Joint UKBTS Professional Advisory Committee ([1])

Position Statement

Chikungunya Virus

November 2014

Approved by: Standing Advisory Committee on Transfusion Transmitted Infections

November 2014 - The contents of this document are believed to be current. Please continue to refer to the website for in-date versions.

Background

Chikungunya was first described in Tanzania in 1952. The name is derived from a local Tanzanian word meaning 'that which bends up', a reference to the stooped posture many patients develop as a result of painful inflammation of the joints commonly associated with the disease.

Chikungunya is a self-limiting febrile illness caused by an alpha virus spread by the same day-biting mosquito as dengue (usually of the Aedes species). It is characterized by arthralgia or arthritis typically in the knee, ankle and small joints of the extremities, which may be persistent, high fever, followed by a maculopapular rash. Buccal and palatal lesions can occur as may nausea and vomiting. Thrombocytopenia may be present leading to bleeding, especially in children. Rarely there may be fulminant liver failure and death. It is known from antibody studies that many infections are asymptomatic. Immunity is long lasting. The virus is known to infect humans, primates, other mammals and birds. There is no evidence of person-to-person transmission except through blood transfer. At present the only treatment available is symptomatic. No vaccine is available.

Although it is possible that the virus could be transmitted by transfusion, or by tissue or organ transplantation, the Standing Advisory Committee on Transfusion Transmitted Infections is not aware of any proven instance of transmission by these routes.

Chikungunya usually occurs in Africa and south and east Asia, but affected areas have been increasing in recent years. In late 2004, large outbreaks of chikungunya fever in the Indian Ocean raised serious public health concerns. The first recognised outbreak in Europe occurred in the northeast of Italy in the summer of 2007. The vector mosquito has become widespread following importation through international trade. It was first noted in Albania in 1979 and by 2007 has been found as far north as Belgium. In September 2010 there were the first reported cases of indigenous infection in France: two 12 year old schoolchildren resident in the south of France. Indigenous infection has not been recorded in the United Kingdom.

Since December 2013, confirmed cases of chikungunya have been reported on many islands in the Caribbean and an increasing number of cases have been observed from many of the affected areas. Cases have also been reported for the first time in French Guiana, a French territory on the north coast of South America, and in July 2014 the first two cases of local acquisition were reported in Florida. A total of 8 cases have now been identified in Florida. Surveillance for CHIKV infections has been enhanced in the region and it is likely that cases will be continue to increase, given the susceptible population, the presence of an effective vector and the movement of people within and in between islands and territories in the Region.

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Large numbers of British residents visit affected areas and the Public Health England (PHE) Special Pathogens Reference Unit in 2006 reported 106 cases of chikungunya infection in travellers returning to the United Kingdom from affected areas. Small numbers of cases were reported in following years: 63 cases for 2009 and 79 for 2010. In the first few months of 2006 the majority of the cases reported were acquired in Mauritius, consistent with the large outbreak of chikungunya in the islands of the Indian Ocean. From September 2006 into 2007, the majority of cases were acquired in India or Sri Lanka. The majority of chikungunya cases reported in 2009 and 2010, where travel history is available (about 80%), were acquired in the Indian sub-continent and south-east Asia/ Far East. The number of imported cases fell to 14 in 2011 and 15 in 2012. India has continued to be the source for the majority of travel-associated chikungunya cases in England, Wales and Northern Ireland, with the Philippines and Cambodia the next most commonly reported countries. No cases in 2011 or 2012 were associated with travel to Indian Ocean islands, and there have been no travel-associated cases in England, Wales and Northern Ireland to date linked with the Caribbean or the Americas. Information about international outbreaks of chikungunya is available on the National Travel Health Network and Centre (NaTHNaC) website: NaTHNaC website.

Visitors to many affected areas will be excluded from donation for six months under current malaria guidelines. However, some affected areas are not covered by malaria exclusions. Visitors to these areas should not donate blood or tissues for six months from their return to the UK if they have been infected or may have been infected with chikungunya, or for four weeks from their return if they have had no symptoms suggesting that they may have been infected with chikungunya.

Countries affected by chikungunya and any applicable time limits are shown in the Geographical Disease Risk Index (GDRI) and any associated Change Notifications.

([1]) **Joint U**nited **K**ingdom **B**lood **T**ransfusion **S**ervices **Professional Advisory Committee**