



PHE Weekly National Influenza Report

Summary of UK surveillance of influenza and other seasonal respiratory illnesses

02 November 2017 – Week 44 report (up to week 43 data)

This report is published weekly on the [PHE website](#). For further information on the surveillance schemes mentioned in this report, please see the [PHE website](#) and the [related links](#) at the end of this document.

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Summary

During week 43 (ending 29 October 2017), influenza activity was low across all surveillance systems and RSV activity continues to increase.

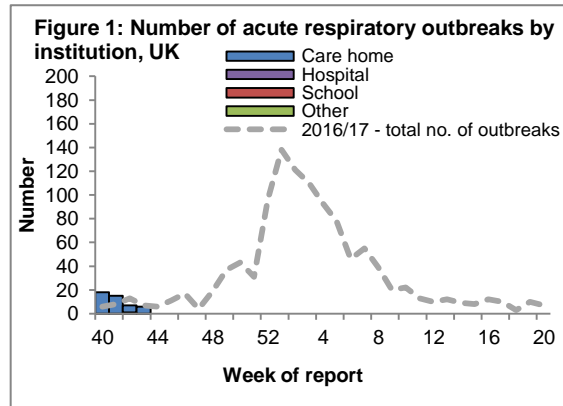
- [Community influenza surveillance](#)
 - Six new acute respiratory outbreaks have been reported in the past 7 days, all six outbreaks were from care homes with no test results available.
- [Overall weekly influenza GP consultation rates across the UK](#)
 - In week 43, the overall weekly influenza-like illness (ILI) GP consultation rate was 6.1 per 100,000 in England, compared to 5.9 per 100,000 in week 42. This is below the baseline threshold of 13.1 per 100,000 for this season. In the devolved administrations, ILI rates were also below baseline thresholds.
 - Through the GP In Hours Syndromic Surveillance system, GP in hours consultations for influenza like illness (ILI) were low in week 43 and small increases in bronchitis/bronchiolitis indicators (including ED attendances and GP OOH consultations) were noted in infants aged <1 year, in line with recent small increases in laboratory reports for respiratory syncytial virus (RSV).
- [Influenza-confirmed hospitalisations](#)
 - In week 43, there were seven admissions to ICU/HDU with confirmed influenza (two influenza A(H3N2), two influenza A(unknown subtype) and three influenza B) reported across the UK (116/155 Trusts in England) through the USSS mandatory ICU scheme with a rate of 0.02 per 100,000, compared to 0.00 per 100,000 in the previous week.
 - In week 43, there were 11 hospitalised confirmed influenza cases (one influenza A(H1N1pdm09), three influenza A(H3N2), three influenza A(unknown subtype) and four influenza B) reported through the USSS sentinel hospital network (22 NHS Trusts across England), with a rate of 0.11 per 100,000 compared to 0.05 per 100,000 in the previous week.
 - No confirmed influenza admissions have been reported from the six Severe Respiratory Failure centres in the UK in week 43.
- [All-cause mortality data](#)
 - In week 43 2017, no statistically significant excess all-cause mortality by week of death was seen through the EuroMOMO algorithm in England and in the devolved administrations.
- [Microbiological surveillance](#)
 - Three samples tested positive for influenza (two influenza A(H3) and one influenza A(unknown subtype)) through the UK GP sentinel swabbing schemes, with an overall positivity of 4.7% in week 43.
 - Eighteen positive detections were recorded through the DataMart scheme (five influenza A(H3), five influenza A(unknown subtype), one influenza A(H1N1)pdm09 and eight influenza B) with a positivity of 1.5% in week 43. RSV activity continues to increase at 9.1% in week 43 and 25.6% in <5 year olds.
- [Vaccination](#)
 - Up to week 43 2017, in 75.8% of GP practices reporting weekly to Immform, the provisional proportion of people in England who had received the 2017/18 influenza vaccine in targeted groups was: 32.7% in under 65 years in a clinical risk group, 33.8% in pregnant women and 58.2% in 65+ year olds.
 - Up to week 43 2017 in 61.8% of GP practices reporting weekly to Immform, the provisional proportion of children in England who had received the 2017/18 influenza vaccine in targeted groups was: 19.1% in 2 year olds and 19.5% in 3 year olds.
 - Flu vaccine uptake data on 4 year olds will be collected through the school delivery programme together with uptake for 5-8 year olds and published in the monthly report, to be published on 23 November 2017.
- [International situation](#)
 - Globally, declining levels of influenza activity were reported in the temperate zone of the southern Hemisphere and influenza activity remained at low levels in the temperate zone of the northern hemisphere. Worldwide, influenza A(H3N2) and B viruses accounted for the majority of influenza detections.

Six new acute respiratory outbreaks were reported in the past 7 days.

- Acute respiratory disease outbreaks

- Six new acute respiratory outbreaks have been reported in the past 7 days, all six outbreaks were from care homes with no test results available.

- Outbreaks should be recorded on HPZone and reported to the local Health Protection Teams and respscidsc@phe.gov.uk.

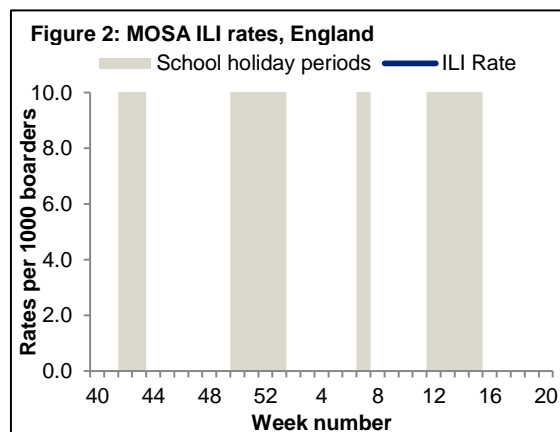


- Medical Officers of Schools Association (MOSA) & PHE surveillance scheme

- Boarding schools in England within the MOSA network are recruited each season to report various respiratory related illnesses including influenza like illnesses (ILI).

- Approximately 20 MOSA schools will be participating in the 2017/18 season. Data will be reported from week 45.

- If you are a MOSA school and would like to participate in this scheme, please email mosa@phe.gov.uk for more information.



- FluSurvey

- Internet-based surveillance of influenza-like illness in the general population is undertaken through the FluSurvey. A project run jointly by PHE and the London School of Hygiene and Tropical Medicine.

- Data will be reported from week 44.

- If you would like to become a participant of the FluSurvey project please do so by visiting the <https://flusurvey.org.uk/en/accounts/register/> website for more information.

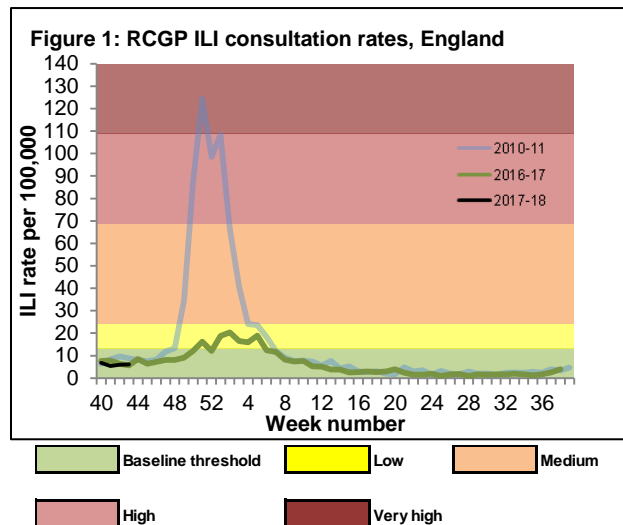
In week 43, the overall weekly influenza-like illness (ILI) GP consultation rate is low and is below the baseline threshold in England. In the devolved administrations, ILI rates were low in week 43.

- GP ILI consultations in the UK

RCGP (England)

- The weekly ILI consultation rate through the RCGP surveillance is at 6.1 per 100,000 in week 43 compared to 5.9 per 100,000 in week 42. This is below the baseline threshold (13.1 per 100,000) (Figure 3*). By age group, the highest rates were seen in 15-44 year olds (8.0 per 100,000) and 65-74 year olds (7.1 per 100,000).

*The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for GP ILI consultations for the start of influenza activity (based on 10 seasons excluding 2009/10) in a standardised approach across Europe. For MEM intensity threshold values, please visit: <https://www.gov.uk/guidance/sources-of-uk-flu-data-influenza-surveillance-in-the-uk#clinical-surveillance-through-primary-care>



UK

- In week 43, overall weekly ILI consultation rates across the countries of the UK were low.
- By age group, the highest rates were seen in the 45-64 in Scotland and Northern Ireland (13.9 per 100,000 and 4.5 per 100,000 respectively) and in the 15-44 year olds in Wales (9.3 per 100,000).

Table 1: GP ILI consultations in the UK for all ages with MEM thresholds applied*

GP ILI consultation rates (all ages)	Week number																
	40	41	42	43	44	45	46	47	48	49	50	51	52	1	2	3	4
England (RCGP)	6.8	5.4	5.9	6.1													
Wales	5.7	6.5	6.6	5.7													
Scotland	4.9	7.4	4.2	7.5													
Northern Ireland	3.4	3.9	3.7	3.3													

*The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for GP ILI consultations for the start of influenza activity (based on 10 seasons excluding 2009/10), in a standardised approach across Europe. For MEM threshold values for each country, please visit: <https://www.gov.uk/guidance/sources-of-uk-flu-data-influenza-surveillance-in-the-uk#clinical-surveillance-through-primary-care>

GP In Hours Syndromic Surveillance System (England)

-The weekly ILI consultation rate through the GP In Hours Syndromic Surveillance system is at 3.7 per 100,000 in week 43(Figure 4).

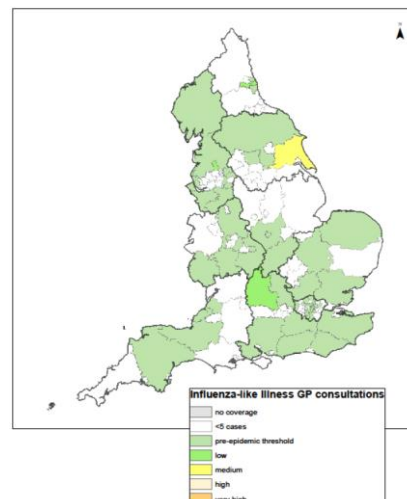
Small increases in bronchitis/bronchiolitis indicators (including ED attendances and GP OOH consultations) were noted in infants aged <1 year, in line with recent small increases in laboratory reports for respiratory syncytial virus (RSV).

Figure 4 represents a map of GP ILI consultation rates in week 42 across England by upper tier Local Authorities (utLA), with influenza-like illness surveillance MEM thresholds applied.

ILI consultation rates presented for each utLA on the map should be interpreted in context of regional and national ILI activity; as MEM thresholds are calculated (based on previous influenza seasons from 2012/13 onwards) separately for each of the nine PHE centres and utLA rates are then compared to Centre-level thresholds only, therefore utLAs with higher background rates than the Centre may appear to have higher ILI activity.

-For further information, please see the syndromic surveillance [webpage](#).

Figure 4: Map of GP ILI consultation rates in week 43

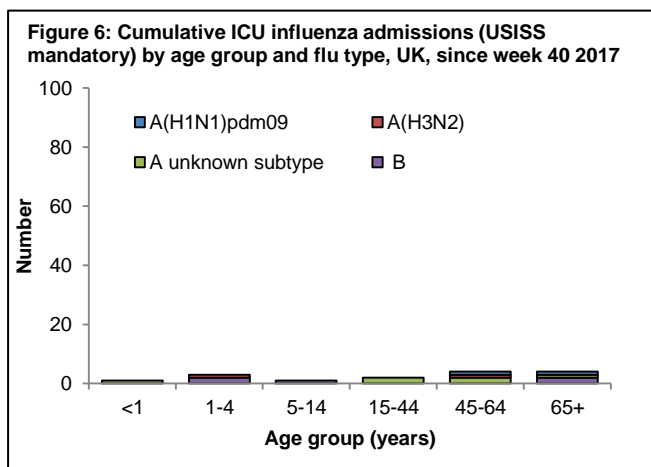
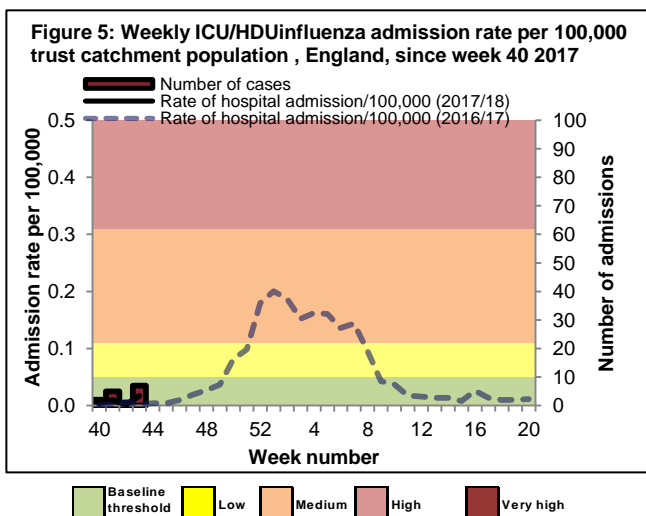


In week 43, there were seven admission to ICU/HDU with confirmed influenza (two influenza A(H3N2), two influenza A(unknown subtype) and three influenza B) reported through the USISS mandatory ICU/HDU surveillance scheme across the UK (116 Trusts). Eleven hospitalised confirmed influenza cases (one influenza A(H1N1pdm09), three influenza A(H3N2), three influenza A(unknown subtype) and four influenza B) were reported through the USISS sentinel hospital network across England (22 Trusts).

- Number of new admissions and fatal confirmed influenza cases in ICU/HDU (USISS mandatory ICU scheme), UK (week 43)

- In week 43, there was seven admission to ICU/HDU with confirmed influenza (two influenza A(H3N2), two influenza A(unknown subtype) and three influenza B) reported across the UK (116/155 Trusts in England) through the USISS mandatory ICU scheme, with a rate of 0.02 per 100,000 (Figures 6 and 7). No deaths were reported to have occurred in week 43.

A total of 15 admissions (two influenza A(H1N1)pdm09, two influenza A(H3N2), six influenza A(unknown subtype) and five influenza B) and three confirmed deaths have been reported since week 40 2017.



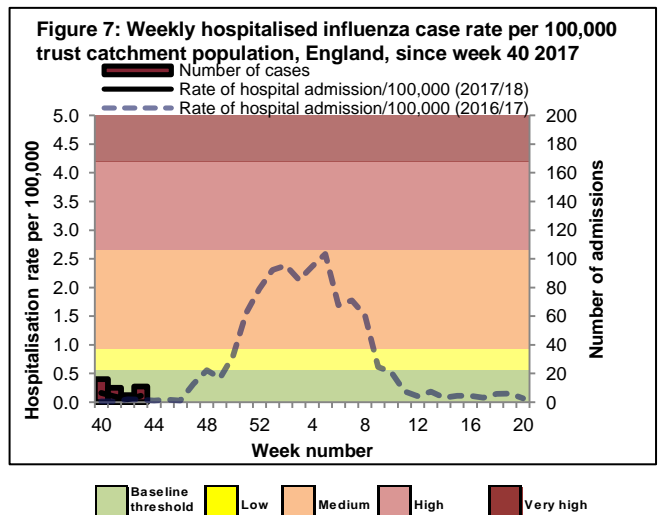
*The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for ICU/HDU admission rates for the start of influenza activity (based on 6 seasons) in a standardised approach across Europe. For MEM threshold values, please visit <https://www.gov.uk/guidance/sources-of-uk-flu-data-influenza-surveillance-in-the-uk#disease-severity-and-mortality-data>

- USISS sentinel weekly hospitalised confirmed influenza cases, England (week 43)

- In week 43, there were 11 hospitalised confirmed influenza cases (one influenza A(H1N1pdm09), three influenza A(H3N2), three influenza A(unknown subtype) and four influenza B) reported through the USISS sentinel hospital network from 22 NHS Trusts across England (Figure 8), a rate of 0.11 per 100,000 compared to 0.05 per 100,000 in the previous week.

A total of 42 hospitalised confirmed influenza admissions (eight influenza A(H1N1)pdm09, 15 influenza A(H3N2), six influenza A(unknown subtype) and 13 influenza B) have been reported since week 40 2017.

*The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for hospital admission rates for the start of influenza activity (based on 6 seasons) in a standardised approach across Europe. For MEM threshold values, please visit <https://www.gov.uk/guidance/sources-of-uk-flu-data>



- USISS Severe Respiratory Failure Centre confirmed influenza admissions, UK (week 43)

- In week 43, there were no laboratory confirmed influenza admissions reported from the six Severe Respiratory Failure (SRF) centres in the UK.

In week 43 2017 in England, no statistically significant excess all-cause mortality by week of death was observed through the EuroMOMO algorithm in England. In the devolved administrations, no significant excess all-cause mortality was observed in week 43 2017.

- All-cause death registrations, England and Wales

- In week 42 2017, an estimated 10,031 all-cause deaths were registered in England and Wales (source: [Office for National Statistics](#)). This is an increase compared to the 9,940 estimated death registrations in week 41 2017.

- Excess all-cause mortality by age group, England, Wales, Scotland and Northern Ireland

- In week 43 2017 in England, no excess mortality by week of death above the upper 2 z-score threshold was seen overall, by age group or subnationally, after correcting ONS disaggregate data for reporting delay with the standardised EuroMOMO algorithm (Figure 8). This data is provisional due to the time delay in registration; numbers may vary from week to week.

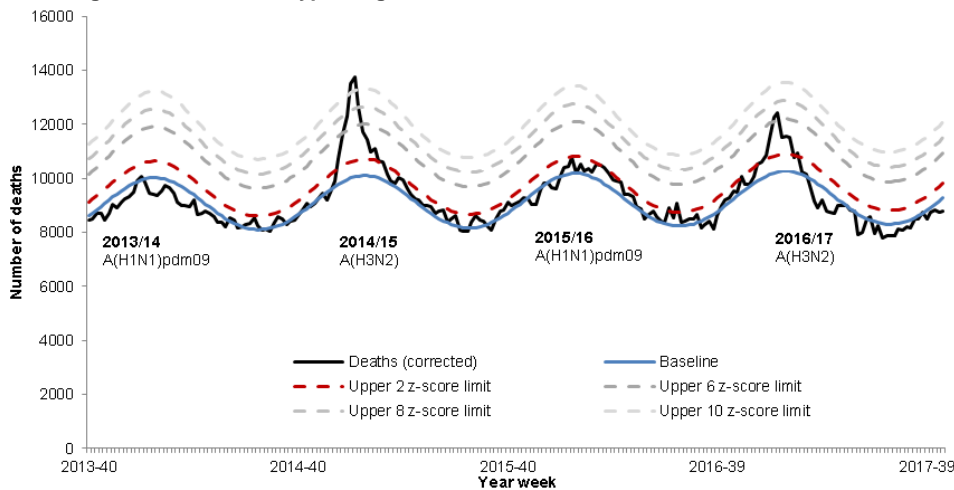
- In the devolved administrations, no significant excess mortality above the threshold was observed in week 43 (Table 2).

Table 2: Excess mortality by UK country, for all ages*

Country	Excess detected in week 43 2017?	Weeks with excess in 2017/18
England	x	NA
Wales	x	NA
Scotland	x	NA
Northern Ireland	x	NA

* Excess mortality is calculated as the observed minus the expected number of deaths in weeks above threshold

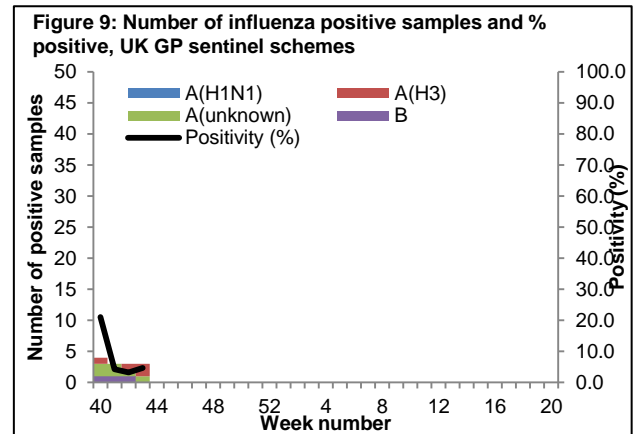
Figure 8: Weekly observed and expected number of all-age all-cause deaths, with the dominant circulating strain influenza A type, England, 2013 to 2017



In week 43 2017, three samples tested positive for influenza (two influenza A(H3) and one influenza A(unknown subtype)) through the UK GP sentinel schemes, with an overall positivity of 4.7%. Eighteen positive detections were recorded through the DataMart scheme (five influenza A(H3), five influenza A(unknown subtype), one influenza A(H1N1)pdm09 and eight influenza B) with a positivity of 1.5% in week 43. RSV activity continues to increase at 9.1% overall and 25.6% in < 5 year olds in week 43.

- Sentinel swabbing schemes in England (RCGP) and the Devolved Administrations

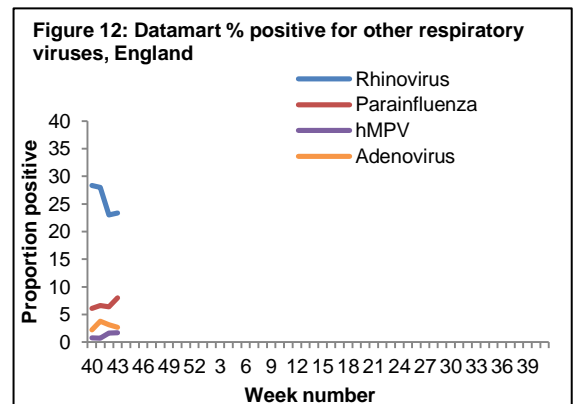
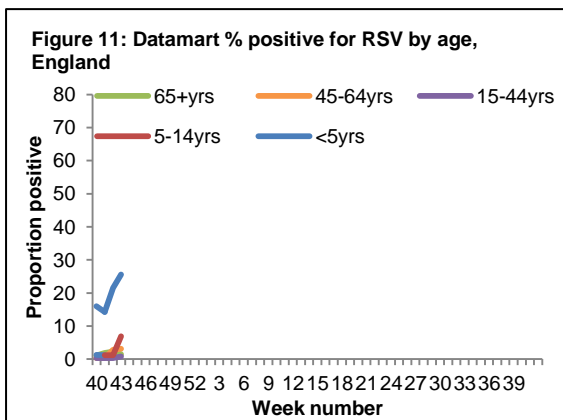
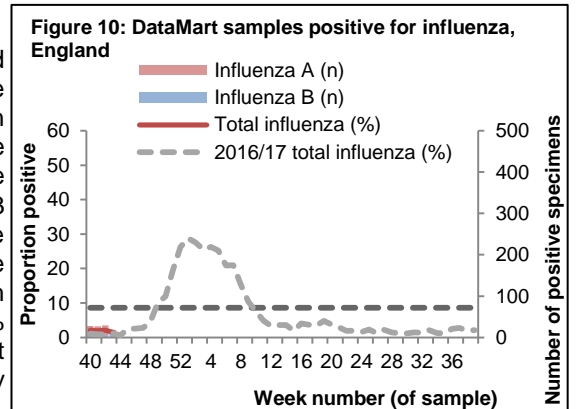
-In week 43, three samples tested positive for influenza (two influenza A(H3) and one influenza A(unknown subtype)) with an overall positivity of 4.7% through the UK GP sentinel swabbing schemes (Figure 9).



NB. Positivity (%) omitted when fewer than 10 specimens were tested

- Respiratory DataMart System (England)

In week 43 2017, out of the 1,210 respiratory specimens reported through the Respiratory DataMart System, 18 samples (1.5%) were positive for influenza (five influenza A(H3), four influenza A(unknown subtype), one influenza A(H1N1)pdm09 and eight influenza B) (Figure 10), which is below the MEM threshold for this season of 8.6%. The overall positivity for RSV continued to increase at 9.1% in week 43 compared to 6.3% in week 42. The highest positivity for RSV by age group was seen in the <5 year olds at 25.6% in week 43, an increase from 21.6% in week 42 (Figure 11). Rhinovirus positivity remained high at 23.4% in week 43. Adenovirus positivity decreased slightly from 3.1% in week 42 to 2.7% in week 43. Parainfluenza positivity remained high at 8.0% in week 43 and human metapneumovirus (hMPV) positivity remained low at 1.7% in week 43 (Figure 12).



*The Moving Epidemic Method has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for GP ILI consultations for the start of influenza activity in a standardised approach across Europe. The threshold to indicate a likelihood of influenza community circulation for Datamart % positive as calculated through the Moving Epidemic Method is 8.6% in 2017/18.

- Virus characterisation

PHE characterises the properties of influenza viruses through one or more tests, including genome sequencing (genetic analysis) and haemagglutination inhibition (HI) assays (antigenic analysis). These data are used to compare how similar the currently circulating influenza viruses are to the strains included in seasonal influenza vaccines, and to monitor for changes in circulating influenza viruses. The interpretation of genetic and antigenic data sources is complex due to a number of factors, for example, not all viruses can be cultivated in sufficient quantity for antigenic characterisation, so that viruses with sequence information may not be able to be antigenically characterised as well. Occasionally, this can lead to a biased view of the properties of circulating viruses, as the viruses which can be recovered and analysed antigenically, may not be fully representative of majority variants, and genetic characterisation data does not always predict the antigenic characterisation

The PHE Respiratory Virus Unit has characterised 35 influenza viruses detected since late summer (Table 3). Of the 7 A(H1N1)pdm09 influenza viruses that have been characterised, all belong in the genetic subgroup 6B.1, which was the predominant genetic subgroup in the 2016/17 season. The two viruses antigenically analysed are similar to the A/Michigan/45/2015 Northern Hemisphere 2017/18 (H1N1)pdm09 vaccine strain.

Genetic characterisation of 20 A(H3N2) influenza viruses detected since late summer, showed that they all belong to genetic subclade 3C.2a, with 12 belonging to a cluster within this genetic subclade designated as 3C.2a1. The Northern Hemisphere 2017/18 influenza A(H3N2) vaccine strain A/HongKong/4801/2014 belongs in genetic subclade 3C.2a.

Eight influenza B viruses have been analysed; 6 characterised as belonging to the B/Yamagata/16/88-lineage and 2 belonging to the B/Victoria/2/1987-lineage. Of 6 influenza B viruses antigenically characterised, two B/Victoria/2/87-lineage viruses were antigenically similar to B/Brisbane/60/2008, the influenza B/Victoria-lineage component of 2017/18 Northern Hemisphere trivalent and quadrivalent vaccines. Four B/Yamagata/16/88-lineage viruses were antigenically similar to B/Phuket/3073/2013, the influenza B/Yamagata-lineage component of 2016/17 Northern Hemisphere quadrivalent vaccine.

Table 3: Viruses characterised by PHE Reference Laboratory, 2017/18

Virus type/subtype	No. viruses characterised			
	Genetic and antigenic	Genetic only	Antigenic only	Total
A(H1N1)pdm09	2	5	0	7
A(H3N2)	0	20	0	20
B/Yamagata-lineage	2	2	2	6
B/Victoria-lineage	1	0	1	2

- Antiviral susceptibility

Influenza positive samples are screened for mutations in the virus neuraminidase gene known to confer oseltamivir and/or zanamivir resistance. Additionally, testing of influenza A (H1N1)pdm09, A(H3N2), and influenza B virus isolates for neuraminidase inhibitor susceptibility (oseltamivir and zanamivir) is performed at PHE-RVU using a functional assay. The data summarized below combine the results of both testing methods. The samples tested are routinely obtained for surveillance purposes, but diagnostic testing of patients suspected to be infected with neuraminidase inhibitor-resistant virus is also performed.

During the current 2017/18 season so far, four influenza A(H3N2) viruses have been tested for oseltamivir and zanamivir susceptibility; three are fully susceptible but one has E119V amino acid substitutions, causing resistance to oseltamivir but not affecting zanamivir susceptibility. Eight influenza A(H1N1)pdm09 virus have been tested for oseltamivir susceptibility and all were fully susceptible. One of the eight influenza A(H1N1)pdm09 virus was tested for zanamivir susceptibility and was fully susceptible. Two influenza B viruses have been tested for oseltamivir susceptibility and were fully susceptible.

- Antimicrobial susceptibility

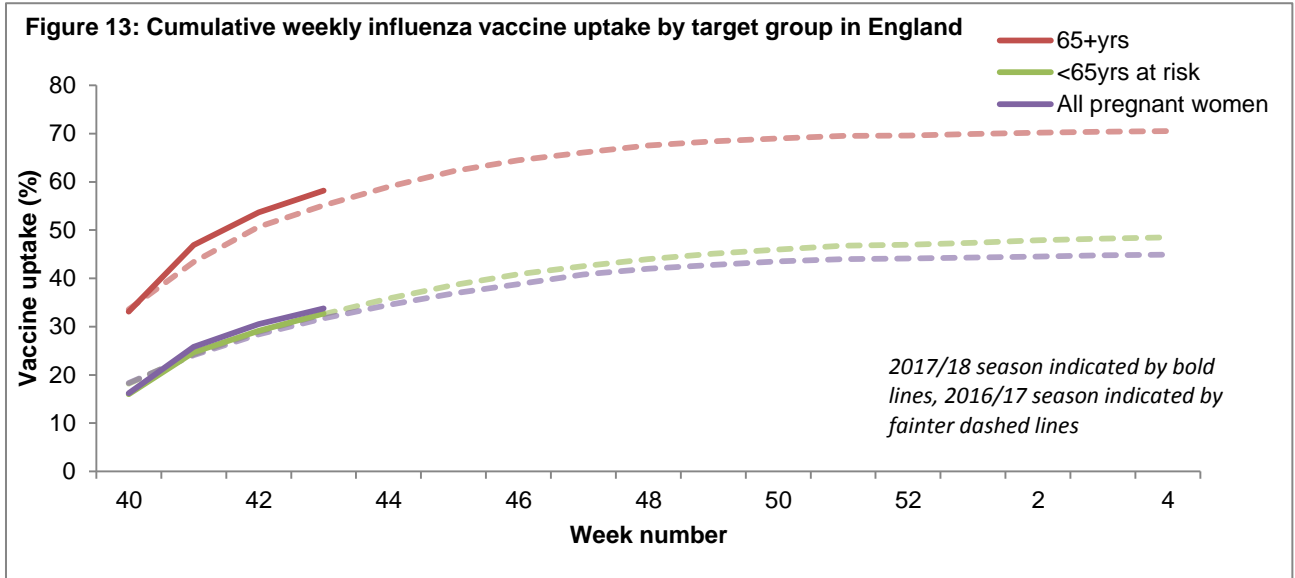
-Table 4 shows in the 12 weeks up to 29 October 2017, the proportion of all lower respiratory tract isolates of *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Staphylococcus aureus*, MRSA and MSSA tested and susceptible to antibiotics. These organisms are the key causes of community acquired pneumonia (CAP) and the choice of antibiotics reflects the British Thoracic Society empirical guidelines for management of CAP in adults.

Table 4: Antimicrobial susceptibility surveillance in lower respiratory tract isolates, 12 weeks up to 29 October 2017, E&W

Organism	Antibiotic	Specimens tested (N)	Specimens susceptible (%)
<i>S. pneumoniae</i>	Penicillin	357	86
	Macrolides	396	80
	Tetracycline	382	82
<i>H. influenzae</i>	Amoxicillin/ampicillin	1297	69
	Co-amoxiclav	1310	87
	Macrolides	471	12
	Tetracycline	1313	98
<i>S. aureus</i>	Methicillin	605	91
	Macrolides	656	68
MRSA	Clindamycin	37	35
	Tetracycline	54	83
MSSA	Clindamycin	320	80
	Tetracycline	519	95

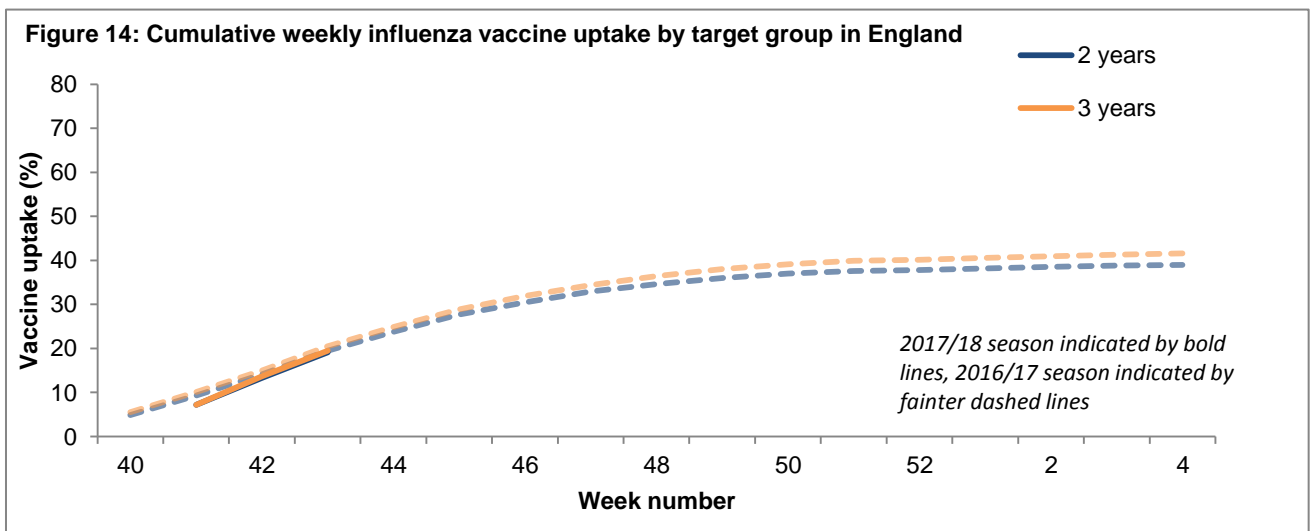
*Macrolides = erythromycin, azithromycin and clarithromycin

- Up to week 43 2017 in 75.8% of GP practices reporting weekly to Immform, the provisional proportion of people in England who had received the 2017/18 influenza vaccine in targeted groups was as follows (Figure 12):
 - 32.7% in under 65 years in a clinical risk group
 - 33.8% in pregnant women
 - 58.2% in 65+ year olds



- In 2017/18, all two- and three-year-olds continue to be eligible for flu vaccination, through their GPs. Up to week 43 2017 in 61.8% of GP practices reporting weekly to Immform, the provisional proportion of children in England who had received the 2017/18 influenza vaccine in targeted groups was as follows (Figure 14):
 - 19.1% in 2 year olds
 - 19.5% in 3 year olds

In addition, the programme has been extended to children of school years Reception (4 year olds), 1, 2, 3 and 4 age. The data for the school programme, including 4 year olds, will be included in the monthly report to be published on 23 November 2017.



Declining levels of influenza activity were reported in the temperate zone of the southern Hemisphere and influenza activity remained at low levels in the temperate zone of the northern hemisphere. Worldwide, influenza A(H3N2) and B viruses accounted for the majority of influenza detections.

- [Europe](#) updated on 27 October 2017 (Joint ECDC-WHO Influenza weekly update)

In week 42, low influenza activity was reported by 39 reporting countries and one country reported medium intensity.

For week 42/2017, 14 (3%) of 500 sentinel specimens tested positive for influenza viruses: 3 unsubtyped A viruses, 4 A(H3N2), 2 A(H1N1)pdm09, 4 B/Yamagata lineage and 1 B virus not ascribed to a lineage.

Since week 40/2017, 21 influenza virus-infected cases were reported by three countries that conduct surveillance of hospitalized laboratory-confirmed influenza cases in intensive care units or other wards: 8 cases in ICU in the United Kingdom, 11 in Ireland and 2 in the Czech Republic from other wards. Of these 21 cases, 16 (76%) were found to be infected with type A viruses and 5 (24%) with type B viruses. Of subtyped A viruses, 5 (71%) were A(H1N1)pdm09 and 2 (29%) were A(H3N2) viruses.

For week 42/2017, 8 563 specimens from non-sentinel sources were tested (such as hospitals, schools, non-sentinel primary care facilities, nursing homes and other institutions), of which 79 were positive for influenza viruses. Of these 79 detections, two thirds were type A and one third type B viruses (Table 2). Among subtyped A viruses (n=20), the vast majority (95%) were A(H3N2) viruses.

For week 42/2017, data from the 20 countries or regions reporting to the EuroMOMO project indicated all-cause mortality at expected levels for this time of the year.

- [United States of America](#) updated on 27 October 2017 (Centre for Disease Control report)

During week 42, influenza activity was low in the United States.

The most frequently identified influenza virus type reported by public health laboratories during week 42 was influenza A. The percentage of respiratory specimens testing positive for influenza in clinical laboratories is low.

The proportion of deaths attributed to pneumonia and influenza (P&I) was below the system-specific epidemic threshold in the National Center for Health Statistics (NCHS) Mortality Surveillance System.

The first influenza-associated pediatric death of the 2017-2018 season occurred and was reported to CDC during week 42 (the week ending October 21, 2017). This death was associated with an influenza A (H1N1)pdm09 virus.

The proportion of outpatient visits for influenza-like illness (ILI) was 1.3%, which is below the national baseline of 2.2%.

- [Canada](#) updated on 27 October 2017 (Public Health Agency report)

Overall, influenza activity remains at inter-seasonal levels across the country in week 42.

The percentage of laboratory tests positive for influenza remains higher for this time of year compared to previous seasons. The majority of influenza detections continue to be A(H3N2).

Influenza-related hospitalizations, primary care consultations for ILI and regions reporting sporadic activity are in the higher range of expected levels for this time of year.

In week 42, 1.6% of visits to healthcare professionals were due to influenza-like illness.

In week 42, 18 influenza-associated hospitalizations were reported by participating provinces and territories.

To date this season, 74 influenza-associated hospitalizations have been reported, 97% of which were associated with influenza A, and 54 cases (73%) were in adults 65 years of age or older. The number of cases is considerably elevated relative to this period last year. Fewer than 5 ICU admissions and deaths have been reported.

- [Global influenza update](#) updated on 30 October 2017 (WHO website)

Declining levels of influenza activity were reported in the temperate zone of the southern hemisphere and in some countries of South and South East Asia. In Central America and the Caribbean, low influenza activity was reported in a few countries. Influenza activity remained at low levels in the temperate zone of the northern hemisphere. Worldwide, influenza A(H3N2) and B viruses accounted for the majority of influenza detections.

In temperate South America, influenza and respiratory syncytial virus (RSV) activity continued a downward trend throughout most of the sub-region. In the tropical countries of South America, influenza and RSV activity remained at low levels overall.

In Southern Africa, influenza activity continued to decrease in South Africa, with influenza B viruses most frequently detected.

In Oceania, seasonal influenza activity continued to decline, with influenza A(H3N2) predominant, followed by B viruses.

In the Caribbean and Central American countries, respiratory illness indicators and influenza activity remained low in general but RSV activity remained high in several countries.

In Southern Asia, influenza activity remained low in general. Influenza A(H1N1)pdm09 and A(H3N2) virus detections continued to be reported in India. In South East Asia, influenza activity decreased in most of the countries, with the exception of Cambodia where an increasing trend of influenza activity continued to be reported, with influenza A(H3N2) viruses predominant.

In Western Asia, influenza activity continued to increase in Oman, with influenza A(H1N1)pdm09 virus predominantly detected followed by a small proportion of A(H3N2) and B viruses. In East Asia, influenza activity remained low in general.

In Western and Middle Africa, influenza detections continued to be reported, with all seasonal influenza subtypes present in the region. In Eastern Africa, little influenza activity was reported with exception of Réunion Island (French Overseas Department) where influenza detections and influenza like illness (ILI) activity remained elevated, with influenza A and B viruses co-circulating.

In Northern Africa, little to no influenza virus detections was reported.

In Central Asia, ILI and severe acute respiratory infection (SARI) indicators appeared to increase in Kazakhstan, Tajikistan and Uzbekistan, with few influenza detections.

In Europe, influenza activity remained low, with detections of predominantly influenza A(H3N2) and B viruses in the past weeks.

In North America, overall influenza virus activity remained low with detections of predominantly influenza A(H3N2) and B viruses in the past few weeks.

The WHO GISRS laboratories tested more than 84,217 specimens from 02 October 2017 to 15 October 2017. 4,193 were positive for influenza viruses, of which 3,269 (78%) were typed as influenza A and 924 (22%) as influenza B. Of the sub-typed influenza A viruses, 524 (20.6%) were influenza A(H1N1)pdm09 and 2,022 (79.4%) were influenza A(H3N2). Of the characterized B viruses, 234 (71.8%) belonged to the B-Yamagata lineage and 92 (28.2%) to the B-Victoria lineage.

- [Avian Influenza](#) latest update on 27 October 2017 (WHO website)

Influenza A(H5) viruses

Since the last update on [25 July 2017](#), one new laboratory-confirmed human case of influenza A(H5N1) virus infection was reported to WHO from Indonesia.

Since 2003, a total of 860 laboratory-confirmed cases of human infection with avian influenza A(H5N1) virus, including 454 deaths, have been reported to WHO from 16 countries. The last human cases of A(H5N1) virus infection reported from Indonesia occurred in 2015.

Influenza A(H5) subtype viruses have the potential to cause disease in humans and thus far, no human cases, other than those with influenza A(H5N1) and A(H5N6) viruses, have been reported to WHO. According to reports received by the World Organisation for Animal Health (OIE), various influenza A(H5) subtypes continue to be detected in birds in Africa, Europe and Asia. For more information on the background and public health risk of these viruses, please see the WHO assessment of risk associated with influenza A(H5N8) virus [here](#).

Influenza A(H7N9)

Between [25 July to 27 September 2017](#), 7 laboratory-confirmed human cases of influenza A(H7N9) virus infection were reported to WHO from China.

As of 27 September 2017, a total of 1564 laboratory-confirmed cases of human infection with avian influenza A(H7N9) viruses, including at least 612 deaths, have been reported to WHO.

Influenza A(H9N2)

Since 25 July 2017, one laboratory-confirmed human cases of A(H9N2) virus infection was reported to WHO from China.

Influenza A(H1N2) variant viruses

Two human infections with influenza A(H1N2)v viruses were detected in the state of Ohio in the United States (U.S).

Influenza A(H3N2) variant viruses

Since 25 July 2017, 19 human infections with influenza A(H3N2)v viruses were detected in the U.S. in several states.

Since reporting of novel influenza A viruses became nationally notifiable in 2005, 403 human infections with influenza A(H3N2)v viruses have been reported to the U.S. CDC and 31 of these occurred in 2017.

- [Middle East respiratory syndrome coronavirus \(MERS-CoV\)](#) latest update on 25 October 2017

Up to 01 November 2017, a total of four cases of Middle East respiratory syndrome coronavirus, MERS-CoV, (two imported and two linked cases) have been confirmed in the UK. On-going surveillance has identified 1,085 suspect cases in the UK that have been investigated for MERS-CoV and tested negative.

Between [31 August and 26 September 2017](#), the national IHR focal point of Saudi Arabia reported nine additional cases of Middle East Respiratory Syndrome (MERS), including four deaths. In addition, four deaths from previously reported cases were reported.

Globally, since September 2012, WHO has been notified of 2,090 laboratory-confirmed cases of infection with MERS-CoV, including at least 730 related deaths. Further information on management and guidance of possible cases is available [online](#). The latest ECDC MERS-CoV risk assessment can be found [here](#), where it is highlighted that risk of widespread transmission of MERS-CoV remains low.

Acknowledgements

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Related links

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Sources of flu data

- [Clinical surveillance through primary care in the UK](#)
- [Outbreak reporting](#)
- [FluSurvey](#)
- [MOSA](#)
- [Real time syndromic surveillance](#)
- MEM threshold [methodology paper](#) and [UK pilot paper](#)

Disease severity and mortality data

- [USISS](#) system
- [EuroMOMO](#) mortality project

Vaccination

- Seasonal influenza vaccine programme ([Department of Health Book](#))
- Childhood flu programme information for healthcare practitioners ([Public Health England](#))
- 2017/18 Northern Hemisphere seasonal influenza vaccine recommendations ([WHO](#))