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Communicable Diseases Watch

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衛生防護中心 Centre for Health Protection

衛生署 Department of Health

2025 Year in Review

Review of Global Situation of Nipah Virus Infection

Global Disease Snapshot

Journal Publication Highlights

Highlights on infectious diseases and events, week 5 - 8:

- Two local cases of psittacosis
- A local case of *Streptococcus suis* infection
- A local confirmed case of severe Community-associated Methicillin-resistant *Staphylococcus aureus* (CA-MRSA) infection
- A sporadic case of necrotising fasciitis due to *Vibrio vulnificus* infection
- A local case of listeriosis
- A sporadic case of brucellosis
- Updated Antibiotic Guidance Notes to Combat Antimicrobial Resistance
- Seminar on Management of Infectious Diseases in Immunocompromised Hosts

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Feature in focus

2025 Year in Review

Reported by Surveillance Division, Communicable Disease Branch, CHP

Key Points

- Hong Kong had two influenza seasons in 2025. The winter season was typical and dominated by influenza A(H1) viruses, while the summer season was prolonged and dominated by antigenically drifted influenza A(H3) viruses (subclade K), recording a high number of school outbreaks.
- COVID-19 activity surged from April to June 2025 due to the NB.1.8.1 variant. However, the overall disease burden in terms of hospital admissions, severe cases, and mortality was lower than in the previous two years.
- Acute gastroenteritis followed its typical winter peak from January to March, with a high number of norovirus institutional outbreaks recorded, especially in elderly care homes and schools.
- Chikungunya fever reached a record high of 82 cases in 2025. The majority were imported from Guangdong Province, with only 11 local cases recorded. Mosquito control measures successfully prevented sustained community transmission.
- Meningococcal disease cases doubled, measles remained low but importation risks persisted, and melioidosis stayed stable with cases concentrated in Sham Shui Po.

Seasonal influenza

Hong Kong experienced two influenza seasons in 2025.

2024/25 winter influenza season

The 2024/25 winter influenza season in Hong Kong began in early January 2025 and lasted for about three months (11 weeks) until March (Figure 1). Both the timing and overall duration aligned closely with patterns observed in previous typical winter seasons (usual range: 12 – 17 weeks). It was predominated by influenza A(H1) viruses which matched the reference strains of the 2024/25 seasonal influenza vaccines (SIV).

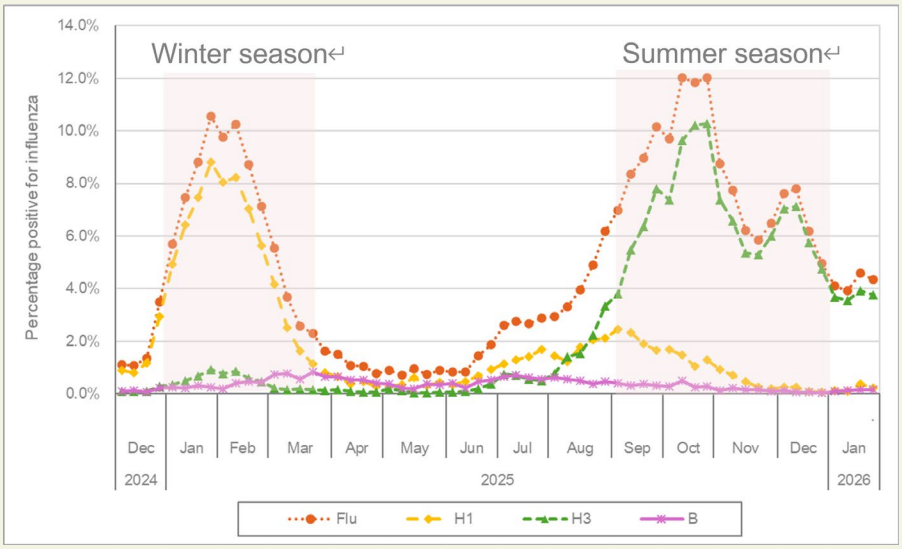

Figure 1 – Percentage of respiratory specimens tested positive for influenza viruses and their subtypes, December 2024 – January 2026.

2025 summer influenza season

The 2025 summer influenza season commenced in September 2025, later than the usual historical timing around July to August. It lasted for approximately four months (18 weeks) until early January 2026. The season was characterised by a significant upsurge in influenza-like illness (ILI) outbreaks reported in schools, following the start of the new school term in September (Figure 2). During the season, a record-high 1 224 institutional outbreaks were reported, marking the highest record in the past decade, and notably exceeding the prior highest total of 862 outbreaks recorded during the 2018/19 winter influenza season. Of these, 1 065 outbreaks occurred in schools, were with primary schools accounting for more than half.

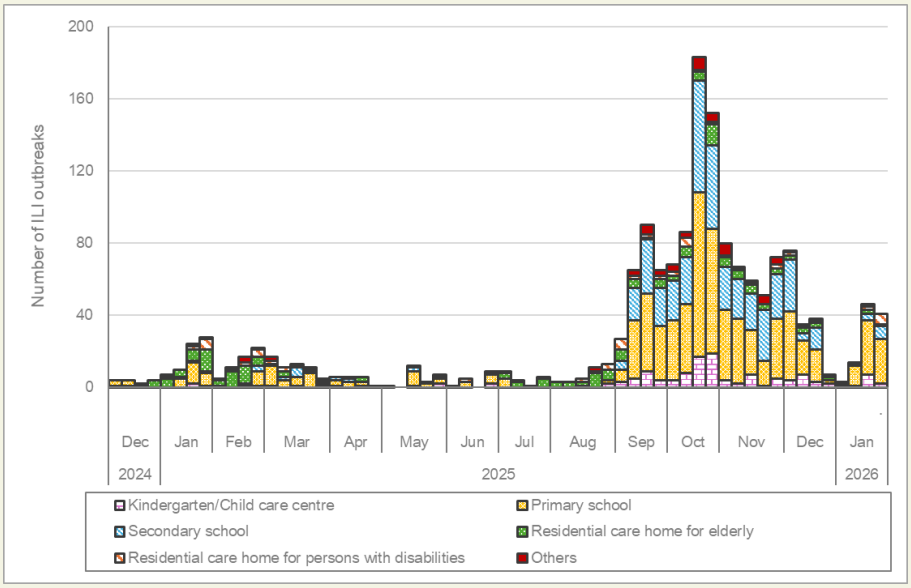

Figure 2 – The weekly number of ILI outbreaks by type of institutions, December 2024 – January 2026.

Influenza A(H3) viruses predominated in this season. An antigenic drifted strain of influenza A(H3) virus, namely subclade K, have been detected locally since last August, similar to the global situation of subclade K detection in more than 34 countries as reported by the World Health Organization in December 2025. Current epidemiological data did not indicate an increase in disease severity by this strain.

COVID-19

COVID-19 has transitioned to an endemic pattern in Hong Kong, with periodic upsurges in activity levels at irregular intervals of approximately every six to nine months. In 2025, Hong Kong experienced an upsurge in COVID-19 activity level between April and June, with its peak in mid-May followed by a gradual decline to baseline levels. Since then, the activity remained at a low level through December 2025. The upsurge was driven by the replacement of dominant circulating

variants from JN.1-related lineages (including KP.2 and KP.3) in 2024 to XDV-related lineages (including NB.1.8.1) since late March 2025 (Figure 3).

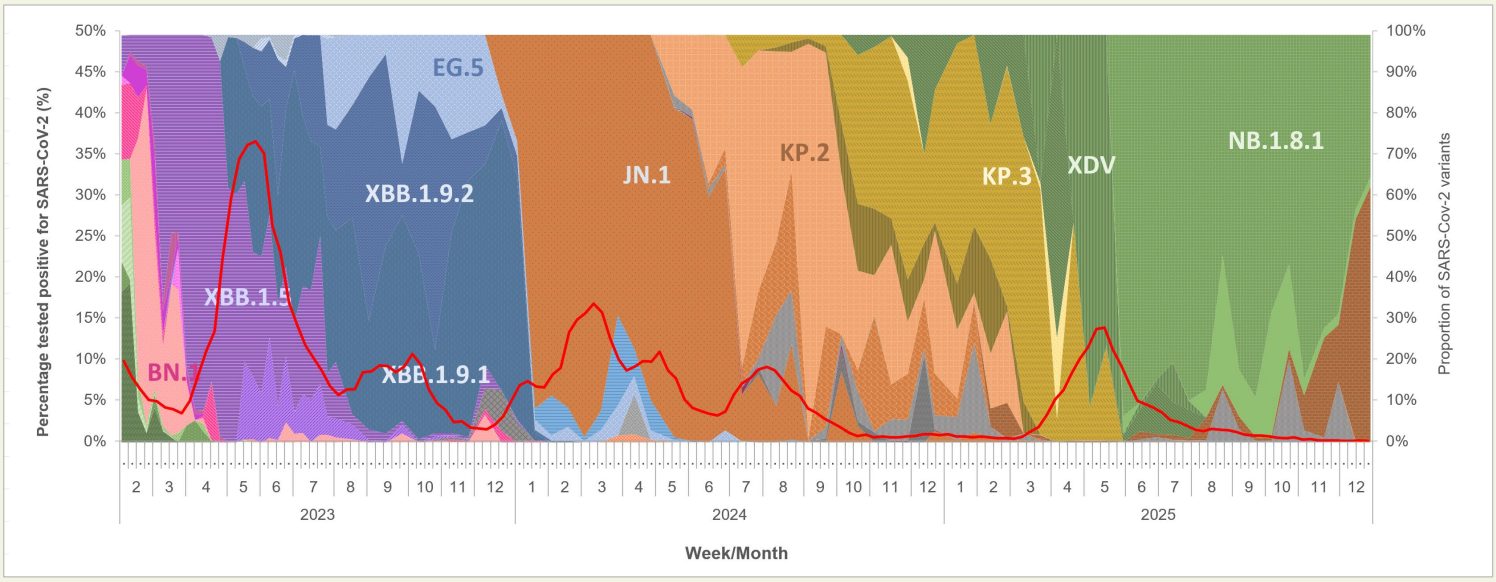

Figure 3 – Percentage positive for SARS-CoV-2 virus among respiratory specimens and proportion of SARS-CoV-2 variants (February 2023 to December 2025).

Since 2023, Hong Kong has observed a consistent downward trend in the overall COVID-19 disease burden, as evidenced by reductions in hospital admission rates, incidence rates of severe cases, and mortality rates (Table 1).

Table 1 – Cumulative annual hospital admission rate, incidence rates of severe cases, and mortality rates in 2023, 2024, and 2025.

	2023	2024	2025
Hospital admission rate (Per 10 000 population)	50.9	23.4	10.1
Severe case (including death) (Per 100 000 population)	41.1	12.7	5.7
Death (Per 100 000 population)	14.6	5.1	1.9

Measles

In the context of ongoing global measles resurgence, the Centre for Health Protection (CHP) of the Department of Health recorded 10 cases of measles in 2025, same as the number of cases recorded in 2024, and substantially lower than pre-pandemic levels in 2018-19 (Figure 4). Six of these cases were locally acquired infections, while four were imported cases from the Philippines, Vietnam and Pakistan where measles remains endemic. The six local measles cases involved two family clusters and one secondary case in a close contact (a 10-month-old infant with exposure to two confirmed cases of one family cluster during a visit to a private clinic). Of all cases, six were adults (aged 22 to 38 years) with unknown or undocumented measles vaccination history while four were unvaccinated children aged below one year (not yet due for vaccination). Clinically, eight cases developed typical measles (80%) while two (20%) were modified measles with milder symptoms.

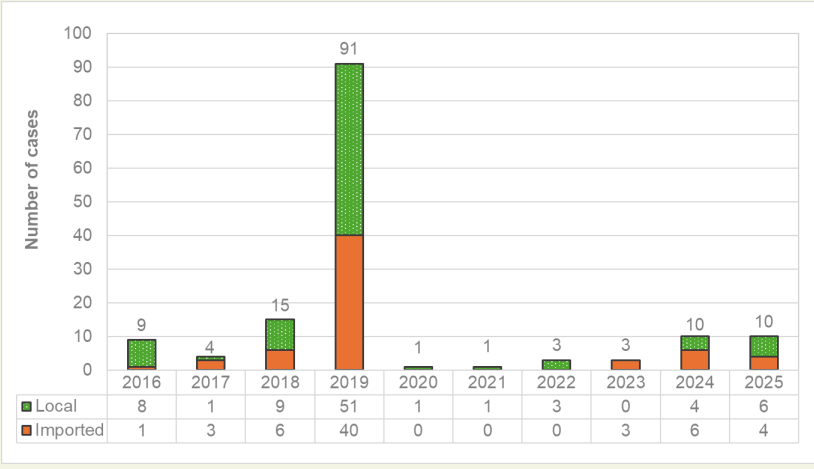

Figure 4 – Measles cases by year since elimination in Hong Kong declared in 2016.

Although Hong Kong maintains consistently high two-dose measles immunisation coverage and robust population immunity, the ongoing global measles resurgence, coupled with a high volume of international travel, continues to pose a significant

importation risk. To mitigate this threat, the CHP has sustained proactive risk communication with relevant stakeholders (such as medical practitioners, hospitals, airport community, cruise agencies, tourism industry, employment agencies of foreign domestic helpers) through issuance of letters, press release and social media publicity reminding the public to take precautions against measles and keep their vaccination up-to-date.

Complementing these efforts, the CHP conducted a measles seroprevalence study on local young adults in 2025 which demonstrated a high seropositivity rate of ≥95%, consistent with the results reported in the 2024 serosurvey among some at-risk groups (foreign domestic helpers, airport workers and non-local born university staff/students). These results affirm that the overwhelming majority of the population are immune to measles.

Acute gastroenteritis

Acute gastroenteritis (AGE) is a common infection in Hong Kong. It can be caused by viruses or bacteria. The disease is usually more active during winter season with the majority of the infections caused by norovirus (NoV).

AGE activity in 2025 followed the typical seasonal pattern of peaking during the winter months (January to March) before declining to baseline levels. The year was marked by a notable surge in NoV-associated institutional AGE outbreaks, exceeding levels recorded in the past 10 years (Figure 5). The number of NoV AGE outbreaks recorded by the CHP increased significantly since December 2024, peaking in January and February 2025, and returned to baseline level in May 2025 (Figure 6).

Overall, a total of 216 institutional AGE outbreaks were recorded in 2025. Causative agents were confirmed in 132 (61.1%) outbreaks. The majority of AGE outbreaks with known causative agents were associated with NoV (97, 73.5%), followed by rotavirus (22, 16.7%), sapovirus (6, 4.5%), and other pathogens (5, 3.8%) (e.g. astrovirus, adenovirus and Aeromonas, etc.). The remaining two outbreaks (1.5%) were associated with multiple pathogens. The majority of NoV outbreaks occurred in residential care homes for the elderly (53, 54.6%), followed by child care centres/kindergartens (14, 14.4%), primary schools (13, 13.4%), secondary schools (4, 4.1%) and hospitals (1, 1.1%). The remaining 12 outbreaks (12.4%) occurred in other institutions (e.g. residential care homes for persons with disabilities and special schools, etc.).

Chikungunya fever

The CHP recorded 82 chikungunya fever (CF) cases in 2025 (71 imported and 11 local cases), far exceeding the total of 22 cases (all imported) reported between 2016 and 2024 (Figure 7). This significant increase was driven by the global

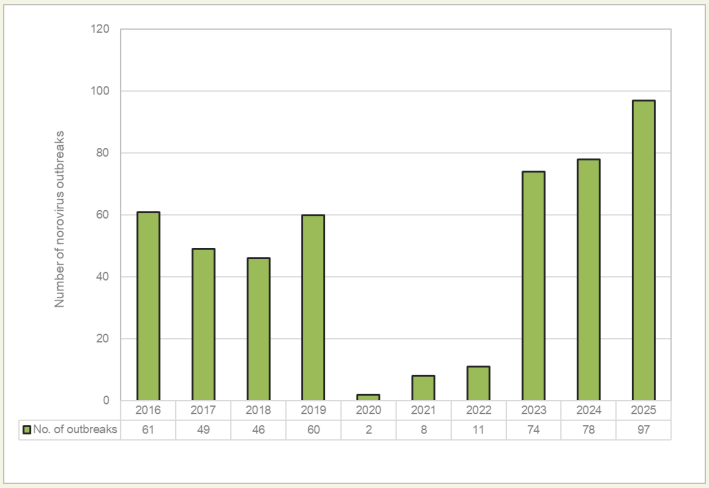

Figure 5 – Number of norovirus AGE outbreaks by year, 2016 to 2025.

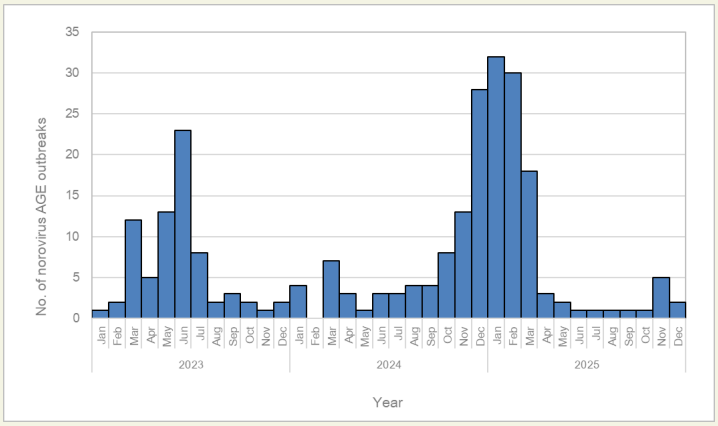

Figure 6 – Number of norovirus AGE outbreaks by month, 2023 to 2025.

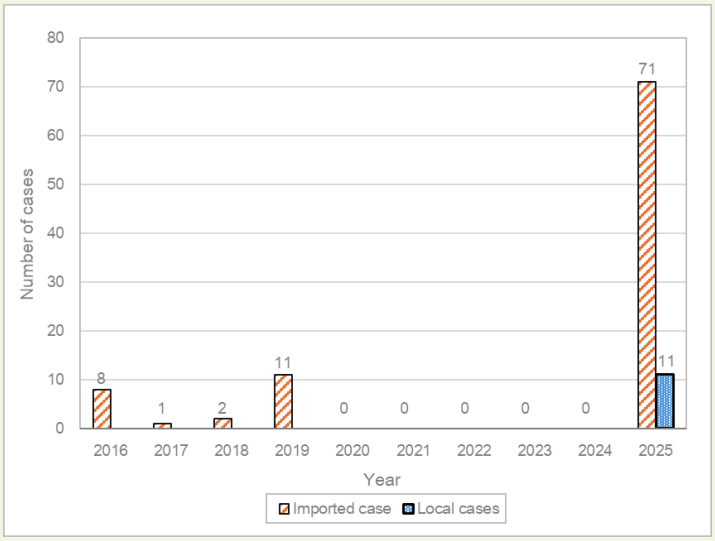

Figure 7 – Number of CF cases recorded in Hong Kong from 2016 to 2025.

upsurge and outbreaks in Guangdong Province of the Chinese Mainland during the second half of 2025, which led to small clusters of local cases stemming from imported infections.

The 82 cases involved 43 males and 39 females aged between one and 83 years (median: 54). Presenting symptoms included fever (77, 93.9%), arthralgia (77, 93.9%) and rash (53, 64.6%). Except for one fatal case involving a 77-year-old male with underlying illnesses, all other cases were mild infections.

Among the 71 imported cases, the majority (56, 78.9%) had travel history to the Guangdong Province (Table 2). The upsurge in imported cases from Guangdong Province correlated with the CF outbreaks that occurred in Guangdong from mid-July to November 2025.

Intensive inter-departmental mosquito control measures successfully limited local transmission from imported CF cases in 2025. A total of 11 local CF cases were recorded in 2025, including two epidemiologically linked clusters and three sporadic cases. The first cluster involved an 82-year-old female and a 55-year-old female, both residing in Wong Tai Sin. The second cluster involved six patients aged between 40 and 63 years, all had exposure or hiking history at Tsing Yi Nature Trails. In response, the trails have been closed temporarily between December 9, 2025 and Febaruay 23, 2026 to facilitate comprehensive mosquito control and prevention efforts by various government departments. No further local cases have been detected since the closure.

Table 2 – Places of infection of imported CF cases in Hong Kong in 2025.

Country/area of infection	Number of cases
Chinese Mainland	59
Guangdong Province	56
Guangxi Zhuang Autonomous Region	1
Yunnan Province	1
Multiple provinces	1
Bangladesh	5
India	2
Indonesia	2
Cuba	1
Sri Lanka	1
Multiple countries	1
Total	**71**

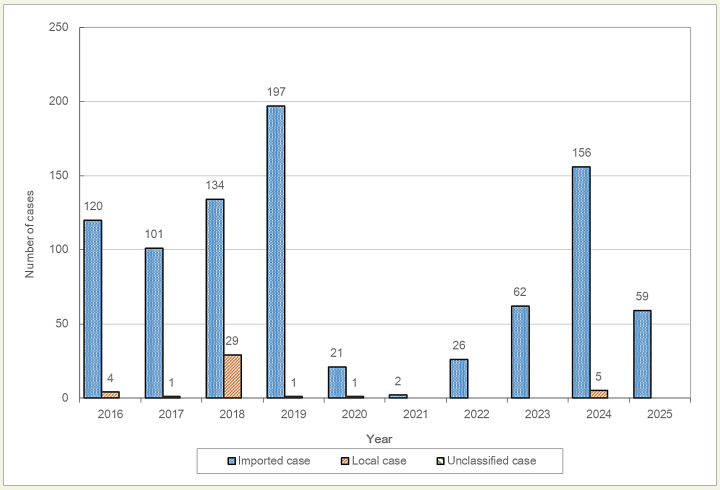

Figure 8 – Number of dengue fever cases recorded in Hong Kong from 2016 to 2025

Dengue fever

The CHP recorded 59 imported cases of dengue fever (DF) in 2025, a marked decrease from the 161 cases (156 imported and five local) in 2024 (Figure 8). No local DF cases were identified in Hong Kong during 2025. The 59 imported cases involved 31 males and 28 females aged between nine and 76 years (median: 40). Presenting symptoms included fever (59, 100%), myalgia (27, 45.8%), headache (25, 42.4%), rash (25, 42.4%), arthralgia (13, 22.0%) and eye pain (7, 11.9%). Among them, 56 patients (94.9%) required hospitalisation. No fatal case was recorded. About 20% of imported cases were from the Philippines (12 cases). Other common places of importation were Indonesia (11 cases), India (nine cases) and Thailand (nine cases) (Table 3).

Table 3 – Places of infection of imported dengue fever cases in Hong Kong in 2025.

Country or area of infection	Number of cases
Philippines	12
Indonesia	11
India	9
Thailand	9
Malaysia	5
Cambodia	4
Chinese Mainland	3
Fiji	2
Sri Lanka	2
Bangladesh	1
Singapore	1
Total	59

Melioidosis

In 2025, the CHP recorded 21 melioidosis cases in Hong Kong, similar to the 23 cases reported in 2024 and 17 cases in

2023, and substantially lower than the 46 cases recorded in 2022 (Figure 9). The number of reported cases has remained stable since the 2022 outbreak in Sham Shui Po. All 21 cases were locally acquired and predominantly affected males (19 males and two females). Their ages ranged from 36 to 92 years (median: 72 years), and 67% of the cases (n=14) affected elderly aged ≥65 years.

The most common presenting symptoms were fever (18, 86%) and cough (8, 38%). Majority of the cases (12, 57%) had diabetes mellitus, which is a recognised risk factor in developing melioidosis. Thirteen cases (62%) resided in Sham Shui Po, which is in accordance with the trend in the past years. The rest of the cases were distributed among six districts including two cases from Eastern and Islands; one case from Kowloon City, Kwai Tsing, Kwun Tong, and Yuen Long respectively.

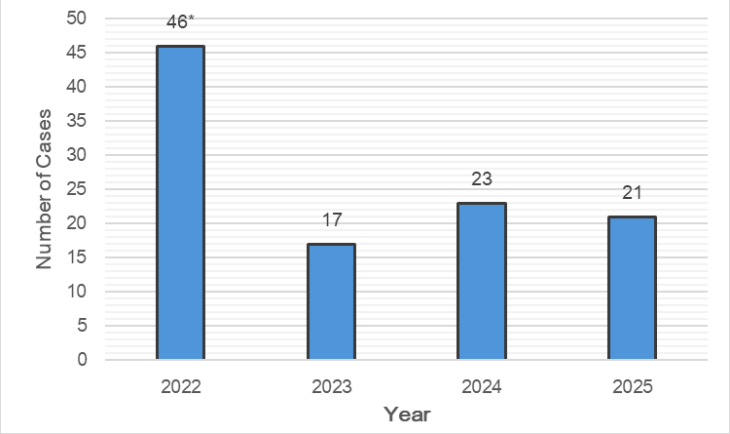

Figure 9 – Melioidosis case number for year 2022 to 2025.

**Melioidosis was listed as a notifiable infectious disease since November 11, 2022. The figures of Melioidosis from January 1 to November 10, 2022 were based on the notifications from Hospital Authority according to the month of laboratory confirmation.*

Invasive meningococcal infection

In 2025, Hong Kong recorded 11 local cases of invasive meningococcal infection (IMD), more than twice the five cases reported in 2024 (Figure 10). The 11 cases encompassed nine males and two females, with ages ranging from seven to 73 years. The majority of cases occurred in adults aged 19–64 years (six cases; 55%), followed by elderly individuals aged ≥65 years (three cases; 27%) and children aged under 18 years. Four cases were characterised by meningitis, three were characterised by septicemia, three were characterised by both meningitis and septicemia, and one case presented as septic arthritis. Serogroup B maintained as the most prevalent serogroup for IMD in Hong Kong in 2025 (Figure 11), confirmed in eight of the 11 cases (73%). Four cases (22%) warranted intensive care unit admission, and two deaths (18%) due to IMD were recorded in 2025.

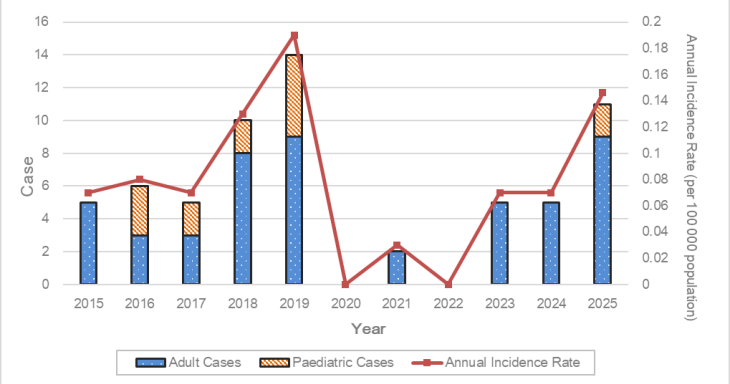

Figure 10 – Distribution of IMD cases in Hong Kong by age group and incidence, 2015 to 2025.

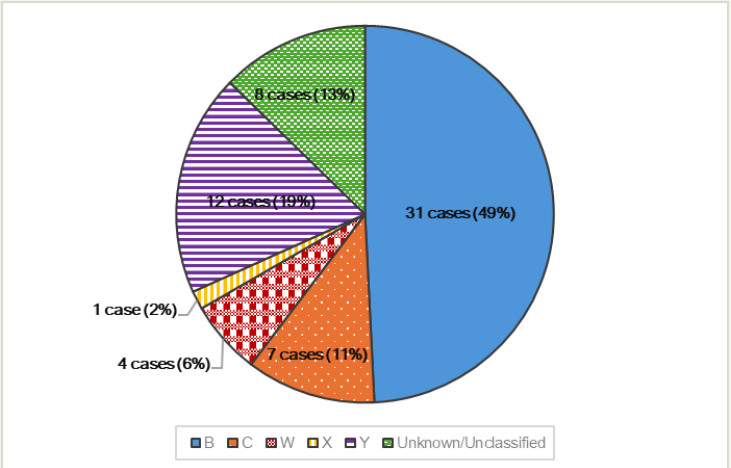

Figure 11 – Distribution of IMD cases in Hong Kong by serogroup, 2015 to 2025.

A cluster involving two adults was recorded at a construction site in a public hospital in April 2025. Following stringent control measures including contact tracing and chemoprophylaxis to close contacts of the two affected adults, no secondary cases were identified. Other than the two epidemiologically-linked cases, all nine remaining cases were sporadic cases.

Way forward

As Hong Kong enters 2026, the CHP will continue to sustain high vaccination coverage, robust surveillance, timely risk communication, stringent infection prevention and control in institutions, and close inter-departmental collaboration, and to ensure the community is well protected against both endemic threats and emerging importation risks in an increasingly interconnected world.

Feature in focus

Review of Global Situation of Nipah Virus Infection

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

- Nipah virus is a zoonotic disease carried by fruit bats, transmitted through animals, contaminated food, and human-to-human contact, with a fatality rate of 40–75% and no approved treatment or vaccine.
- Major outbreaks have occurred in Bangladesh, India, Malaysia, Singapore, and the Philippines, with seasonal cases in India and Bangladesh often linked to raw date palm sap consumption.
- In 2026, India reported two confirmed cases in West Bengal and Bangladesh reported one fatal case in Rajshahi Division.
- Prevention measures include avoiding contact with bats and sick animals, practicing good hygiene, washing and peeling fruits, and avoiding raw date palm sap or unpasteurised juices

Introduction

Nipah virus infection is an emerging zoonotic disease. It was first identified in 1998-99 during outbreaks among pig farmers and people with close contact with pigs in Malaysia and Singapore. It can infect a wide range of animals including pigs, horses, goats, sheep, cats and dogs, often causing severe or fatal diseases in these animals.

Fruit bats from the *Pteropodidae* family, especially of *Pteropus* genus are considered the natural host of Nipah virus and are present in different parts of Asia and Australia. Infection with Nipah virus does not appear to cause disease in fruit bats.

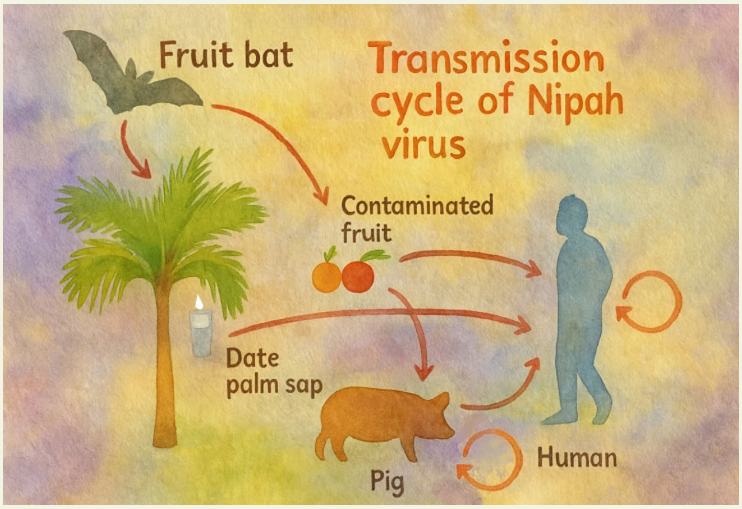

Figure 1 - Transmission cycle of Nipah Virus.

Zoonotic spillover to humans occurs mainly through direct contact with infected animals, such as fruit bats, via their contaminated respiratory droplets, nasal secretions and tissues. It can also be transmitted via consuming food contaminated with urine, droppings or saliva from infected bats, usually fruits or fruit products (particularly raw date palm sap) (Figure 1). Human-to-human transmission is also possible through close contact with contaminated secretions and excretions of infected persons. Transmissions have been reported in household and healthcare settings.

The incubation period ranges from around three to 14 days, but can be as long as 45 days. It was reported that up to 11% of patients could be asymptomatic[1]. Early clinical presentations include non-specific flu-like symptoms like fever, headache, vomiting, sore throat and muscle ache. Other symptoms include dizziness, drowsiness and decrease in consciousness. Severe cases may develop complications like pneumonia, seizure, encephalitis, coma and even death. The case fatality rate ranges from 40% to 75%. Among the patients who survive acute encephalitis, around 20% of them may have persistent nerve problems. There are currently no approved anti-viral drugs or vaccines for Nipah virus infection.

Global epidemiology

Emergence in Malaysia (1998-1999)

Nipah virus was first identified in late 1998 during an outbreak of encephalitis among pig farmers in Malaysia. By March 1999, scientists confirmed a novel virus as the causative pathogen and the virus was named by the village where it originated. Close contact with Nipah virus-infected pigs was recognised as the risk factor of the outbreak. Nipah virus had spread to Singapore in the same year, through importation of infected pigs from Malaysia, with 11 abattoir workers having contracted the disease. Immediate actions such as mass culling of pigs and banning importations from Malaysia contained the outbreak by May 1999. No new outbreaks have been reported from Malaysia or Singapore since then (Figure 2).

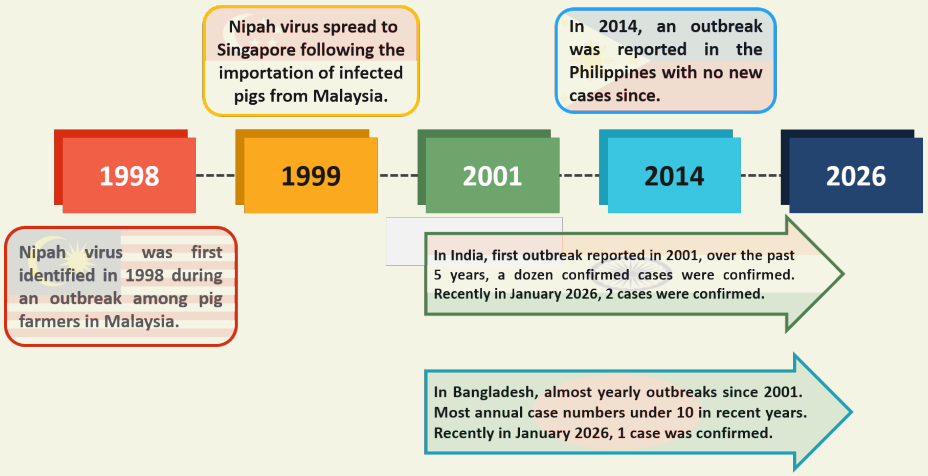

Figure 2 - Past and current outbreaks of Nipah Virus infections globally.

Isolated outbreak in the Philippines

In 2014, an outbreak was reported in the Philippines. Investigation identified 17 cases and epidemiologic data suggested that the most common route of virus transmission to humans was direct exposure to infected horses, contact with contaminated body fluids during slaughtering of sick horses, or consumption of undercooked meat from infected horses. Although the origin of the horse infections was unclear, the most likely source was fruit bats of the family *Pteropodidae*. They were reportedly found near one of the outbreak epicentre villages.

Outbreaks in India and Bangladesh

Over the past two decades, multiple outbreaks of human Nipah virus infection have been recorded in India and Bangladesh (Figure 2). In both countries, the disease exhibits seasonal outbreaks linked to bat activities and cultural practices, such as the consumption of raw date palm sap which might be contaminated with Nipah virus by fruits bats.

Outbreaks in India

In India, the first outbreak was reported between January and February 2001 in the district of Siliguri, a leading commercial city of West Bengal. The yearly number of Nipah virus infection cases reported in India has remained less than 10 cases except for 2001 and 2018, when 66 and 18 cases were reported respectively. Over the past five years, 12 confirmed cases were reported in India.

On January 26, 2026, India notified two laboratory-confirmed cases of Nipah virus infection in West Bengal State. The first case is a female nurse and the second case is a male nurse. Both cases were between 20 – 30 years old, from Barasat, West Bengal. Both cases developed symptoms typical of severe Nipah virus infection and were admitted to hospital in January 2026. Indian health authorities identified and tested over 190 contact persons, including health and care workers and community contacts. All samples from contact persons tested negative for Nipah virus. No further cases have been detected as of January 27.

Enhanced surveillance and infection prevention and control measures by the Government of India are in place while investigations into the source of exposure are ongoing. The World Health Organization (WHO) assessed the current risk posed by Nipah to be low at the national, the regional and global levels.

Outbreaks in Bangladesh

Nipah virus infection outbreaks were first detected in Bangladesh in 2001. Outbreaks have been reported almost every year since then. The disease is now endemic in Bangladesh, with outbreaks typically occurring between December and May, coinciding with the date palm sap harvesting season. As of latest data provided by the WHO, Bangladesh has documented 348 Nipah virus cases through its Nipah surveillance system, with a case fatality rate of 72%. Nearly half of these cases (n=162) were primary cases with a confirmed history of consuming raw date palm sap or tari (fermented date palm sap). The yearly number of cases reported in Bangladesh has remained under 10 since 2016, except for 2023, when 14 cases were reported.

On February 3, 2026, Bangladesh reported the first confirmed case of Nipah virus infection in 2026, which occurred in Rajshahi Division in Northwestern Bangladesh. The patient is a female between 40 – 50 years old with symptom onset on January 21, 2026. She developed fever, headache and muscle cramps, followed by hypersalivation, disorientation, and convulsion. Subsequently, the patient became unconscious and later died on January 28. Reportedly, she had repeated consumption of raw date palm sap before symptom onset. A total of 35 contact persons have been identified, all tested samples were found negative for Nipah virus. As of February 3, no additional cases have been identified.

The Ministry of Health and Family Welfare of Bangladesh initiated outbreak investigation using a coordinated One Health approach with multiple control measures implemented including active contact tracing, local advocacy meeting, community awareness programmes and health education campaigns. In response, the WHO assesses the overall risk at the regional, national

and global level to be low.

Local situation

To date, there has been no confirmed cases of Nipah virus infection in Hong Kong. Globally, the main source of foodborne transmission of Nipah virus is consumption of raw date palm juice contaminated by fruit bats. These unprocessed tree sap ferments quickly and therefore are usually consumed locally and not packed for export outside of India or Bangladesh.

The main natural reservoir, bats belonging to the *Pteropodidae* family and *Pteropus* species, are not found in Hong Kong. According to information from Agriculture, Fisheries and Conservation Department, one species of fruit bat, *Rousettus leschenaultii*, which has been shown to be able to carry Nipah virus, were found in Hong Kong. So far, no Nipah virus has been detected in the bats in Hong Kong.

In response to the latest Nipah virus infection outbreak in India, the Centre for Health Protection (CHP) of the Department of Health has stepped up efforts to strengthen community awareness through issuing press release and social media posts. Temperature screening and medical assessments for travellers arriving from relevant flights from India and Bangladesh have been implemented. If travellers show compatible symptoms and relevant exposure/ travel history, they will be referred to hospitals for further investigation. So far, no suspected cases have been identified. The CHP's current risk assessment indicates a low risk of importation of Nipah virus into Hong Kong. The CHP will continue to closely communicate with the WHO and relevant overseas health authorities to obtain the latest updated epidemiological information for risk assessment.

Prevention of Nipah Virus Infection

To minimise the risk of Nipah virus infection, members of the public are advised to take precautionary measures when travelling to affected regions such as India and Bangladesh.

- Avoid contact with wild animals or sick farm animals, particularly bats, pigs, horses, and domestic or feral cats.
- Stay away from places known to be bat roosting sites.
- Maintain good personal hygiene by washing hands frequently with liquid soap and water, especially after contact with animals or their droppings/secretions, or after caring for or visiting sick people.
- Practise good food hygiene: thoroughly wash and peel fruits before eating; do not consume fruits that show signs of bat bites or have been found on the ground; and avoid drinking raw date palm sap, toddy, or similar unpasteurised juice.

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Universal decolonization for methicillin-resistant Staphylococcus aureus and carbapenem-resistant Acinetobacter in elderly homes: A large cohort of over 16 000 residents in Hong Kong[1]

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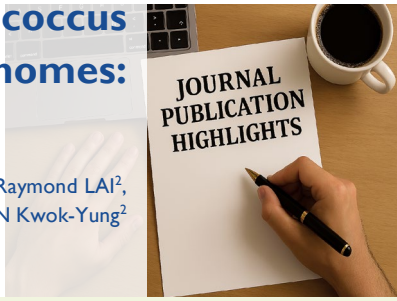

The Centre for Health Protection (CHP) of the Department of Health (DH), in collaboration with the Hospital Authority (HA), conducted a study to investigate the effectiveness of decolonization therapy for methicillin-resistant *Staphylococcus aureus* (MRSA) and carbapenem-resistant *Acinetobacter* (CRA) in residential care homes for the elderly (RCHEs). A universal decolonization programme was implemented in RCHEs in Hong Kong in 2023. RCHE residents applied 10% povidone-iodine nasal ointment once daily, Monday to Friday, every alternate week, and used 2% chlorhexidine gluconate solution for bathing on alternate days. Group 1 residents received decolonization at both RCHEs and hospitals, while Group 2 underwent decolonization only at the RCHEs. The residents who stayed in the RCHEs other than the participating RCHEs served as the control group when they admitted to the network hospitals.

A total of 257 RCHEs with 16 190 residents participated in this study. For MRSA, Group 1 showed a significant reduction in infections by 12.2% (p=0.035) compared with the baseline. Reductions in MRSA bacteremia and mortality were also detected but were not statistically significant. CRA showed no significant reduction across all outcomes.

The decolonization approach effectively reduced MRSA hospitalization, demonstrating potential for tackling antimicrobial resistance. The lack of CRA effectiveness might be attributed to environmental contamination being more significant for *Acinetobacter* transmission. The findings suggest that regional decolonization strategies could alleviate hospital burden, though feasibility, compliance, and resource implications require further consideration before wider implementation.

Reference

1 Ma ES, Wong SC, Cheng VC, Lung DC, Lee SY, Luk K, Lai RW, Chuang VW, Hsu E, Chow V, Liu A, Chen H, Tsui EL, Yuen KY. Universal decolonization for methicillin-resistant Staphylococcus aureus and carbapenem-resistant Acinetobacter in elderly homes: A large cohort of over 16 000 residents in Hong Kong. Public Health Pract (Oxf). 2025 Dec 12;11:100706. doi: 10.1016/j.puhip.2025.100706.

Natural clearance of colonization with vancomycin-resistant Enterococcus and carbapenemase-producing Enterobacterales: a 13-year study among territory-wide residents of residential care home for the elderly in Hong Kong[1]

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The CHP, in collaboration with HA, conducted a 13-year (2012-2024) retrospective study that tracked 3 626 Vancomycin-resistant Enterococcus (VRE) and 4 434 carbapenemase-producing Enterobacterales (CPE) colonized residents in RCHEs. Monthly stool specimens or rectal swabs were collected after discharge from hospitals and cultured using selective media. Clearance of VRE and CPE was defined as negative results for at least two and three consecutive specimens collected at RCHEs at least 48 hours apart respectively.

CPE cases consisted of older residents with a higher female proportion compared to the VRE cases, but mortality rates were similar for both groups (around 25%). CPE carriage duration significantly exceeded VRE (p<0.01), with 50% clearance achieved by 85 days (VRE) and 131 days (CPE). For 90% of cases, clearance took 400 days (VRE) and 818 days (CPE). Longer hospital readmission stays and lower RCHE occupancy were significantly associated with prolonged carriage.

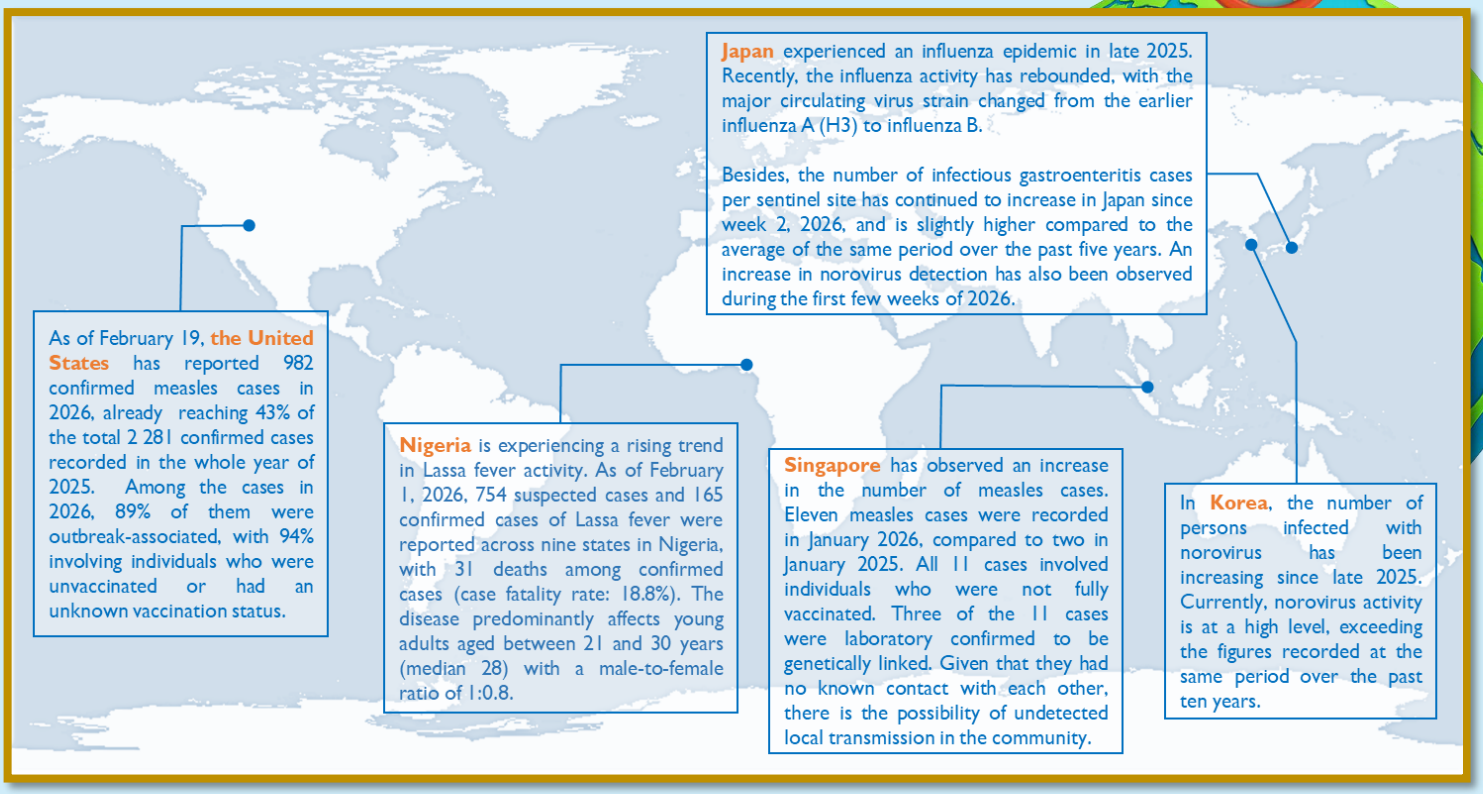
This large study of natural clearance duration among RCHE residents within long-term care setting provides insight into improving guidelines of screening of previously colonized patients and implications for contact precautions to prevent transmission among the vulnerable populations.

Reference

[1] Ma ES, Lai RW, Chuang VW, Shing BS, Lui L, Hsu E, Kiu E, Chen H, Tsui EL. Natural clearance of colonization with vancomycin-resistant Enterococcus and carbapenemase-producing Enterobacterales: a 13-year study among territory-wide residents of residential care home for the elderly in Hong Kong. Antimicrob Resist Infect Control. 2026 Jan 30. doi: 10.1186/s13756-026-01702-1. Epub ahead of print.

Global Disease Snapshot

Major Outbreaks and Emerging Infections



Sources of information

Ministry of Health, Labour and Welfare: https://www.mhlw.go.jp/content/001659148.pdf; https://kansen-levelmap.mhlw.go.jp/Byogentai/Pdf/data2j.pdf; https://id-info.jihs.go.jp/surveillance/idwr/idwr/2026/idwr2026-06.pdf; https://kansen-levelmap.mhlw.go.jp/Byogentai/Pdf/data11e.pdf

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News in Brief

Two local cases of psittacosis

The Centre for Health Protection (CHP) of the Department of Health (DH) recorded two local sporadic cases of psittacosis on February 3 and 16, 2026 respectively.

The first case involved a 76-year-old man with underlying illnesses residing in Shatin. He developed cough and myalgia since January 16. He was noted to have fever upon admission to a public hospital on January 26 due to fall. Chest X-ray showed right upper zone opacity. His sputum collected on January 29 was tested positive for *Chlamydia psittaci* DNA. He was treated with antibiotics and his condition remained stable. He did not keep any birds at home. He spotted pigeons at a park he visited but he did not have direct contact with any birds, bird droppings or carcasses. He had no recent travel and he lived with his wife who remained asymptomatic.

The second case involved a 74-year-old woman with underlying illnesses residing in Kwun Tong. She presented with fever, headache, myalgia, cough and shortness of breath since February 7. She consulted a general practitioner on February 11 and was referred to a public hospital. Her clinical diagnosis was pneumonia. Her sputum collected on February 12 tested positive for *Chlamydia psittaci* DNA. She was treated with antibiotics and her condition remained stable. She did not keep any birds at home. She did not have direct contact with any birds, bird droppings or carcasses. She had no recent travel and she lived alone.

Case details were referred to Agriculture, Fisheries and Conservation Department and Food and Environmental Hygiene Department for follow-up as appropriate.

A local case of *Streptococcus suis* infection

On February 7, 2026, the CHP recorded a sporadic case of *Streptococcus suis (S. suis)* infection involving a 67-year-old woman with underlying illness who resides in Wan Chai. She experienced low back pain radiating to her left lower leg since February 2 and fever since February 3, and she was admitted to a public hospital on February 5. Blood culture grew *S. suis*. She was treated with antibiotics and her condition remained stable.

During the incubation period, she purchased raw pork from multiple meat stalls in various wet markets in Wan Chai and North Point, and handled raw pork without wearing gloves during food preparation. She recalled sustaining a minor cut injury on the middle finger of her left hand during food preparation in late January, but she neither sought medical attention nor applied any wound care. The wound subsequently developed redness and swelling. Her household contact remained asymptomatic.

A local confirmed case of severe Community-associated Methicillin-resistant *Staphylococcus aureus* (CA-MRSA) infection

The CHP recorded a local case of severe CA-MRSA on February 16, involving a 55-year-old man residing in Mongkok with underlying diseases. He developed fever, cough and sputum on January 30. He was admitted to a public hospital on the same day for management. The clinical diagnosis was pneumonia. His sputum specimen collected on February 2 tested positive for CA-MRSA. His condition stabilised following antibiotic treatment. His household contacts remained asymptomatic.

A sporadic case of necrotising fasciitis due to *Vibrio vulnificus* infection

The CHP recorded a sporadic case of necrotizing fasciitis caused by *Vibrio vulnificus* infection in Southern district on February 15, 2026. The patient was a 73-year-old retired man with underlying medical condition.

He developed abdominal pain, diarrhea, chills and rigors on February 10, and painful swelling and redness over his right hand and forearm on February 12. He was admitted to a public hospital on February 13. The clinical diagnosis was necrotising fasciitis of the right upper limb complicated by septic shock. Emergency surgical debridement was performed, followed by antibiotic therapy and intensive care support.

Cultures from wound swab, soft tissue and blood samples all yielded *vibrio vulnificus*. There was no recent travel history. According to his family, the patient had gone fishing with friends in a dinghy during the incubation period. His home contacts remained asymptomatic.

A local case of listeriosis

The CHP recorded a local case of listeriosis on February 2, involving a 78-year-old female with underlying illnesses residing in Sham Shui Po. She was admitted to a public hospital on February 11 for loss of appetite and decreased general condition. Her blood specimen collected on February 15 grew *Listeria monocytogenes*. She was treated with antibiotics and her condition

remained stable. According to her household contact, she did not have any travel history or consume any high-risk food during the incubation period. Her household contact remained asymptomatic.

A sporadic case of brucellosis

On February 23, 2026, CHP recorded a sporadic case of brucellosis affecting a 11-year-old boy with good past health. He presented with fever, cough with sputum and abdominal pain since February 4 and was admitted to a private hospital on February 11. His blood specimen collected on February 12 was cultured positive for *Brucella melitensis*. The clinical diagnosis was brucellosis and he was treated with antibiotics. He recovered and was discharged on February 18.

During the incubation period, he visited several zoos in Thailand and Shenzhen with his family, where he interacted with the animals. He also consumed beef and lamb hot pot in Hong Kong and overseas during the incubation period. The source of infection is still under investigation. His home contacts remained asymptomatic.

Updated Antibiotic Guidance Notes to Combat Antimicrobial Resistance

On January 29, the CHP released the updated "Antibiotic Guidance Notes in Community Setting" (Guidance Notes). This initiative aims to assist doctors in community setting on appropriate prescription of antibiotics, addressing the problem of antimicrobial resistance (AMR).

The updated Guidance Notes, based on the latest local disease epidemiology, AMR surveillance data, and overseas clinical guidelines, focus on seven common community infections. They serve as a crucial resource for doctors to avoid prescribing unnecessary antibiotics when managing these common infections, thereby reducing the risk of resistance.

Private doctors are key players in combating AMR, accounting for approximately half of antimicrobial usage in each year over the past decade. Recent data shows that while private doctors and hospitals have utilised a significant proportion of "Access" category antimicrobials, which the World Health Organization considers to be at lower risk of developing drug resistance, their usage remain below the 70% target set by the 2024 United Nations General Assembly High-level Meeting on AMR.

The CHP, in collaboration with the Hong Kong Medical Association, hosted two online seminars and issued a Letter-to-Doctors encouraging adherence to the updated Guidance Notes. Additionally, new health educational posters and pamphlets have been developed to inform patients about the safe use of antibiotics (Figure 1). Public cooperation is essential in this endeavor. The CHP urges individuals to consult doctors for having a cold or flu-like symptoms, avoid demanding antibiotics, and practice good hygiene to minimize the risk of drug-resistant infections. The updated Antibiotic Guidance Notes and health education materials can be found at CHP website: https://www.chp.gov.hk/en/features/49811.html.

Figure 1 - New poster for public education on proper use of antibiotics.

Seminar on Management of Infectious Diseases in Immunocompromised Hosts

Infectious diseases in immunocompromised hosts pose significant clinical and public health challenges, given their atypical presentations, increased severity, and the need for tailored diagnostic and therapeutic approaches. To provide an update on these areas, the Infection Control Branch (ICB) of the CHP and the Infectious Disease Control Training Centre (IDCTC) of the Hospital Authority jointly organised a seminar on "Management of Infectious Diseases in Immunocompromised Hosts" on February 5 to 6, 2026 (Photo 1).

Photo 1 - Speakers, organising committee, and participants of the Seminar on Management of Infectious Diseases in Immunocompromised Hosts

The first day of the seminar covered a wide range of topics related to infections in patients with human immunodeficiency virus (HIV) infection. The programme included sessions on national and overseas HIV epidemiology and control strategies, outcomes and challenges of free antiretroviral therapy programmes, opportunistic infections in advanced HIV, and the prevention of mother-to-child transmission, as well as paediatric HIV treatment and long-term care. Local perspectives on HIV epidemiology, testing, and management challenges were presented alongside updates on tuberculosis–HIV co-infection.

The second day of the seminar focused on primary immunodeficiency, addressing the approach to adults with recurrent infections, recognition and management of inborn errors of immunity, emerging therapies in primary immunodeficiency, and long-term outcomes in affected patients (Photo 2). The seminar also covered antimicrobial resistance in immunocompromised hosts and advances in diagnostic technologies.

Distinguished speakers from Hong Kong, the Chinese Mainland, the United Kingdom, the United States, Australia, Singapore, and Thailand shared their expertise and experiences. The seminar was well received, bringing together over 400 healthcare professionals from both public and private sectors, and provided a valuable platform for knowledge exchange and strengthening collaboration in the prevention and management of infectious diseases in immunocompromised hosts.

Details of the seminar and training materials are available on the IDCTC training portal at https://icidportal.ha.org.hk/Trainings/View/1196.

Photo 2 - Speakers and moderators of day 2 programme focusing on inborn errors of immunity.