conditions. While the overall case fatality rate (CFR) has remained below 1% in most settings, fatality up to 15-fold or higher has been observed in patients with immunosuppression and vulnerable infants[1].

Latest Global Epidemiology

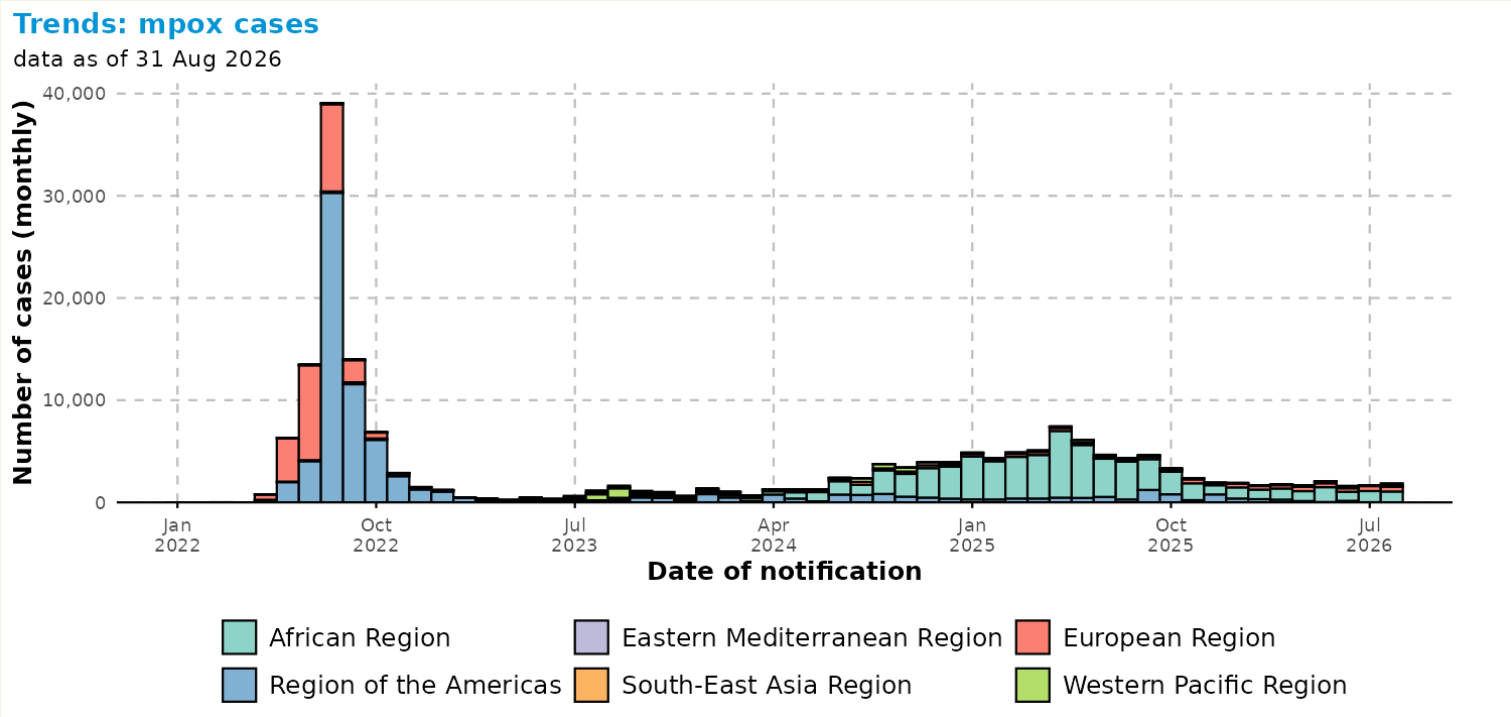


Figure 1 – Epidemic curve of confirmed mpox cases in all WHO regions since 2022.

Source: WHO. Available at: https://worldhealthorg.shinyapps.io/mpx_global/#sec-global

Globally, from January 1, 2022 to August 31, 2026, 145 countries across all World Health Organization (WHO) regions reported 193 009 confirmed cases of mpox. The number of cases reported globally has declined dramatically since the peak in 2022. (Figure 1). According to the latest data from the WHO, in August 2026, 44 countries across all WHO regions reported 1 867

confirmed mpox cases, an 11% increase compared with July 2026. Africa remains the most affected region globally. More than half (57%, n=1 060) of all confirmed mpox cases reported to the WHO in August 2026 were reported from the WHO African Region. As of September 27, 2026, according to latest WHO data, eight countries in Africa have reported active community transmission of mpox in the preceding six weeks, with 602 confirmed cases including four deaths (CFR 0.7%).

On the other hand, in the WHO Western Pacific Region, where Hong Kong is located, 1 381 cases have been reported in the past twelve months (as of August 31, 2026). A gradual upward trend in the monthly confirmed case figures has been observed since the beginning of 2026 (Figure 2). According to the WHO, this upward trend has been largely driven by an increase in cases reported in Australia and the Chinese Mainland, with the latter associated with returning travellers from Thailand in mid-April 2026[2].

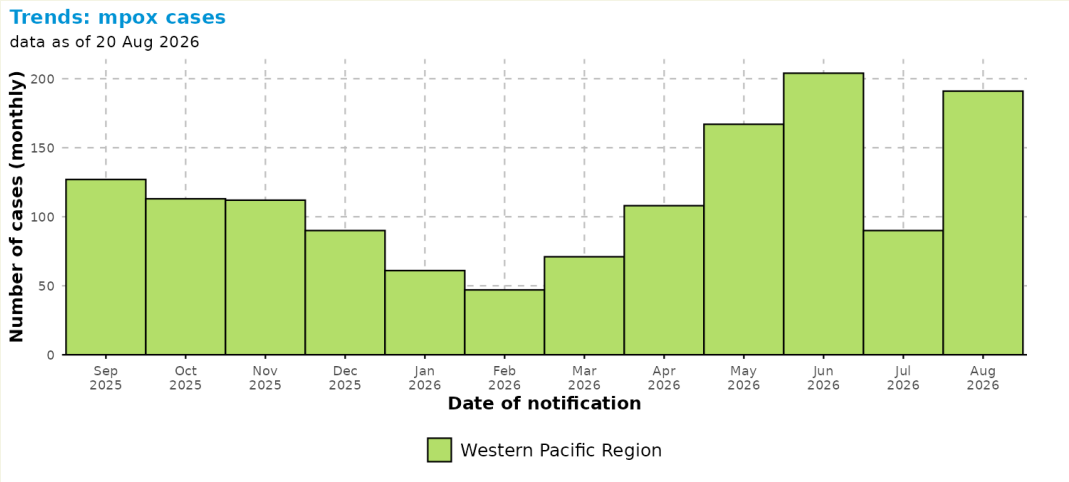


Figure 2 – Epidemic curve of monthly number of confirmed mpox cases in the WHO Western Pacific Region.

Source: WHO. Available at: https://worldhealthorg.shinyapps.io/mpx_global/#sec-global

The Chinese Mainland has been experiencing an increasing trend of mpox cases this year (Figure 3). According to the latest data from the National Disease Control and Prevention Administration of China (NDCPA), the number of confirmed mpox cases in the Chinese Mainland was at a record high of 360 cases in the month of September 2026, a marked increase from 83 and 153 cases in July and August respectively[3]. This shows that the overall increasing pattern is observed regionally.

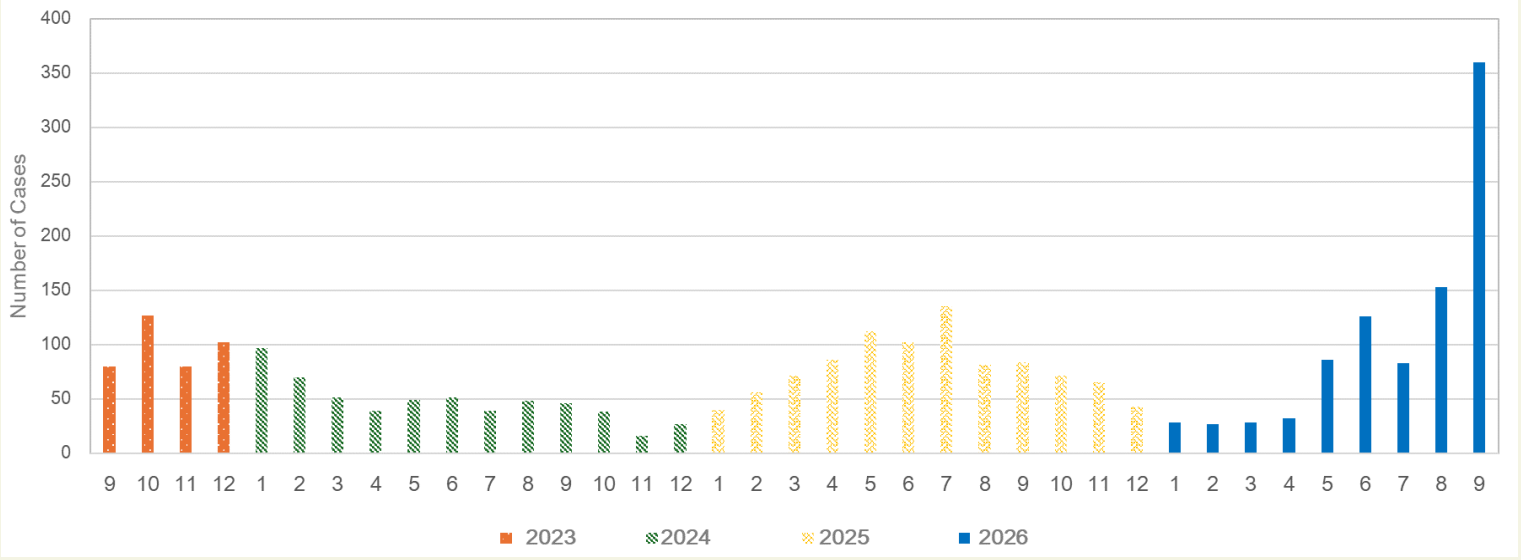


Figure 3 – Number of Confirmed Mpox Cases in Chinese Mainland from 2023 to 2026. Source: NDCPA

Recent Upsurge and Updated Local Epidemiology of Mpox in Hong Kong

As of October 26, 2026, Hong Kong has recorded 116 mpox cases (91 local cases and 25 imported cases) since 2022. All patients were male aged 16 to 61 years. Of these, 32 cases have been recorded in 2026, including 24 local cases and eight

imported cases (Figure 4). The number recorded so far this year has already exceeded the total annual numbers in 2024 and 2025 (14 and 16 respectively).

For 2026, the number of mpox cases in Hong Kong has increased markedly during August and September. Since the implementation of a series of targeted prevention and control measures, the number of cases in October has significantly decreased.

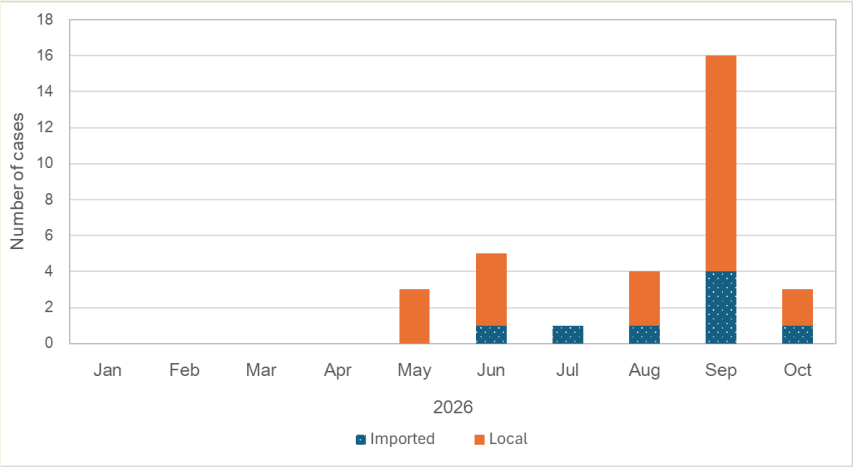


Figure 4 – Epidemic Curve of Confirmed Mpox Cases in Hong Kong in 2026 (as of October 26, 2026).

The epidemiological characteristics of the cases recorded in recent months are similar to cases reported previously. Among the 23 cases reported between August 1 and October 26 (17 local cases and six imported cases), all patients were MSM, with a median age of 31 years old (range 25 – 48 years). Epidemiological investigations showed that all of them had engaged in high-risk behaviours during the incubation period, including unprotected sex with male strangers or multiple partners. Twenty-two cases (96%) presented with anogenital rash and 21 cases (91%) presented with systemic symptoms. Eight (35%) were known to be HIV-positive at the time of mpox diagnosis and only five (22%) patients had previously received mpox vaccination. The majority (70%, n=16) had engaged in high-risk sexual behaviours with strangers during the incubation period, with 13 cases using dating apps to look for sexual partners.

Evolving Epidemiology of Monkeypox Virus Subclades

The multi-country mpox outbreak that began in 2022 which affected over 140 countries and territories worldwide was caused by clade IIb MPXV. On the other hand, clade Ib MPXV was first detected in September 2023 and has since been reported in 65 countries. Initially, most clade Ib cases outside Africa were travel-related, involving individuals exposed in Central or East African countries with community transmission of clade Ib MPXV. However, since late 2025, sexual transmission of clade Ib MPXV has been reported in several regions outside Africa, including the Americas, European, South-East Asia and Western Pacific Regions. The WHO has concluded that the CFR of clade Ib MPXV is similar to that of clade IIb MPXV[1].

Among the 28 confirmed cases recorded in Hong Kong this year with genome sequencing performed, 14 cases were clade Ib and 10 cases were clade IIb, while genetic analysis of the remaining 4 cases could not identify the clade due to insufficient viral load. Some of these cases were subsequently found to have identical genetic sequences, suggesting that they may have shared a common source of infection or belonged to the same transmission chain.

Protective Effect of Vaccination in Local Population

According to the WHO, people vaccinated with two doses of the MVA-BN (JYNNEOS) vaccine have 82% less chance, and those vaccinated with one dose have 76% less chance, of getting mpox than those who did not get the vaccine. In particular, people living with HIV can be safely vaccinated and should be considered for vaccination, as they may be at higher risk of contracting mpox as well as developing more severe disease[4]. Some people may still develop mpox after vaccination, although the vaccine continues to protect against severe disease.

Local data also suggested that vaccination can effectively shorten the duration of illness of mpox. Among the cases recorded in 2026 with available and completed clinical data, the median duration of illness among vaccinated individuals (11.5 days, range 8 – 23 days) was 37.8% shorter than that among unvaccinated individuals (18.5 days, range 10 – 26 days) (Mann-Whitney U test, p = 0.04) (Table 1).

Table 1 – Analysis of the effect of vaccination on the duration of illness among mpox cases in Hong Kong in 2026.

VACCINATION STATUS	MEDIAN LENGTH OF ILLNESS (Days)
Vaccinated (1 or 2 doses)	11.5
Unvaccinated (0 dose)	18.5
STATISTICAL ANALYSIS RESULTS	
% Reduction	37.8%
p-value (Mann-Whitney U Test)	0.04

In addition, among confirmed cases with complete data reported since 2022, 53.5% (n=61) presented with disseminated lesions across multiple anatomical sites, while 46.5% (n=53) developed localised lesions at a single anatomical site only. Thirty-nine patients had received the JYNNEOS mpox vaccine, and 76.9% (n=30) of this cohort developed localised disease only, with lesions confined at a single anatomical site. Based on our local data, pre-exposure prophylaxis vaccination provides a vaccine effectiveness of 86.7% (95% CI 67.6–94.6) against disease progression (Table 2).

Table 2 – Analysis of the effect of vaccination on the progression of lesions among mpox cases in Hong Kong

VACCINATION STATUS	DISSEMINATED LESIONS (MULTIPLE ANATOMICAL SITES)	LESIONS CONFINED TO A SINGLE ANATOMICAL SITE
Vaccinated	9 (23.1%)	30 (76.9%)
Unvaccinated	52 (69.3%)	23 (30.7%)
STATISTICAL ANALYSIS		
Odds Ratio	Pearson Chi-Square	p-value
0.133	22.07	< 0.01

Stepping Up Public Education and Mpox Vaccination for At-Risk Populations

In response to the recent upsurge of mpox in Hong Kong, the Centre for Health Protection (CHP) of the Department of Health (DH) has strengthened public education and awareness on mpox. This includes stepping up outreach on social media platforms and collaborating with the operators of relevant dating apps to regularly promote information on mpox prevention and vaccination to users in Hong Kong. In addition, the CHP has deployed staff to conduct health promotion activities at a number of sex-on-premises venues. Since late September 2026, an additional mpox vaccination centre has been set up at the CHP Building in Mong Kok to enhance access for eligible high-risk groups. The CHP has also coordinated with relevant non-governmental organisations (NGOs) which provide services for MSM population to organise outreach vaccination services at their venues.

The CHP has set up a mpox hotline (2125 2373) to provide health assessments and advice to high-risk individuals, and to arrange vaccination for individuals when appropriate. To help control the spread of disease and safeguard the public health of local communities, in cases when CHP identifies a specific sex-on-premises venue as posing a transmission risk, the venue will be advised to cease operation temporarily.

Overall Risk to Local General Population is Low

The declaration by the WHO in September 2025 that mpox no longer constituted a Public Health Emergency of International Concern reflected a sustained decline in global case numbers and improved global surveillance and response capacities. In its latest rapid risk assessment, the WHO continues to assess the overall global public health risk of mpox as moderate for individuals with multiple sexual partners and low for all other individuals. The recent local upsurge nonetheless underscores the importance of ongoing vigilance against the disease. As shown by our analysis, local transmission remains concentrated within the MSM community. Together with the robust public health measures in place, the risk of widespread mpox transmission in the broader Hong Kong community remains low.



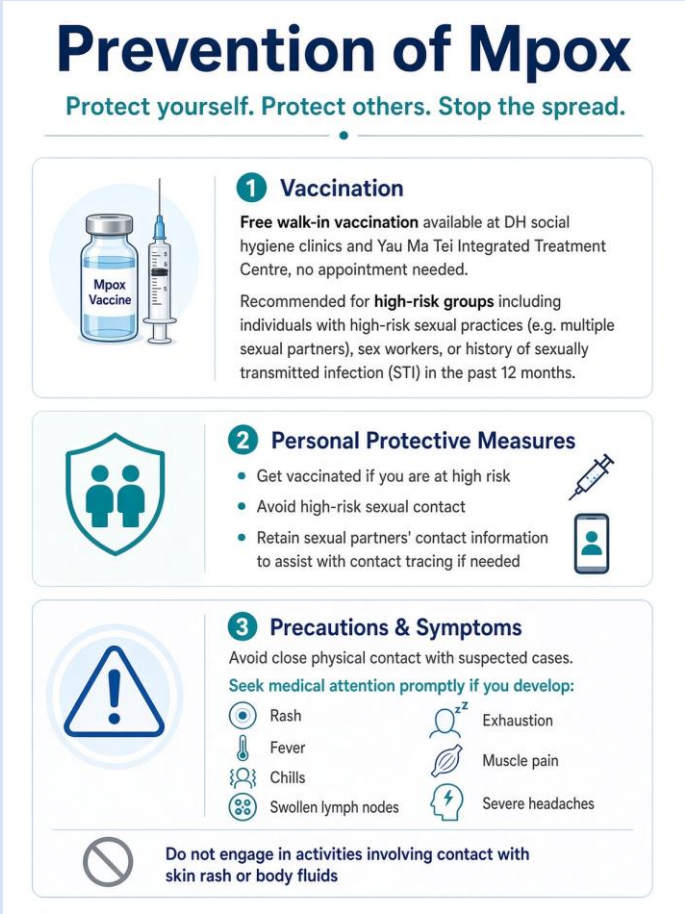
Prevention of Mpox



Mpox vaccines provide protection against infection and severe disease. According to the recommendation of the Scientific Committee on Vaccine Preventable Diseases and the Scientific Committee on Emerging and Zoonotic Diseases under the CHP in 2022, a third-generation mpox vaccine is recommended as post-exposure prophylaxis for contacts of confirmed cases and as pre-exposure vaccination for individuals at high risk of exposure. A two-dose regimen is required, while those who have previously received smallpox vaccine need only one dose.

The DH has been providing free walk-in mpox vaccination services for high-risk groups, including individuals with high-risk sexual practices (such as having multiple sexual partners), sex workers, or having a history of sexually transmitted infection within the past 12 months, at any of the DH's social hygiene clinics and the Yau Ma Tei Integrated Treatment Centre, without prior appointments.

Individuals who have engaged in high-risk sexual contact, particularly with strangers, are advised to remain vigilant and take appropriate personal protective measures, including receiving mpox vaccination and avoiding high-risk sexual contact, so as to lower the risk of infection. The CHP also strongly urges persons with high-risk behaviours to retain their sexual partners' contact information to facilitate contact tracing when necessary.



The public, especially those at higher risk of exposure, should take precautions and avoid close physical contact with persons suspected of being infected. They should seek medical attention as soon as possible if they experience relevant symptoms, including rash, fever, chills, swollen lymph nodes, exhaustion, muscle pain, and severe headaches. They should not engage in activities with others that may involve contact with skin rash or body fluids.

References

[1] World Health Organization (WHO) (2024). *WHO Rapid Risk Assessment - Mpox, Global v.7*. Available at: https://www.who.int/publications/m/item/who-rapid-risk-assessment-mpox--global-v.7.

[2] World Health Organization (WHO) (2026). *Mpox Global Surveillance Dashboard*. Available at: https://worldhealthorg.shinyapps.io/mpx_global/#sec-global.

[3] National Disease Control and Prevention Administration (2026). *2026 年 8 月全国传染病疫情概况*. Available at: https://www.ndcpa.gov.cn/jbkzzx/c100016/common/content/content_20978588550246277l2.html.

[4] World Health Organization (WHO) (2025). *Mpox: Vaccines*. Available at: https://www.who.int/news-room/questions-and-answers/item/mpox-vaccines.

Feature in focus

Infection Control Guidelines for Clinical Procedures Involving Skin Penetration

Reported by Dr WONG Leung-chun, Jonathan, Resident, and Dr LUI Leo, Associate Consultant, Infection Control Branch, CHP



Image generated by AI

Key Points

- CHP released the guidenline in August 2026 to provide guidance for procedures involving the use of instruments that breach the skin barrier in clinical settings, to reduce infection transmission risk.
- Skin penetration procedures can transmit various types of pathogens; all blood and body fluids should be treated as potentially infectious, and risks also affect operators via sharps injuries.
- The guideline covers key stages—before, during and after procedures—emphasising clean environments, sterile instruments (single-use preferred), proper reprocessing, hand hygiene, aseptic technique and safe waste disposal.

The Centre for Health Protection (CHP) of the Department of Health (DH) released the "Infection Control Guidelines for Clinical Procedures Involving Skin Penetration" in August 2026 to provide practical guidance on infection control practices for procedures involving the use of instruments that breach the skin barrier in clinical settings. These procedures carry a risk of infection transmission if infection control measures are not adequately implemented. The guideline aims to support healthcare workers and operators in reducing preventable risks and improving procedural safety.

The guideline is available on the CHP website in both English and Chinese: https://www.chp.gov.hk/en/resources/346/index.html (Figure 1)

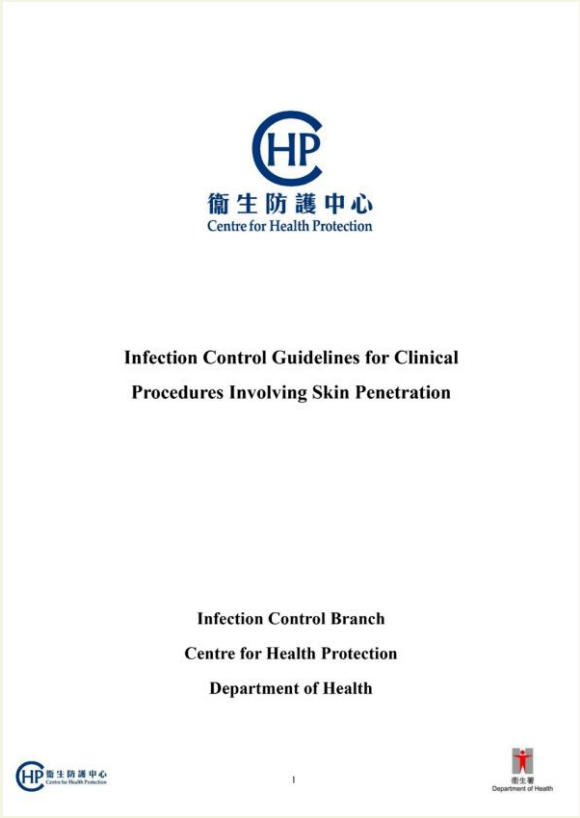


Figure 1 – Cover of the "Infection Control Guidelines for Clinical Procedures Involving Skin Penetration" (English version).

Infection risks associated with skin penetration procedures and how the new guideline helps

Skin penetration procedures may be associated with the transmission of a range of infectious agents, including viruses (such as hepatitis B virus, hepatitis C virus, and human immunodeficiency virus), bacteria (such as *Staphylococcus aureus* and *Mycobacterium* spp.), and fungi (such as *Candida* spp.). A key message reinforced in the guideline is that all blood and other body fluids should be treated as potentially infectious, as infections may be asymptomatic and a person's infection status may not be known. As such, transmission may occur in the absence of appropriate infection control measures, particularly when there are lapses in aseptic techniques, reprocessing of reusable medical devices, hand hygiene, environmental decontamination, or standard precautions. The infection risks are not limited to recipients of procedures but also extend to operators, particularly in the context of sharps injuries. However, appropriate infection control measures can effectively reduce these risks in healthcare settings.

The new guideline was developed with reference to established infection control principles and relevant national and overseas guidelines on procedures involving skin penetration. To facilitate practical implementation, the guideline is organised into key domains, including environmental hygiene, instrument selection, processing and storage, preparation of operators and recipients, aseptic techniques, waste management, post-procedure advice, and management of occupational exposures. This structure is intended to support users in identifying relevant infection control requirements at each stage of care, from preparation to post-procedure follow-up. To support practical use, the guideline differentiates between operators and recipients, clarifying how the recommendations apply in different contexts. Key recommendations of the guidelines are highlighted in the ensuing paragraphs.

Before the procedure

The procedure environment should be kept clean, dry, well-ventilated, and adequately lit. A well-maintained environment is considered fundamental to reducing microbial contamination and supporting safe clinical practice. It is important to ensure that proper environmental cleaning and disinfection are performed using appropriate disinfectants, hand hygiene facilities are readily accessible within the procedure area, and hand hygiene can be performed at appropriate moments without delay.

Regarding the safe handling and processing of instruments used in skin penetration procedures, all instruments that penetrate the skin must be sterile, and that single-use disposable instruments are preferred. Reprocessing of reusable medical devices should follow strict procedures, including cleaning, disinfection and sterilisation according to the risk level of the device. Cleaning is highlighted as the essential first step, involving the removal of visible and invisible contaminants using appropriate detergents or enzymatic agents. Reusable instruments can be categorised into critical, semi-critical and non-critical items, based on their level of contact with sterile tissue, mucous membranes or intact skin. Each category is associated with specific reprocessing requirements, ranging from sterilisation to high- or low-level disinfection. Proper storage of sterile and disinfected items is also emphasised to prevent recontamination, with storage areas required to be clean, dry and appropriately maintained.



Figure 2 – Summary of infection control requirements before the procedure.

Hepatitis B vaccination is recommended for non-immune operators. Operators should observe standard precautions when performing skin penetration procedures, maintain good personal hygiene and wear appropriate protective clothing, including surgical masks when indicated. Hand hygiene is highlighted as a cornerstone of infection control and should be performed at key moments, including: before patient contact, before aseptic procedures, after exposure to body fluids, after patient contact, and after contact with the patient's environment. Gloves should be worn when there is a risk of exposure to blood or body fluids, but glove use does not replace the need for hand hygiene. Gloves should be changed between recipients, and hand hygiene should be performed after removing gloves and before donning new gloves.

Additional recommendations include maintaining short nails, avoiding jewellery, and ensuring that any breaks in the skin are properly covered. Operators with respiratory symptoms are advised to wear a surgical mask and seek medical advice to reduce transmission risk.

Recipient preparation is also an important component of infection control. Relevant medical history and risk factors, such as chronic illness, immunosuppression or existing infections, should be reviewed prior to the procedure. Recipients are advised to maintain good personal hygiene and, where appropriate, clean the intended procedure site beforehand. The skin at the procedure site should be inspected, and the procedure should not proceed if signs of infection or inflammation are present. Recipients with respiratory symptoms are also advised to take precautions, including wearing a surgical mask if appropriate.

During the procedure

Aseptic technique is a central element of the guideline. Hand hygiene must always be performed before any aseptic procedure, and sterile instruments must be handled in a manner that avoids contamination. Proper skin antisepsis, including appropriate selection of antiseptic agents, correct application technique and sufficient drying time prior to the procedure, should be practised. Operators are also advised to handle instruments carefully and ensure accountability for all instruments used during the procedure (Figure 3).



Figure 3 – A clinical procedure involving skin penetration. Source: Hospital Authority.

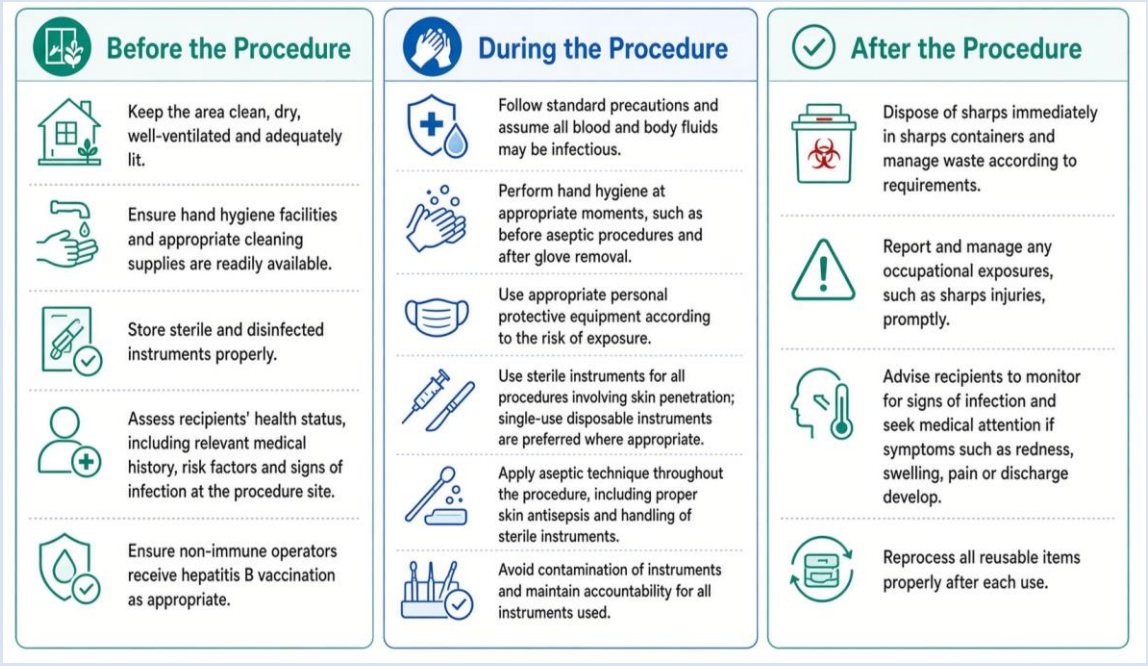
After the procedure

Safe disposal of waste and sharps is highlighted as essential to preventing occupational injuries and environmental contamination. Used sharps should be disposed of into puncture-resistant containers, and waste should be managed in accordance with relevant regulatory requirements. Clear guidance is provided for managing sharps injuries, including immediate wound care, incident reporting, medical evaluation and follow-up testing where appropriate. After the procedure, recipients should monitor for signs of infection such as redness, swelling, pain or discharge, and seek medical attention promptly if symptoms develop.



Highlights of "Infection Control Guidelines for Clinical Procedures Involving Skin Penetration"





Global Disease Snapshot

Major Outbreaks and Emerging Infections



As of October 21, 2026, West Nile virus infections in Europe reached an unprecedented peak, with 1 965 locally acquired human cases reported across 20 countries, since the beginning of the 2026 transmission season. **Italy** remains the most heavily impacted nation, documenting 770 cases. Additionally, both **Greece** and **France** experienced historic surges in transmission, recording their highest caseloads to date with 457 and 173 cases, respectively.

On October 2, 2026, an employee of the Irkutsk Antiplague Research Institute in Irkutsk Oblast of **Russia** died after being hospitalised for severe pneumonia of unknown etiology. Russian health authorities informed the WHO that laboratory testing of the case and all close contacts were negative results for high-threat pathogens, including plague.

Measles cases in the **United States** in 2026 have surpassed the 2025 total of 2 289 infections, escalating significantly to 4 588 confirmed cases across 47 jurisdictions as of October 22, 2026. Nationally, 43 active outbreaks have been identified this year, with outbreak-associated infections accounting for 96% of the total case volume. This epidemiological surge is primarily driven by substantial regional concentrations, specifically in Pennsylvania with 1 327 cases, South Carolina with 670 cases, and Utah with 535 cases.

In October 2026, **France** reported the first documented case of human disease caused by Shamonda virus. Shamonda virus primarily affects animals such as cattle, sheep, goats and horses. It is thought to spread through midges, which pass the disease from animal to animal. The case affected a severely immunocompromised patient. The patient died in early October. Investigations into whether the virus caused or contributed to the patient's death and how the infection was acquired are ongoing.

The 2026 Ebola outbreak (Bundibugyo virus) has primarily impacted the **Democratic Republic of the Congo (DRC)**, which has documented 9 964 confirmed cases and 4 841 fatalities as of October 24, 2026, reflecting a 49% case fatality rate. Epidemiological spread includes **Kenya**, which identified its initial imported case on October 6, 2026 involving a citizen returning from the **DRC** via **Uganda**. By October 23, 2026, this localised cluster expanded to nine confirmed cases and two death. Concurrently, on October 20, 2026, **Nigeria** officially confirmed an imported case within the Federal Capital Territory involving a female traveller with recent travel history to **Uganda**.

Sources of information

European Centre for Disease Prevention and Control (ECDC): https://www.ecdc.europa.eu/en/west-nile-fever/surveillance-and-disease-data/disease-data-ecdc

World Health Organization (WHO) - African Region: https://afro.who.int/countries/nigeria/news/nigeria-confirms-imported-case-ebola-bundibugyo-virus-disease

Ministry of Health Kenya @ X: https://x.com/MOH_Kenya/status/2113716817155817908

The U.S. Centers for Disease Control and Prevention (US CDC): https://www.cdc.gov/measles/data-research/index.html

European Centre for Disease Prevention and Control (ECDC):
https://www.ecdc.europa.eu/en/news-events/severely-ill-patient-france-becomes-first-ever-human-infected-shamonda-virus
https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2026.31.42.2600883?

World Health Organization (WHO): https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON620

News in Brief



A local case of leptospirosis

On September 22, the Centre for Health Protection (CHP) of the Department of Health (DH) recorded a case of leptospirosis affecting a 50-year-old man residing in Yau Tsim Mong. He presented with fever, vomiting and diarrhoea since July 26. He was admitted to a public hospital on July 30. His clinical specimen tested positive for Leptospira serogroups *Icterohaemorrhagiae* and *Celledoni*. He was treated with antibiotics and his condition improved from critical to stable. He recovered and was discharged from hospital on August 25. During the incubation period, he had direct contact with muddy water while working in construction sites. His household contact and colleagues who worked with him remained asymptomatic. The case was referred to the Agriculture, Fisheries and Conservation Department (AFCD) and the Food and Environmental Hygiene Department (FEHD) for follow-up. After the construction work had been completed, the muddy water had already been cleared, as confirmed upon inspection.

Two sporadic cases of necrotising fasciitis caused by *Vibrio vulnificus* infection

The CHP recorded two sporadic cases of necrotising fasciitis caused by *Vibrio vulnificus (V. vulnificus)* infection on September 22 and 23 respectively.

The first case involved a 76-year-old woman with underlying illnesses residing in Eastern District. The patient purchased raw fish from a fish stall and handled it with bare hands at home on September 20. She subsequently noticed a wound on her left index finger. She rinsed the wound under running water but did not apply any disinfectant. She presented with fever, pain and swelling of the left hand and forearm on September 20 and was admitted to a public hospital on September 21. A wound swab collected on the same day tested positive for *Vibrio vulnificus*. The clinical diagnosis was necrotising fasciitis of the left upper limb. She was treated with antibiotics, and multiple excisional debridement procedures were performed on the left upper limb. She recovered and was discharged on October 9. The CHP has notified the FEHD of the case for disinfection of the fish stall concerned.

The second case involved a 73-year-old man with underlying illnesses residing in Southern District. The patient sustained an injury to his right index finger on September 17 while handling raw prawns at a seafood market in the Chinese Mainland. On September 18, he presented with fever, bruising over the injured finger, and painful swelling of the right hand and forearm. He was admitted to a public hospital on the same day. The clinical diagnosis was necrotising fasciitis of the right upper limb. Multiple excisional debridement procedures and amputation of the right index finger were performed from September 19 onwards. Tissue collected from the right index finger on September 19 cultured positive for *Vibrio vulnificus*. He recovered and was discharged on October 7.

Two local cases of psittacosis

The CHP recorded two local cases of psittacosis on September 21, 2026.

The first case involved a 65-year-old man with good past health who resided in Tai Hang. He presented with fever, cough and shortness of breath since September 10 and had sought medical attention. He was brought to a public hospital on September 15 and admitted for management of pneumonia. A sputum specimen collected on September 18 tested positive for *Chlamydia psittaci* DNA. His condition improved after antibiotic treatment, and he was undergoing rehabilitation in a general ward. He had no travel history during the incubation period. He lived alone and did not keep birds at home. He did not recall any direct contact with birds, bird droppings, or carcasses.

The second case involved a 55-year-old man with good past health who also resided in Wan Chai. He presented with fever, cough, sputum production and runny nose since September 7 and had sought medical attention. On September 14, he developed confusion and was brought to a public hospital. He was admitted to the ICU on the same day. An endotracheal aspirate specimen collected on September 17 tested positive for *Chlamydia psittaci* DNA. His condition remained critical. He had no travel history during the incubation period. He regularly visits a market in Wan Chai where pigeons were observed nearby. The case details were referred to the AFCD and the FEHD for follow-up.

A sporadic case of *Streptococcus suis* infection

On October 8, 2026, the CHP recorded a sporadic case of *Streptococcus suis* infection affecting an 80-year-old man. He presented with malaise, chills and rigor on October 6, followed by a fever on October 7. He attended Accident and Emergency Department of a public hospital on the same day and was admitted for treatment. His blood was cultured positive for *Streptococcus suis*. His family members prepared raw pork at home, where he might have been exposed during the food preparation process. He was treated with antibiotics, and his condition remained stable upon treatment. His home contacts were asymptomatic.

DH participated in WHO's IHR Exercise Crystal 2026

The CHP participated in the annual table-top International Health Regulations (IHR) Exercise Crystal organised by the World Health Organization (WHO)'s Regional Office for the Western Pacific (WPRO) on September 23. Representatives of the Centre for Food Safety (CFS) of the FEHD and the AFCD also participated in the exercise. The exercise simulated a scenario in which suspected food contamination caused illnesses among a number of residents. The exercise provided an invaluable opportunity for Hong Kong to test relevant government departments' response plan, prevention and control measures and co-ordination efforts on foodborne diseases. Representatives of the CHP, the FEHD and the AFCD co-ordinated the cross-sectoral response according to the evolving scenario and shared information swiftly with the WPRO. This exercise also strengthened communication and information sharing mechanisms between Hong Kong and the WHO WPRO, and the respective focal points in other regions, for responding to different public health emergencies.



Photo 1 – CHP colleagues participated in the annual IHR Exercise Crystal organised by the WPRO, together with the representatives of the FEHD and the AFCD, to enhance emergency response mechanisms and cross-sectoral collaboration capabilities.



Photo 2 – The exercise host of the WPRO concluded the exercise with a debriefing by reviewing the outcomes and exchanging views to explore ways to improve cross-regional emergency response and collaboration mechanisms.