Outbreaks of Meningococcal Meningitis during Hajj: changing face of an old enemy

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N. meningitides is the leading cause of meningitis worldwide and a significant public health problem in most countries. The worldwide incidence of meningococcal meningitis probably exceeds 100,000 cases per year. It has been estimated that in the third world countries >310,000 persons per year suffer from infections caused by N. meningitides, resulting in 35,000 deaths. Meningococcal disease usually presents as meningitis in 80-85% of cases, whereas in the remaining 15 - 20% cases, it presents with pure septicemia without meningitis. Even with timely antibiotic therapy, the case fatality rate for meningococcal meningitis is between 5 - 10%, and similar proportion suffers from long term sequelae. Case fatality rate for septicemia can, however, be as high as 70% in developing countries and 19% in developed countries. Among different serogroups of N. meningitides, serogroups A, B and C accounts for up to 90% of the disease. The serogroups B and C are responsible for the majority of cases in Europe and the Americas and serogroups A and C predominating throughout Asia and Africa. The annual pilgrimage to Mecca attracts approximately 2 million people from more than 140 different countries. Overcrowding provides the ideal condition for the transmission of infections like typhoid, cholera and invasive meningococcal meningitis. Outbreaks of typhoid and cholera have also been recorded during Hajj. Although most early cases of meningitis were reported in pilgrims, the outbreaks quickly spread to their immediate contacts and then to those with no pilgrim contact, and cases were continued to be identified even 3 to 4 months after the Hajj most likely as a result of pilgrims assimilating in the community and dispersing bacteria. There have been several epidemics of invasive meningococcal infection throughout the world in the past 15 years which have been clearly linked to Hajj pilgrimage. The first reported international outbreak following the Hajj, caused by Neisseria meningitides serogroup A, occurred during 1987. The epidemic emphasized the potentially high risk of transmission of N. meningitides during the pilgrimage. This prompted the Saudi authorities to implement compulsory vaccination policy with bivalent A/C vaccine for all pilgrims coming to Mecca. In 1992 another group A meningitis outbreak occurred in Mecca during Umra and Ramadan but this out break was not known to have spread beyond Saudi Arabia. Small outbreak of serogroup W135 occurred in

The number of
cases reported from England and Wales in 2001 was similar to the number reported during 2000, despite a change in recommendation for pilgrims to receive quadrivalent vaccine (against serogroups A, C, Y and W 135), instead of A/C vaccine recommended in 2000. The case fatality ratio remained high and sustained transmission of the virulent outbreak strain was seen. The quadrivalent A, C, Y, and W 135, vaccine is highly immunogenic in both children and adults and the reason for this apparent 'failure' of the vaccine was likely due to late availability of the vaccine prior to 2001 Hajj season. Although a small number of cases of meningococcal meningitis in Mecca during the 2001 Hajj week, >109 cases of meningococcal meningitis (predominantly Hajj pilgrims from outside Saudi Arabia), including 35 deaths, were reported cumulatively during the period 9th February - 22nd March 2001.5-7

There are a limited number of studies which looked at the nasopharyngeal carriage of meningococci among Hajj pilgrims. One such study, to assess the risk of meningococcal disease among returning pilgrims and non-pilgrims from Saudi Arabia and their close contacts, was conducted by CDC. It was found that the carriage of serogroup W135 among returning pilgrims and non-pilgrims was 0.8% and 0.9% respectively. On the basis of low rate of carriage in the study population, prophylactic antibiotics were not recommended for returning Hajjis.8

Another prospective study of meningococcal carriage was conducted in Singapore pilgrims before departing for Hajj, and in pilgrims and their household contacts two weeks after return from Hajj. Around 17% of the returning pilgrims were found to be meningococcal carriers. The prevalence of meningococcal carriage in the household contacts was 8.2% of whom 42% were carrying the W135 clone. This study clearly demonstrated high acquisition rate of serogroup W135 N. meningitides strain during 2001 Hajj and emphasized the importance of administering quadrivalent meningococcal vaccine to all the Hajj pilgrims. The findings of the study also raised an important issue of administering chemoprophylaxis to pilgrims before return to their home countries to eradicate carriage and thereby protect household contacts.9

In this issue of JPMA Talal M. Karima et al. reported clinical, epidemiological, and laboratory features of 105 confirmed cases of meningococcal meningitis from King Faisal Hospital, Mecca, Saudi Arabia during Hajj 2000. About 1/3 of the cases also had meningococcemia. The overall case fatality rate was significantly high (34%) despite appropriate antibiotic use. Some of the factors identified in the study, for higher than expected mortality were delay in diagnosis, delay in the administration of antibiotic, older age group, and patients with serious concurrent medical problems. Interestingly the mortality was highest among Hajjis from the Indian sub-continent (33%) including maximum number of deaths among Pakistani Hajjis (18%). Majority of the isolates (44) belonged to serogroup A, followed by W 135 strain (19). As documented in previous outbreaks with W 135 strain, this particular study also found W 135 strain to be more invasive and more fatal. Another important question raised in the study is the reliability of A & C vaccination and vaccination certificates received by the pilgrims especially in Pakistan and India.10 This is certainly a very valid concern by the authors and must be looked into seriously by the ministry of health and local health authorities.

The risk of contracting meningococcal disease is greatest (1 in 30) among people who live in the same household than other members of the community; the attack rate is increased by about 500 to 1200 times. The risk is highest in the first seven days after a
case and fall rapidly during the following week. The incubation period is 2 to 10 days, and for practical purposes a 7-day period is considered sufficient to identify close contacts for prophylaxis. Antibiotic prophylaxis should be given as soon as possible after diagnosis of the index case. The drug of choice is Rifampicin 600mg BID for 2 days, but single dose of ciprofloxacin 500 mg or an IM injection of ceftriaxone 250 mg may also be used. The protection lasts for several days to a few weeks. The risk for contacts is indeed still significant after two weeks and may persist for six months or even longer. Therefore immunization should be considered. The ideal protection is provided by simultaneous administration of the anti-infective drug and quadrivalent meningococcal vaccine. This approach is particularly suitable for outbreaks because of prolonged risk of transmission.  

Unfortunately mass vaccination of the population may not be feasible because of the limited available resources and also it may not be a cost effective practice outside hyper-endemic areas. Selective epidemic response immunization programs have been recommended by WHO for controlling epidemics of an outbreak of the relevant serogroups in restricted areas where an outbreak has occurred and to people at imminent risk, including children and infants. Similarly due to high acquisition rates and nasopharyngeal colonization, especially during an epidemic outbreak of meningococcal meningitis, chemoprophylaxis of returning Hajjis and their close contacts should be a logical option. For 2002 Umra and Hajj seasons, the ministry of health in Saudi Arabia has added to health requirements for all arrivals, such that vaccination against meningococcal meningitis with the quadrivalent vaccine (serogroup A, C, Y, and W135) is mandatory and is part of visa requirement. This is in response to increased reports worldwide in 2000 and 2001, of meningococcal disease caused by the serogroup W135. Some pilgrims may still have a valid certificate following a previous immunization with A and C vaccine. If traveling on Hajj again, they still require the additional protection afforded by the quadrivalent vaccine.

An accurate epidemiological surveillance system is vital if epidemics are to be detected early. The ministry of health and local health authorities must be on alert and more proactive in providing adequate training to local health workers, ensure prompt communication to the local physicians in the community and make provision for experienced and properly equipped diagnostic laboratory facilities. Public awareness among Hajjis and in the community about the seriousness of this issue should be enhanced by educational campaigns through media, highlighting the seriousness of this problem and availability of quadrivalent vaccines and chemoprophylaxis for prevention of this life threatening disease. Also it is very important for the health authorities to make sure that all Hajjis receive vaccination certificates only after mandatory immunization.

References