

Arboviral and other illnesses in travellers returning from Brazil, June 2013 to May 2016: implications for the 2016 Olympic and Paralympic Games

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We evaluated EuroTravNet (a GeoSentinel subnetwork) data from June 2013 to May 2016 on 508 ill travellers returning from Brazil, to inform a risk analysis for Europeans visiting the 2016 Olympic and Paralympic Games in Brazil. Few dengue fever cases ($n = 3$) and no cases of chikungunya were documented during the 2013–15 Brazilian winter months, August and September, the period when the Games will be held. The main diagnoses were dermatological (37%), gastrointestinal (30%), febrile systemic illness (29%) and respiratory (11%).

We analysed travel-associated morbidity in ill travellers returning from Brazil and presenting at 22 EuroTravNet sites during June 2013 to May 2016. As the Olympic and Paralympic Games will take place during August and September, the cooler months in Brazil, we focused on the main vector-borne diseases reported during these

months. Very few cases of dengue fever ($n = 3$) and no cases of chikungunya were reported during August and September in three consecutive years. The main syndromic diagnoses were dermatological (37%; $n = 189$), gastrointestinal (30%; $n = 152$), febrile systemic illness (29%; $n = 148$) and respiratory (11%; $n = 58$).

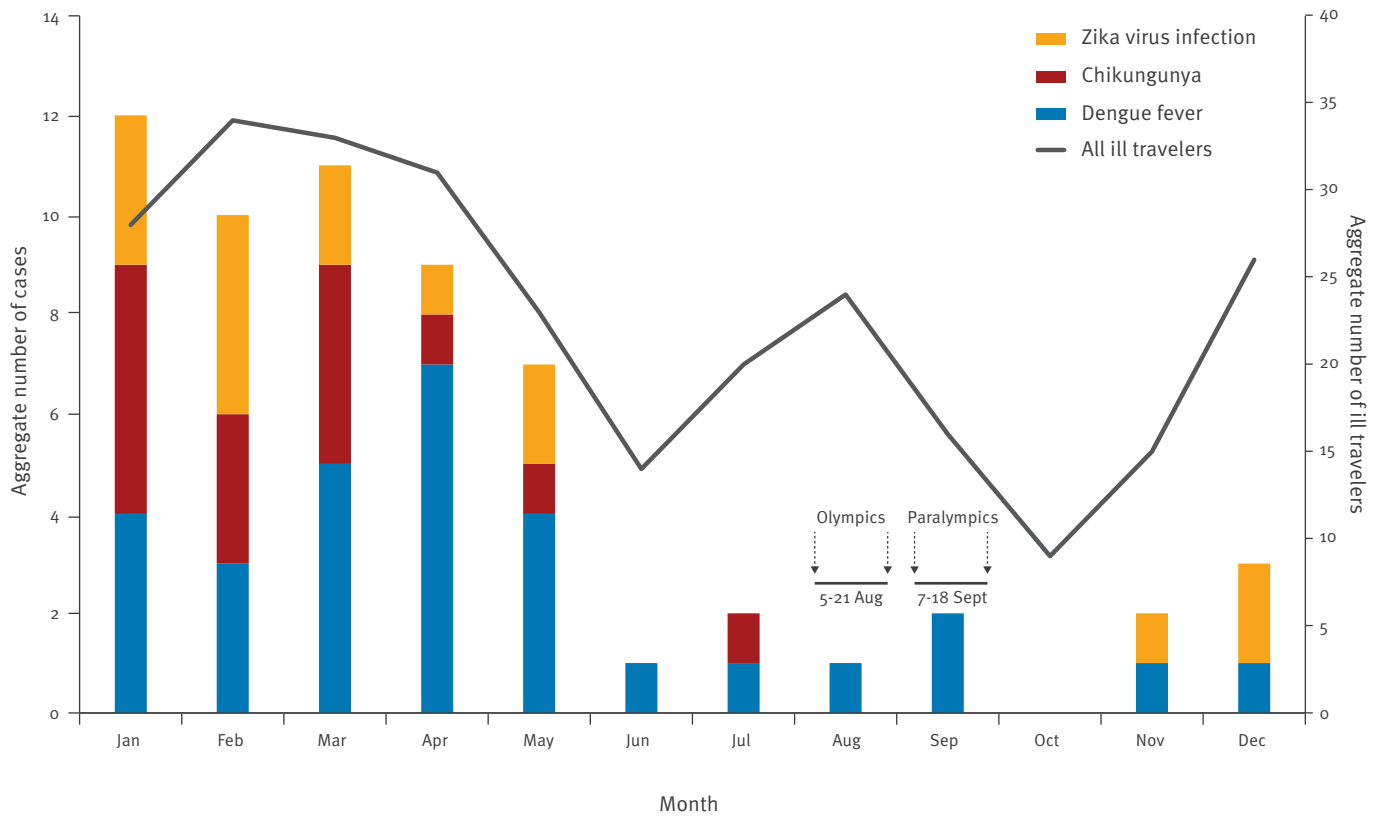
Findings

A total of 508 ill returning European travellers were recorded during the study period, June 2013 to May 2016 (Table 1). Most patients were tourists (68%; $n = 339$) and 27% ($n = 136$) had documented pre-travel advice. The median duration of travel was 22 days (range: 2–2,588). A total of 27 patients were hospitalised (5%).

The main syndromic diagnoses are shown in Table 2.

FIGURE 1

Aggregate monthly number of cases of dengue fever^a, chikungunya^b and Zika virus infection^c among ill travellers returning from Brazil presenting at EuroTravNet sites^d by month of infection and aggregate number of returning travellers with any illness, by month of travel, June 2013–May 2016 (n = 273)



The period of the 2016 Olympic and Paralympic Games is indicated.

^a Dengue fever cases were seen at EuroTravNet sites in each of the study years.

^b Chikungunya cases were seen at EuroTravNet sites in 2014–16 (the end of the study period being May 2016).

^c Zika virus has only recently emerged in Brazil [8]. Cases of Zika virus infection were seen at EuroTravNet sites in 2015–16 (the end of the study period being May 2016). No cases of Zika virus infection in returning travellers from Brazil were reported at EuroTravNet sites from August to September in 2015.

^d EuroTravNet, a subnetwork of GeoSentinel [1], comprises European sites specialised in travel or tropical medicine that contribute clinician-based data on ill travellers [2].

^e Based on travel dates, date of symptom onset and known incubation period.

^f Travel duration of 22 days or less.

The most frequent specific dermatological diagnoses were parasitic skin infections, in particular cutaneous larva migrans. Arthropod bites and skin and soft tissue infections were also among the most common dermatological conditions.

Most patients with gastrointestinal disease had acute diarrhoea of unknown aetiology, while infection with *Giardia intestinalis* and geohelminths (i.e. soil-transmitted) accounted for the most frequent aetiological diagnoses.

The most frequent causes of febrile systemic illnesses during the study period were dengue fever, chikungunya and Zika virus infection (ZVI). The number of cases according to month of infection over the study period is shown in the Figure. The first reported case of chikungunya acquired the infection in March 2014, and the first case of ZVI acquired the infection in May 2015. There were three cases of malaria: two *Plasmodium falciparum* and one *P. vivax* malaria. No deaths were recorded.

TABLE 1Demographic and travel characteristics of ill travellers returning from Brazil presenting at EuroTravNet^a sites, June 2013–May 2016 (n = 508)

| Characteristic | Number (%) ^b |
|--|-------------------------|
| Male | 271 (53) |
| Median age in years (range) | 34 (0–79) |
| Pre-travel advice obtained | |
| Yes | 136 (27) |
| No | 185 (36) |
| Unknown | 187 (37) |
| Travel reason | |
| Tourism | 339 (67) |
| Visiting friends and relatives | 75 (15) |
| Business | 72 (14) |
| Missionary, volunteer, researcher, community service worker, humanitarian, aid worker, education worker, student | 22 (4) |
| Travel duration in Brazil, in days | |
| Median (range) | 22 (2–2,588) |
| <30 | 323 (64) |
| ≥30 | 164 (32) |
| Not documented | 21 (4) |
| Hospitalisation | |
| Yes | 27 (5) |

^a EuroTravNet, a subnetwork of GeoSentinel [1], comprises European sites specialised in travel or tropical medicine that contribute clinician-based data on ill travellers [2].

^b Unless otherwise specified.

Among those with respiratory syndromes, no causative agent was identified, with the exception of the three influenza cases.

EuroTravNet and study inclusion criteria

EuroTravNet, a subnetwork of GeoSentinel [1], comprises 22 European sites specialised in travel or tropical medicine that report clinician-based data on ill travellers [2]. Sites enter anonymised data on demographics, travel history, reason for travel, pre-travel advice, hospitalisation, major clinical symptoms and final, clinician-verified diagnoses. In our study, only travellers with Brazil as a single country of exposure were included. Only confirmed and probable diagnoses were included and patients whose only travel was for ‘migration’ were excluded. Every patient had at least one diagnosis (from a list of 556 possible diagnostic codes). Diagnoses were based on the recognition of a specific causative pathogen using the best reference diagnostic tests available. Syndromic codes were used when clinical indicators suggested a specific diagnosis without identification of a causative pathogen.

Background

International mass gatherings pose a risk for communicable disease outbreaks and onward rapid, global spread of infection [3]. The Olympic Games will take place mainly in Rio de Janeiro, Brazil, on 5–21 August 2016, followed by the Paralympic Games, on 7–18 September 2016. More than 400,000 visitors to the Games are expected [4]. The European Centre for

Disease Prevention and Control (ECDC) recently issued a health risk assessment for European citizens visiting the Games [5], based mainly on extrapolation of data obtained from the Brazilian population. Data on illness in travellers returning from Brazil will provide additional information on which to base an accurate risk assessment for Europeans attending the Games. A previous study on this topic was conducted by GeoSentinel (the Global Surveillance Network of the International Society of Travel Medicine) among travellers to Brazil between July 1997 and May 2013 [6]. Our study presented here reports more recent data, with a focus on European travellers and mosquito-borne viral infections.

Discussion

European travellers returning from Brazil during the past three years had a pattern of travel-related illnesses similar to that previously described in a broader population of travellers to Brazil, with the exception of an increase in arboviral infections starting in 2014 [6]. On the basis of our results, mosquito bite prevention, food and water precautions and avoidance of skin contact with soil should be recommended for travellers to Brazil. Vaccination against influenza should be considered for those in risk groups. Vaccination against illnesses such as yellow fever and malaria prevention should be considered, based on individual itineraries in Brazil as detailed in the ECDC health risk assessment [5]. Although no case of measles was reported in our analysis, there is a theoretical risk of contracting

TABLE 2

Main syndrome groups and diagnoses of ill travellers returning from Brazil presenting at EuroTravNet sites^a, June 2013–May 2016 (605 diagnosis in 508 patients)

| Syndrome groups and diagnoses | Number (%) ^b |
|--|-------------------------|
| Dermatological | |
| Total | 189 (37) |
| Cutaneous larva migrans, hookworm-related | 57 (11) |
| Insect bite | 38 (8) |
| Skin and soft tissue infections | 30 (6) |
| Tungiasis | 8 (2) |
| Other parasitic infections (myiasis, scabies and cutaneous leishmaniasis) | 7 (1) |
| Tick bite | 7 (1) |
| Animal bites requiring rabies post-exposure prophylaxis | 6 (1) |
| Rash of unknown aetiology, non febrile | 6 (1) |
| Fungal infection | 5 (1) |
| Gastrointestinal | |
| Total | 152 (30) |
| Acute diarrhoea, aetiology unknown | 43 (8) |
| Giardiasis | 21 (4) |
| Intestinal helminthiasis (strongyloidiasis, hookworm infection, ascariidiasis) and schistosomiasis | 19 (4) |
| Other intestinal infections with documented pathogen ^c | 13 (3) |
| Chronic diarrhoea (>2 weeks), aetiology unknown | 10 (2) |
| Irritable bowel syndrome, post infectious | 6 (1) |
| Febrile systemic illness | |
| Total | 148 (29) |
| Unspecified febrile illness | 60 (12) |
| Dengue fever | 32 (6) |
| Chikungunya | 15 (3) |
| Zika virus infection | 14 (3) |
| Other febrile systemic illness with documented pathogen ^d | 9 (2) |
| Respiratory | |
| Total | 58 (11) |
| Upper respiratory tract infection | 28 (6) |
| Influenza-like illness or confirmed influenza ^e | 16 (3) |
| Pneumonia | 8 (2) |

^a EuroTravNet, a subnetwork of GeoSentinel [1], comprises European sites specialised in travel or tropical medicine that contribute clinician-based data on ill travellers [2].

^b Percentage of patients with a given syndrome or diagnosis; one or more diagnoses are possible for each ill returning traveller.

^c *Salmonella* spp. infection (n=5), *Shigella* spp. infection (n=4), *Dientamoeba fragilis* infection (n=2), *Campylobacter* spp. infection (n=1), *Cryptosporidium* spp. infection (n=1).

^d *Plasmodium falciparum* malaria (n=2), *P. vivax* malaria (n=1), cytomegalovirus infection (n=1), Epstein–Barr virus infection (n=1), visceral leishmaniasis (n=1), leptospirosis (n=1), extrapulmonary tuberculosis (n=1), meningococcal sepsis (n=1).

^e Influenza B infection (n=2), influenza A infection (n=1).

measles virus [7] and non-immune travellers should be up to date with their routine vaccinations.

Two limitations of this EuroTravNet analysis are firstly that we captured only ill returning travellers who present at a network site and secondly, we have no denominator data. However, our network has an important sentinel function in identifying new and emerging imported infections and trends [2], as evidenced by our recording the importation of chikungunya cases from Brazil, starting in 2014, in the present study. The first case of ZVI exported from Brazil was reported to

EuroTravNet in May 2015, soon after the first cases were documented locally in Brazil and in a traveller returning to Italy [8,9]. Overall, mosquito-borne viral infections acquired by European travellers in Brazil showed a clear seasonal pattern, with most cases of dengue fever and chikungunya being observed between December and May. In the past three years, very few returning travellers with dengue fever and none with chikungunya acquired the infection during August and September, the months the Olympic and Paralympic Games will be held. This seasonal pattern is similar to that observed over recent years in the

Brazilian population. A recent publication showing a 'heat map' and epidemiological data on local dengue virus transmission in Rio de Janeiro during August to September each year during 2001 to 2015 highlights the fact that these are the 'cold' periods, with minimal transmission of dengue virus [10]. Given that Zika virus is transmitted via the same *Aedes aegypti* vector, we consider that the risk of acquiring ZVI during the 2016 Olympic and Paralympic Games in Brazil will be low.

Despite this, mosquito prevention measures should be recommended for travellers and pregnant women should be discouraged from travel to Brazil during this period [5]. Furthermore recommendations to prevent onward sexual transmission of Zika virus should be observed; these are constantly updated by the European Commission [11]. Of note, infected travellers may return home to European metropolitan areas with high-density populations of *Aedes albopictus* [12] and ambient temperatures that are conducive to autochthonous outbreaks of arboviral infections in large susceptible populations. This underscores the importance of surveillance of travel-associated infections and vigilance regarding mosquito control in Europe.

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Conflict of interest

None declared.

Authors' contributions

P. Gautret and P. Schlagenhauf analysed the results and drafted the manuscript; all authors contributed to revising the manuscript and/or providing data.

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