A00 *Cholera*

Case report universally required by *International Health Regulations*

RATIONALE FOR SURVEILLANCE

Cholera causes an estimated 120 000 deaths per year and is prevalent in 80 countries. The world is currently experiencing the 7th pandemic. In Africa epidemics have become more frequent and case-fatality rates are high. Refugee or displaced populations are at major risk of epidemics due to the conditions prevailing in the camps (unsafe water, poor sanitation and hygiene). Control of the disease requires appropriate surveillance with universal case reporting. Health education of the population at risk and improvement of living conditions are essential preventive measures. Case reporting universally is required by the *International Health Regulations.*

RECOMMENDED CASE DEFINITION

Clinical case definition

- *In an area where the disease is not known to be present:* severe dehydration or death from acute watery diarrhoea in a patient aged 5 years or more **or**
- *In an area where there is a cholera epidemic:* acute watery diarrhoea, with or without vomiting in a patient aged 5 years or more*

Laboratory criteria for diagnosis

Isolation of *Vibrio cholerae* O1 or O139 from stools in any patient with diarrhoea.

Case classification

Suspected: A case that meets the clinical case definition.

Probable: Not applicable.

Confirmed: A suspected case that is laboratory-confirmed.

Note: In a cholera-threatened area, when the number of "confirmed" cases rises, shift should be made to using primarily the "suspected" case classification.

* Cholera does appear in children under 5 years; however, the inclusion of all cases of acute watery diarrhoea in the 2-4 year age group in the reporting of cholera greatly reduces the specificity of reporting. For management of cases of acute watery diarrhoea in an area where there is a cholera epidemic, cholera should be suspected in all patients.

RECOMMENDED TYPES OF SURVEILLANCE

Routine surveillance (this may be integrated with surveillance of diarrhoeal diseases: see acute watery diarrhoea).

Immediate case-based reporting of suspected cases from periphery to intermediate level and central level. All suspected cases and clusters should be investigated.

Aggregated data on cases should also be included in routine weekly / monthly reports from peripheral to intermediate and central level.

International:

The initial suspected cases should be reported to WHO (mandatory).

Aggregated data on cases should be reported to WHO (mandatory).

Outbreak situations:

- During outbreak situations surveillance must be intensified with the introduction of active case finding
- Laboratory confirmation to be performed as soon as possible
- Thereafter weekly reports of cases, ages, deaths, regions, and hospital admissions to be set up

RECOMMENDED MINIMUM DATA ELEMENTS

Case-based data for investigation and reporting

- Age, sex, geographical information
- Hospitalization (Y / N)
- Outcome

Aggregated data for reporting

- Number of cases by age, sex
- Number of deaths

RECOMMENDED DATA ANALYSES, PRESENTATION, REPORTS

- Use weekly numbers, not moving averages
- Case-fatality rates (graphs)
- Weekly / monthly plots by geographical area (district) and age group (GIS) (graphs)
- Comparisons with same period in previous five years

PRINCIPAL USES OF DATA FOR DECISION-MAKING

- Detect outbreaks, estimate the incidence and case-fatality rate
- Undertake appropriately timed investigations
- Assess the spread and progress of the disease
- Plan for treatment supplies, prevention and control measures
- Determine the effectiveness of control measures

SPECIAL ASPECTS

At least one reference laboratory in each country is recommended for species identification.

Once the presence of cholera in an area has been confirmed, it becomes unnecessary to confirm all subsequent cases; shift should be made to using primarily the “suspected“ case classification.

Monitoring an epidemic should, however, include laboratory confirmation of a small proportion of cases on a continuing basis.

For countries where cholera is rare or previously unrecognized, the first cases should be confirmed by laboratory diagnosis (including demonstration of toxigenic *Vibrio cholerae* O1 or O139 in faeces if possible).

CONTACT

Regional Offices

See Regional Communicable Disease contacts on pages 18-23.

Headquarters: 20 Avenue Appia, CH-1211 Geneva 27, Switzerland
Communicable Diseases Surveillance and Response (CSR)
E-mail: tikhomirove@who.ch/ outbreak@who.ch
Tel: (41 22) 791 2624 / 2662 /2111 Fax: (41 22) 791 4893 / 0746 attn CSR