Between 21 Apr and 29 May 2017, the National IHR Focal Point of Saudi Arabia reported 25 additional cases of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) infection including six fatal cases:

- On 16 May 2017, the IHR NFP of the United Arab Emirates reported two additional cases of MERS-CoV. Both cases were reported from Al Ain city and both have reported direct links to dromedaries.
- On 23 May 2017, the National IHR Focal Point of Qatar reported one additional case of MERS-CoV in a 29-year-old male from Doha, who had frequent contact with dromedaries.

Saudi Arabia accounts for 81.5 percent of the total number of cases of MERS-CoV infection and 95.1 percent of the total number of fatalities attributable to MERS-CoV infection reported to the WHO.

While transmission of the MERS-CoV documented in Bisha and Wadi Aldawasir appears to have been interrupted, nosocomial transmission is still continuing in Riyadh as seen in the section above. With today's [6 June 2017] addition of two more nosocomial infections, the tally of cases/infections related to the nosocomial transmission in Riyadh is now up to 16 cases (11 of whom are identified as asymptomatic contacts), with an additional three cases identified in Riyadh still under investigation for possible high-risk exposure.

Comment
On 06 June, there were a total number of 1,632 (laboratory-confirmed) MERS-CoV cases including 668 deaths (case fatality rate: 40.9%).

Close contacts to dromedary camels are common throughout the Arabian Peninsula, and it remains a puzzle as to why Saudi Arabia has 80% of the reported cases. It may be a simple proportion according to the population size with Saudi Arabia being by far the most populous country with approximately 22 million inhabitants.

MERS-CoV does not seem at present to have pandemic potential even though the outbreak in Korea from a single traveller showed that close contact to patients, in that case in overcrowded health care facilities, can facilitate rapid spread.

In contrast to Korea, the situation in Saudi Arabia seems to be the continuous introduction into humans resulting in new transmission chains giving rise to a limited number of new cases, and indeed the transmission potential, $R_0$, has been estimated to be below 1.

Why is Saudi Arabia different?
One reason could be the continuous import of dromedaries from East Africa. A study by Miguel et al found a frequency of MERS-CoV of up to 15.7% (95%CI: 8.2-28.0) in camels bred in Ethiopia, up to 12.2% (95% CI: 7-20.4) in camels bred in Burkina Faso and up to 7.6% (95% CI: 1.9-26.1) in camels bred in Morocco [1]. As imported animals could be a source of MERS-CoV in Saudi Arabia, pilot screening of these animals is urgently needed to test this hypothesis.
The findings in that study also indicate that travelers with undiagnosed pneumonia from countries in East Africa from Ethiopia (Somalia, Eritrea, Sudan ?) throughout the Sahel where camels are common, should be tested for MERS-CoV.


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