Cholera Situation in the Americas

Since the previous issue of the Epidemiological Bulletin, the evolution of cholera in the Americas has been characterized by a pattern of intense transmission. Although there are no reports of new countries that have been affected, the following information has been received. In May, Mexico reported twice as many cases as the average for the previous months in 1992, and the states of Jalisco, San Luis Potosí, and Sinaloa registered cases for the first time. In Central America all the countries, with the exception of Costa Rica, saw a rise in the number of cases reported during the period from the end of April through May compared with the two previous months. In Honduras and Nicaragua the infected area increased in size. In Costa Rica an autochthonous case was identified as part of a limited outbreak in which nine other asymptomatic individuals were found to be infected with *V. cholerae* 01, El Tor biotype, Inaba serotype. In the Andean area, repeating the trend observed last year, Ecuador and Peru saw a reduction in the number of cases reported during the month of May. In Brazil the infected area continued to spread, and as of May 1992 cases had been reported from more than 300 municipalities in 14 states, 73% of them in the northeastern part of the country. The United States of America reported a total of 75 cases associated with an investigation of cholera among passengers on an Aerolíneas Argentinas flight between Buenos Aires and Los Angeles, California. No information has been provided on the probable source of the infection. According to the reports received from the countries, the trend appears to be one of continued cholera transmission in the Hemisphere with seasonal peaks in incidence (Figure 1). As of 6 June, the countries that had reported cases during 1992 were: Argentina, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, French Guiana, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, Suriname, the United States of America, and Venezuela.

(Source: Information from country reports consolidated by the Health Situation and Trend Assessment Program, PAHO.)

The recent publication of the World Health Organization, WHO Guidance on Formulation of National Policy on the Control of Cholera (WHO/CDD/SER/92.16), sets forth the Organization’s position in several important areas relating to the control of cholera.

With regard to surveillance and reporting, the following case-definition criteria are recommended: suspected case: (a) a patient 5 years of age or older who develops serious dehydration or dies from acute watery diarrhea in an area where the disease has not been reported; (b) a patient 5 years of age or older who develops acute watery diarrhea, with or without vomiting, in an area where an epidemic is occurring. Confirmed case: any diarrhea patient with isolation of *Vibrio cholerae* 01.

For reporting at the national level, collection of a minimum set of data elements is recommended. Information on sources and modes of transmission may be obtained through epidemiological investigation. With regard to international notification, it is emphasized that authorities in countries where the presence of cholera has been confirmed should report to PAHO/WHO on a weekly basis and include at least the number of new cases and deaths since the last report, together with cumulative totals for the year, by region or some other relevant geographical division. It is not necessary to distinguish between confirmed and suspected cases; all cases should be reported as cholera.

Regarding the use of the laboratory, it is emphasized that in the event of a suspected case, a sufficient number of feces samples should be examined to identify the responsible agent and test its sensitivity to antibiotics. Once the presence of cholera in an area is confirmed, it is not necessary to examine samples from all, or even many, of the cases or contacts in the area, and in fact, it is better not to promote this practice since it places an unnecessary burden on the laboratories. The evolution of an epidemic in a given area should be followed through bacteriological tests of samples from a small number of patients.

It is reiterated that WHO does not recognize any situation in which the traditional cholera vaccine should be used.

With regard to the international spread of cholera, it is pointed out that at the present time no country requires that travelers entering its territory be vaccinated against cholera. Furthermore, WHO recommends that the countries should not implement any cordon sanitaire, quarantine, or control of their borders in their efforts to prevent the spread of cholera.

In reference to chemoprophylaxis, attention is called to the fact that mass prophylaxis should not be used in efforts to control cholera. Selective chemoprophylaxis may be considered, but only when surveillance has demonstrated that on the average, at least one of every five family contacts has become ill after the appearance of the first case.

In view of the small risk of tourists becoming ill with cholera, the recommendation on this subject is that
tourism should not be restricted in areas affected by cholera.

With regard to water supply and sanitation, it is emphasized that cholera can only be reliably prevented by ensuring that all populations have access to adequate excreta disposal and drinking water systems.

Since large-scale investments are needed in order to upgrade or build new environmental health infrastructure that is capable of providing such systems, priority should be given in the near term, to: Drinking water: a) drinking water should be adequately disinfected; disinfection practices should be improved in distribution systems and in rural systems; b) chlorine or iodine tablets may be distributed to the population with instructions for their use; c) when chemical water treatment is not possible, emphasis should be placed on the need to boil water before it is consumed; d) water quality control should be improved, surveillance and control of residual chlorine should be intensified, and bacteriological tests should be implemented and analyzed at various points in the production and distribution systems. With regard to sanitation: a) quality control of wastewater treatment plants should be improved; b) the use of treated wastewater for irrigation should be carefully controlled, in accordance with national and international standards; c) large-scale chemical treatment of wastewater is rarely justified, even in emergencies, because of its high cost, unpredictable effects, and possible negative impact on the environment and health; d) health education should emphasize safe disposal of excreta.

In reference to food and cholera, the following general recommendations are made:

When the physical or chemical characteristics or processing of food are such as to prevent the presence of V. cholerae, there is no reason to expect any risk of cholera transmission, and hence there is no justification for actions that restrict the sale, transportation, or consumption of such foods as measures to control the disease.

With regard to food in international trade, it is noted that although in theory there is a risk of cholera transmission with some of the food products that are sold on the international market, this possibility has rarely proven to be significant, and hence authorities should seek more satisfactory mechanisms than the application of embargoes on imports.

Finally, with regard to health education, it is recommended that those responsible for the mass media should provide the health authorities with the necessary free time and editorial space to disseminate information and educate the public on cholera control.