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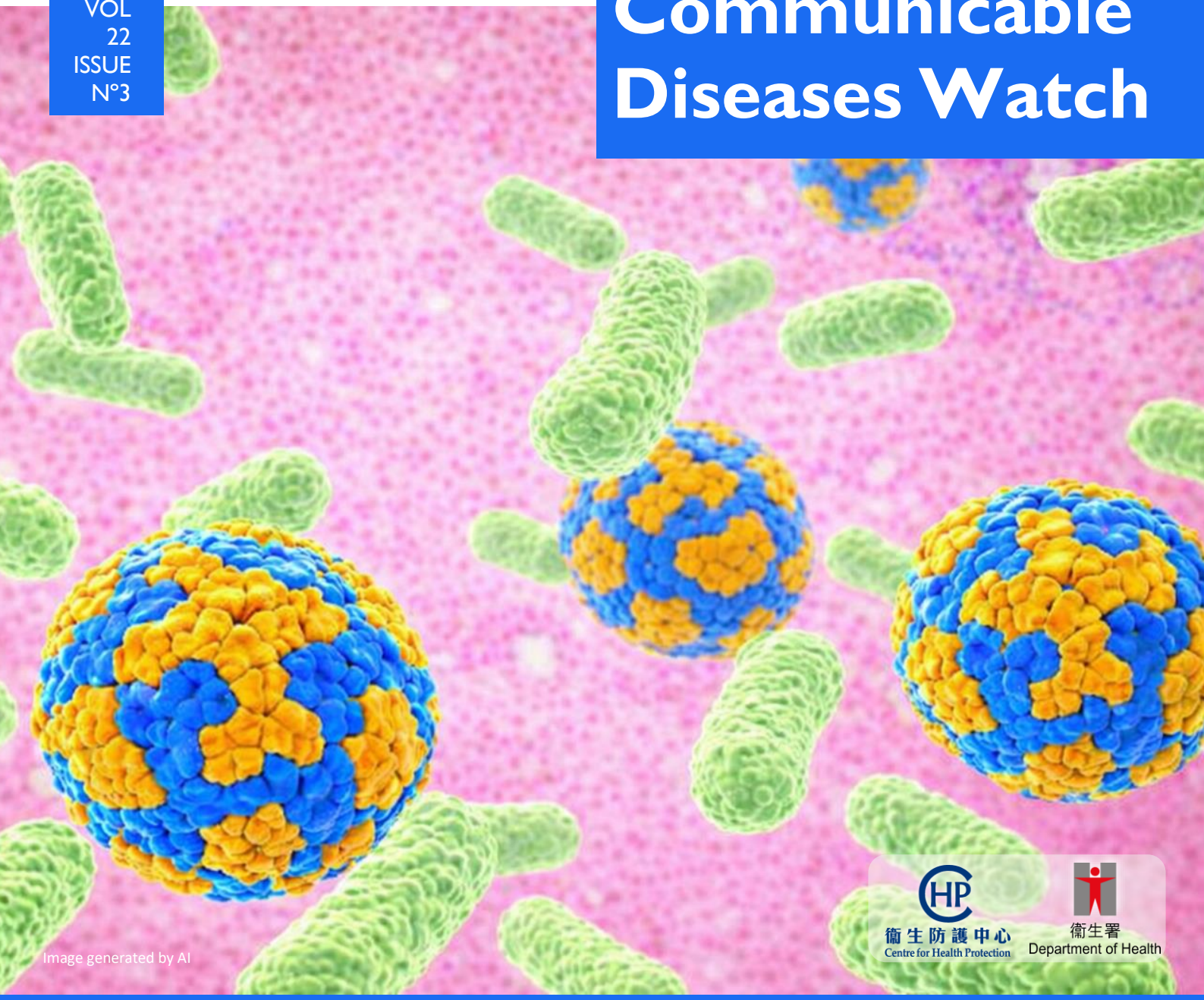
Communicable Diseases Watch



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Updated Situation of Hepatitis A Infection in Hong Kong

Updates to "Recommendations on Prevention of Surgical Site Infection" (3rd Edition)

Global Disease Snapshot

Highlights on infectious diseases and events, week 9 - 12:

- Two local sporadic cases of listeriosis
- A local case of psittacosis
- A local case of severe community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA) infection

 This monthly publication is produced by the Centre for Health Protection (CHP) of the Department of Health, 147C, Argyle Street, Kowloon, Hong Kong ***ISSN*** *1818-4111*

Feature in focus

Updated Situation of Hepatitis A Infection in Hong Kong

Reported by Dr KWOK Yan-tung, Terri, Senior Medical and Health Officer, Epidemiology Division, and Dr HO Mei-lin, Senior Medical and Health Officer, Enteric and Vector-borne Disease Section, Surveillance Division, Communicable Disease Branch, CHP

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Key Points

- Hepatitis A is an inflammation of the liver caused by the hepatitis A virus (HAV).
- The disease is common in areas with poor sanitation and limited access to clean water, but outbreaks among people in high-risk groups such as men who have sex with men (MSM), drug users and people travelling to areas of high endemicity have been reported in many developed countries and areas.
- Since late 2025, the Centre for Health Protection (CHP) has recorded an increase in hepatitis A infections involving MSM in Hong Kong.
- The CHP has been offering free hepatitis A vaccination to MSM at designated clinics since March 12, 2026, with an aim to control the transmission chain.
- The public should maintain good personal, environmental and food hygiene to prevent HAV infection. Persons who are at increased risk for acquiring hepatitis A or with increased risk for severe adverse consequences should consider getting hepatitis A vaccination for personal protection.

Introduction

Hepatitis A is an inflammation of the liver caused by the hepatitis A virus (HAV). It is primarily transmitted through the ingestion of food or water contaminated with HAV, or through contact with contaminated hands before eating. The virus can also be transmitted through high-risk sexual contacts. The incubation period of hepatitis A is usually 14 to 28 days but can be up to 50 days. Common symptoms include fever, malaise, abdominal discomfort, loss of appetite, nausea, diarrhoea and jaundice. There is no specific treatment for hepatitis A. It is important to avoid unnecessary medications that can adversely affect the liver (e.g., paracetamol). Unlike hepatitis B and C, HAV infection does not cause chronic liver disease, but it can cause debilitating symptoms and rarely fulminant hepatitis (acute liver failure), which is often fatal.

Global situation

The number of global HAV infections was estimated at 158.94 million in 2019[1]. The disease is common in areas with poor sanitation and limited access to clean water. According to the World Health Organization (WHO), the South-East Asia Region had the greatest number of hepatitis A cases, while the African Region had the highest disease incidence[1]. The global number of HAV cases increased by about 4% between 2010 and 2019.

In areas with low endemicity, including western Europe and North America, outbreaks among people in high-risk groups are more likely, such as men who have sex with men (MSM), drug users and people travelling to areas of high endemicity. Scientific literatures indicate that, apart from foodborne transmission, hepatitis A outbreaks have occurred among MSM populations in many regions worldwide in the past. Between 2016 and 2017, hepatitis A outbreaks involving mostly MSM were reported in the European Regions (15 countries including France, Germany, Italy, Spain and the United Kingdom) and the Americas (Chile and the United States)[2]. Japan also reported an outbreak among MSM in Shinjuku, Tokyo, in 2018[3]. Due to the long incubation period, outbreaks transmitted through person-to-person contact tend to persist longer.

Local situation

Viral hepatitis, including hepatitis A, is a statutory notifiable disease in Hong Kong. In the past 10 years (2016 – 2025), the Centre for Health Protection (CHP) of the Department of Health recorded a total of 564 HAV infections, with the annual number of cases ranging from 15 to 117 (median = 51) (Figure 1). The cases involved 358 males and 206 females, with ages ranging from three to 95 years (median = 37 years). Eighty-three cases (15%) were classified as imported cases. There is no seasonal pattern observed.

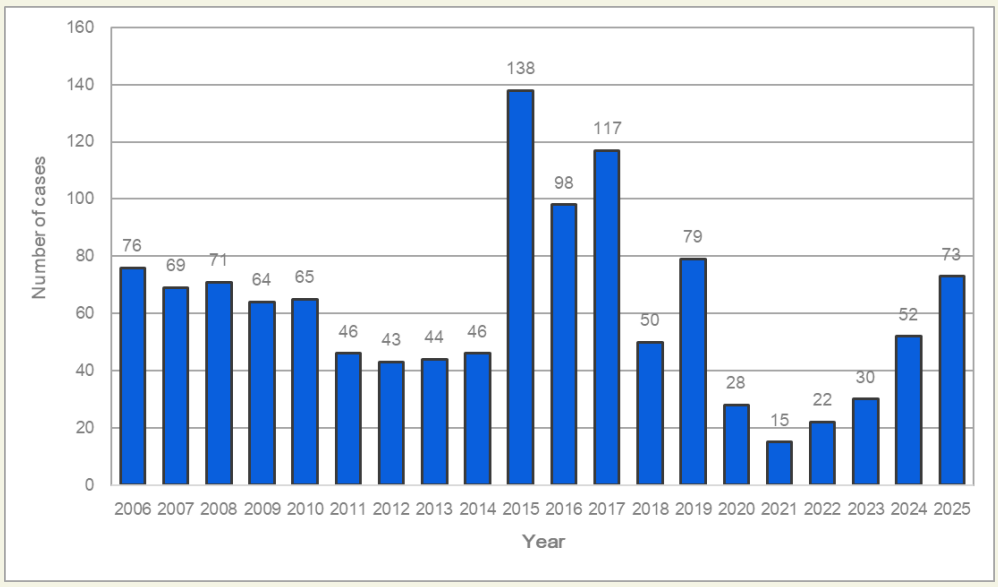


Figure 1 – Annual number of hepatitis A cases recorded by CHP, 2006 to 2025.

Of note, there was an outbreak of hepatitis A among MSM in Hong Kong between 2015 and 2017. A total of 54 hepatitis A cases affecting MSM were recorded from September 2015 to December 2017, with at least 37 (69%) known to have HIV infection. To control the outbreak, hepatitis A vaccination was offered to MSM at designated clinics in early 2017, which led to a marked decrease in cases among MSM.

Increase in hepatitis A infections among MSM since late 2025

Since September 2025, there was an upsurge in acute HAV infections, with 11 cases reported in that month, compared to an average of 3.75 cases reported per month during the first eight months of 2025. This increase has persisted, with a total of 70 cases recorded from September 2025 to mid-March 2026, including 54 males and 16 females (Figure 2).

The number of female cases remained at a stable level. A significant shift in the male-to-female ratio was noted, increasing from 1.0–1.5:1 during 2018 to August 2025, to 3.4:1 from September 2025 to mid-March 2026 (Figure 3).

Ongoing genetic analysis by the CHP's Public Health Laboratory Services Branch found that 26 out the 50 cases with available viral samples harboured an identical genetic sequence sequences within the genotyping window, while the remaining cases exhibited 19 different types of sequences. Among these 26 cases with identical genetic sequence, 24 were males, and 15 of them were identified as MSM, aged between 20 and 55 years (median: 34 years).

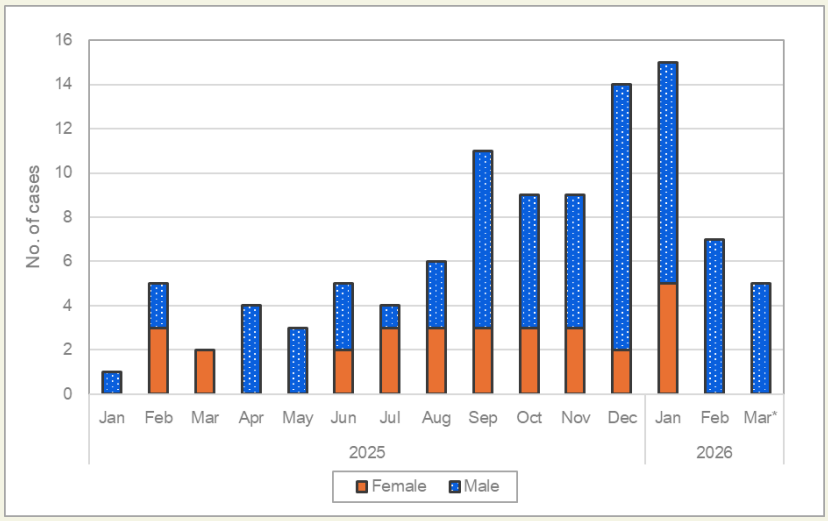


*Figure 2 – Number of hepatitis A cases recorded by month and gender, January 2025 to March 2026. (*as of March 14, 2026).*

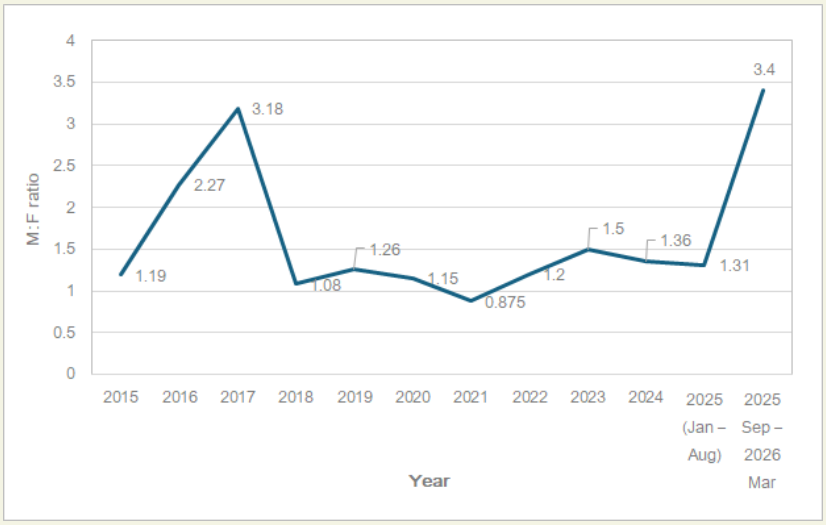


Figure 3 – Male-to-female ratio of hepatitis A cases from 2015 to 2026. (as of March 14, 2026).

Epidemiological findings

Epidemiological investigations conducted thus far have not identified any common food or water sources among the cases. There was also no other cases among their household contacts. Epidemiological and laboratory investigations suggest that person-to-person sexual transmission among males is a key driver of the current surge in hepatitis A cases, as evidenced by the marked increase in the proportion of MSM among cases since September 2025 and the clustering of infections with identical genetic sequences in this group.

Vaccination for MSM to control the hepatitis A outbreak

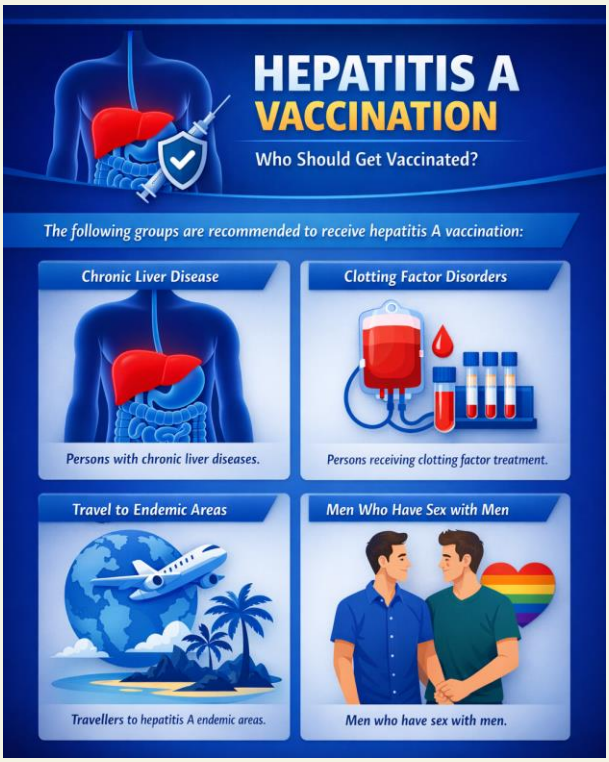
According to the Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the CHP, individuals in high-risk groups, including MSM, are recommended to receive hepatitis A vaccine to protect their personal health. In light of the current situation, the CHP launched a hotline (2125 2683) for MSM starting from March 11, 2026 to provide MSM with health advice and assessment. To control the transmission chain, MSM with Hong Kong resident status who did not have past history of hepatitis A infection or unvaccinated will be offered two doses of hepatitis A vaccine free of charge at CHP's designated clinics (Wan Chai Male Social Hygiene Clinic, Yau Ma Tei Male Social Hygiene Clinic, Fanling Social Hygiene Clinic, or Yau Ma Tei Integrated Treatment Centre). Bookings can be arranged via the above hotline.

In addition, health messages on hepatitis A have been disseminated to the target group through the Special Preventive Programme of the CHP, relevant non-governmental organisations, community partners, and social media channels.

Prevention of Hepatitis A

The public should maintain good personal, environmental and food hygiene to prevent HAV infection.

- Maintain good personal hygiene
  - Wash hands with liquid soap and water for at least 20 seconds before eating/handling food and after toilet use or handling vomitus/faeces. Alcohol-based handrub does not kill hepatits A virus.
  - Wear gloves and a mask when handling vomitus or faeces, then wash hands thoroughly.
  - Use serving chopsticks and spoons; avoid sharing food and drinks.
  - Stay home and seek medical advice if vomiting or diarrhoea develops.
  - Exclude infected persons from food handling and caring for children, the elderly or immunocompromised people.
- Maintain good environmental hygiene
  - Keep premises and kitchen utensils clean.
  - Disinfect frequently touched surfaces with 1:99 diluted household bleach (15 – 30 minutes contact time), then rinse and dry. Use 70% alcohol on metal surfaces.
  - For visible contamination, wipe with disposable towels first, then disinfect with 1:49 diluted bleach.
- Maintain good food hygiene
  - Follow the 5 Keys to Food Safety. Drink only boiled or bottled water from reliable sources. Avoid ice of unknown origin.
  - Purchase food from hygienic and reliable sources and eat only thoroughly cooked food.
  - Wash shellfish thoroughly and cook to an internal temperature of 90°C for 90 seconds, or boil at 100°C until shells open then for an additional three to five minutes. Discard any that do not open.
  - Use separate utensils for raw and cooked food during hotpot.



Hepatitis A vaccination is a safe and effective means to prevent the infection. Persons who are at increased risk for acquiring hepatitis A or with increased risk for severe adverse consequences should discuss with their doctors about hepatitis A vaccination for personal protection. The following groups are recommended to receive hepatitis A vaccination:

- Persons with chronic liver diseases;
- Persons with clotting factor disorders receiving plasma-derived replacement clotting factors;
- Travellers to endemic areas of hepatitis A; and
- Men who have sex with men.

References

[1] World Health Organization, "WHO Position Paper on Hepatitis A Vaccines," Weekly Epidemiological Record 97 (2022): 493–512. Available at: https://iris.who.int/server/api/core/bitstreams/61dbf312-2a7c-41d5-a2d2-782ec11cb711/content

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Feature in focus

Updates to "Recommendations on Prevention of Surgical Site Infection" (3rd Edition)

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

Key Points

- SSI remains a significant cause of healthcare-associated infection and can lead to complications, prolonged hospitalisation and increased healthcare burden.
- The third edition of the "Recommendations on Prevention of Surgical Site Infection" is a guideline that incorporates major updates from major international authorities while adapting them to the local healthcare settings, to support healthcare workers in adopting best practices to prevet SSI.
- The guideline includes eight aspects, which covers the preoperative phase, intraoperative phase and post-operative phase.
- Effective SSI prevention requires coordinated effort from surgeons, anesthesiologists, nurses, pharmacists, infection control professionals, and other supporting staff throughout the surgical pathway.

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Surgical site infection (SSI) remains one of the most common healthcare-associated infections internationally and in Hong Kong. SSIs can lead to prolonged hospital stays, additional medical costs and significant complications, making prevention an important priority for all surgical teams. Effective SSI prevention requires coordinated effort from surgeons, anesthesiologists, nurses, pharmacists, infection control professionals, and other supporting staff throughout the surgical pathway (Figure 1).

Figure 1 – An operating theatre with a multidisciplinary team at work, highlighting the importance of coordinated effort in reducing the risk of surgical site infection. Source: Hospital Authority.

The Infection Control Branch (ICB) of the Centre for Health Protection (CHP), in collaboration with the Scientific Committee on Infection Control (SCIC), published the local guidelines "Recommendations on Prevention of Surgical Site Infection" in December 2025 to support healthcare workers in adopting best practices (Figure 2). In recent years, major international authorities, including the Society for Healthcare Epidemiology of America (SHEA), the National Institute for Health and Care Excellence (NICE), the Asia Pacific Society of Infection Control (APSIC) and the World Health Organization (WHO), have updated their SSI prevention guidelines. Locally, antimicrobial stewardship principles under the Interhospital Multi-disciplinary Programme on Antimicrobial ChemoTherapy (IMPACT) framework have evolved as well. After a comprehensive review of existing evidence, international standards and local experience, the ICB and the SCIC released the Third Edition of "Recommendations on Prevention of Surgical Site Infection" with a reorganisation of the content along the patient's surgical journey. By considering recommendations from global authorities and adapting them to local healthcare settings, the updated edition aims to support healthcare workers across Hong Kong in delivering safer surgical care and reducing complications. Selected aspects of the recommendations are highlighted below.

Figure 2 – Cover of the Third Edition of "Recommendations on Prevention of Surgical Site Infection".

Preoperative phase

- Maintaining good blood glucose control for diabetic patients and encouraging patients to stop smoking well before elective operations are emphasised. Both risk factors are known to be associated with increased risk of SSI.
- For elective colorectal surgeries, combined use of oral antibiotics and mechanical bowel preparation when appropriate is recommended to reduce SSI risk.
- This edition is cross-referenced with another publication "Recommendations on Disinfection and Sterilisation of Surgical Instruments for Hospital Setting", which provides detailed requirements for proper reprocessing of reusable surgical instruments in hospitals.
- To ensure more consistent and evidence-based prescribing practices on antimicrobial prophylaxis across surgical services, clearer guidance on the timing, drug selection and recommended duration of prophylaxis for relevant procedures are provided, together with refined advice on re-dosing during operations of extended duration.

Intraoperative phase

- For operating theatre ventilation requirements, the minimum filtration standards for all incoming air are updated to align with current standards from the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE). Guidance on appropriate mask, head covering, and glove use throughout the procedure has also been clarified.
- Double gloving is now positioned as a consideration when glove perforation risk is high and contamination consequences are serious, as existing evidence supports its protective value for staff.
- The recommendation on surgical skin preparation has been enriched with more detailed instructions on antiseptic agent selection, based on WHO and NICE guidelines. These agents are advised to be applied in the operating theatre prior to incision and allowed to dry completely before draping.
  - The use of alcohol-based chlorhexidine for preoperative skin antisepsis is preferred.
  - If chlorhexidine cannot be used due to allergy or sensitivity, an alcohol-based povidone-iodine solution is recommended instead.
  - Where alcohol is contraindicated, such as in specific vulnerable surgical sites, an aqueous chlorhexidine solution may be used.
  - If both alcohol and chlorhexidine are unsuitable, an aqueous povidone-iodine preparation is suggested.
- Sterile items should be assembled as close as possible to the time of use, acknowledging the practical realities of theatre workflow while maintaining good aseptic practice consistent with international recommendations (Figure 3).
- For perioperative measures related to maintaining key physiological conditions that support safe surgery and wound healing, the recommendation on maintaining a normal body temperature has been refined to distinguish between active warming methods, such as forced-air warming systems or warmed intravenous fluids, and passive measures, including pre-warmed blankets or a slightly warmer operating theatre environment. These measures help prevent drops in body temperature during surgery, which can slow immune response, reduce oxygen delivery to tissues and increase the risk of infection. Furthermore, ongoing core temperature monitoring is important, because even small reductions in temperature during surgery may significantly increase SSI risk.
- Other recommendations include maintaining adequate tissue perfusion, ensuring good blood flow and oxygen delivery to the surgical site through appropriate hydration and avoidance of unnecessary physiological stress (Figure 4). Good perfusion supports the immune system and allows the body to heal more effectively, reducing the likelihood of infection.
- Wound irrigation using aqueous iodophor prior to closure may be considered in selected procedures, based on a review of local practice patterns and emerging evidence suggesting that, in certain cases, such irrigation may help reduce bacterial contamination before the wound is closed.

Figure 3 – Sterile instruments and medications, which should be assembled as close as possible to the time of use to reduce the risk of contamination. Source: Dr J. WONG.

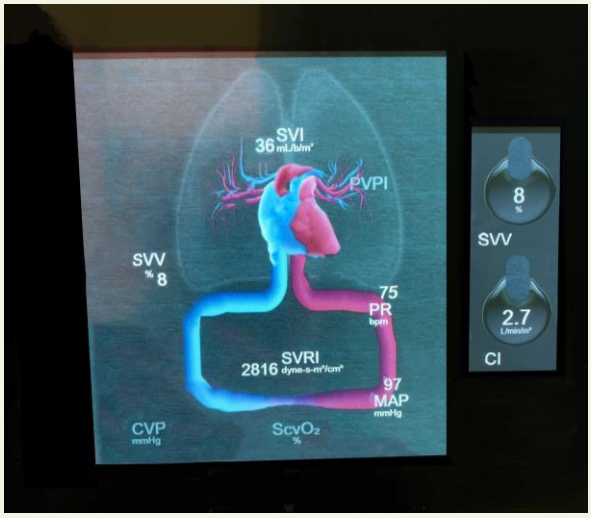


Figure 4 – A haemodynamic monitoring system, which guides intraoperative management to ensure adequate tissue perfusion, an important factor in reducing the risk of surgical site infection. Source: Dr J. WONG.

Post-operative phase

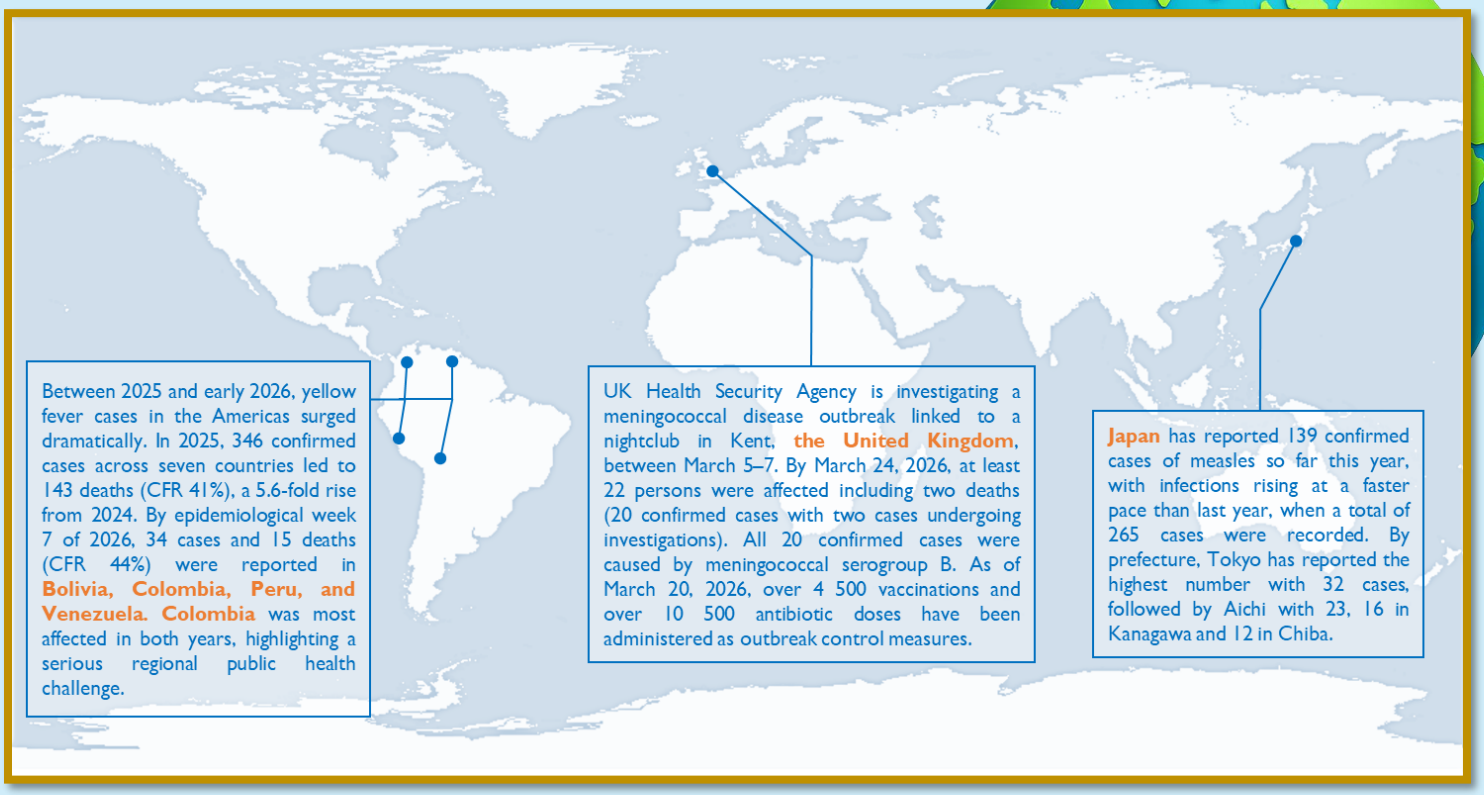
- Recommendations on proper wound care include keeping the dressing clean and monitoring for signs of infection, as well as supporting the maintenance of good postoperative blood glucose control, even in patients without diabetes. Elevated blood sugar levels following surgery can impair white-blood-cell function and delay wound healing, creating conditions that favour bacterial growth. Keeping glucose within a healthy range supports the body's natural defences and improves healing outcomes.
- Continued SSI surveillance helps ensure early detection and intervention if infective complications arise. Together, these measures help lower the risk of infection and support safer recovery after surgery.

The Scientific Committee on Infection Control (SCIC): https://www.chp.gov.hk/en/static/24007.html

The Third Edition of "Recommendations on Prevention of Surgical Site Infection":
https://www.chp.gov.hk/files/pdf/recommendations_on_prevention_of_ssi_3rd_ed_dec_2025.pdf

Global Disease Snapshot

Major Outbreaks and Emerging Infections



Sources of information

UK Health Security Agency: https://www.gov.uk/government/publications/invasive-meningococcal-disease-statistical-releases/notified-cases-of-invasive-meningococcal-disease; https://www.gov.uk/government/news/cases-of-invasive-meningococcal-disease-confirmed-in-kent

Pan American Health Organization: https://www.paho.org/en/documents/epidemiological-alert-yellow-fever-americas-region-13-march-2026

Japan Institute for Health Security: https://id-info.jihs.go.jp/surveillance/idwr/diseases/measles/graph/2026/meas26-11.pdf

News in Brief

Two local sporadic cases of listeriosis

The Centre for Health Protection (CHP) of the Department of Health (DH) recorded two local sporadic cases of listeriosis on March 5 and 11, 2026 respectively.

The first case involved a 38-year-old pregnant woman with good past health residing in Tai Po. She presented with fever and myalgia since February 20 at second trimester of gestation, and was admitted to a private hospital on March 2. Her blood specimen collected on March 2 grew *Listeria monocytogenes*. The clinical diagnosis was sepsis and she was treated with antibiotics. She then presented with premature rupture of membranes on March 5 and was transferred to a public hospital on March 7 for further management. She was subsequently found to have oligohydramnios on March 13, and the pregnancy was terminated on March 18. The patient had no travel history and recalled no known high-risk exposure during the incubation period. Her household contact remained asymptomatic.

The second case involved a 64-year-old male with underlying illnesses residing in Mong Kok. He presented with cough, runny nose, nausea and loss of appetite since March 7. He then developed fever, shortness of breath and confusion, and was admitted to a public hospital on March 9. His blood specimen collected on March 9 grew *Listeria monocytogenes*. The clinical diagnosis was sepsis and diabetic ketoacidosis. His condition stabilised after being treated with antibiotics. During incubation period, he had no travel history. He recalled consuming salmon sashimi but otherwise no known high-risk exposure. His household contacts remained asymptomatic.

A local case of psittacosis

The CHP recorded one local case of psittacosis in Kwun Tong on March 17, 2026.

The case involved a 98-year-old woman with underlying illnesses residing in an old age home in Kwun Tong. She developed cough, fever, myalgia, and shortness of breath since March 7 and was admitted to a public hospital on March 9, where she was clinically diagnosed with pneumonia. Her sputum sample collected on March 12 tested positive for *Chlamydia psittaci* DNA. She was treated with antibiotics and remained stable throughout. During the incubation period, she had no travel history. It was noted that pigeons frequently perched outside the window next to the patient's bed, where a lot of bird droppings was noted in that area. Health advice was provided to the old age home and property management to cleanse and disinfect area involved. Other residents were asymptomatic and have been put under medical surveillance. The case details were referred to the Agriculture, Fisheries and Conservation Department and the Food and Environmental Hygiene Department for follow-up as appropriate.

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 March 18, involving a 42-year-old man with underlying illnesses residing in Wong Tai Sin. He presented with cough and fever since February 18. He later developed shortness of breath and attended a private hospital on March 4. He was admitted on the same day. The clinical diagnosis was pneumonia. His sputum collected on March 4 was tested positive for CA-MRSA. He was treated with antibiotics. His condition was stable and he was discharged on March 14. His household contacts remained asymptomatic.