

ទ្វាយប្រាប់ ការពារុករែបគ្រោះ គ្រែចំកែវិកាង

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ការពិនិត្យ - តុលាកម្ម 2530

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IMPORTED PARALYTIC POLIOMYELITIS

UNITED STATES OF AMERICA. — In May 1986, a 29-year-old Californian woman contracted paralytic poliomyelitis while travelling in Asia. She had worked and travelled in Nepal from January through 2 May, and she visited Burma between 3 and 9 May. On 10 May, she travelled to Thailand, where she had onset of fever (a temperature of 38.9 °C), malaise, and a feeling of weakness lasting 1 day. On 16 May, she again had symptoms: fever (a temperature of 40.1 °C), headache, and low back pain. On 17 May, she experienced weakness in the lower extremities (right more than left), constipation, and urinary retention. On 19 May, she was unable to walk and was hospitalized in Bangkok. A flaccid paralysis of the lower extremities without sensory or bulbar involvement was noted. Cerebrospinal fluid contained 90 leukocytes, of which 93% were lymphocytes.

The patient returned to the United States on 6 June, confined to a wheelchair. On examination, she was noted to have flaccidity and no deep-tendon reflexes in the right lower extremity. Her sensory modalities were intact; constipation and urinary retention had resolved. Poliovirus type 1 was isolated from stool collected on 22 June and subsequently characterized as "wild-like" by genomic sequencing. Electromyography and nerve-conduction studies performed on 26 June were consistent with axonal neuropathy of poliomyelitis. The results of serological tests for immunoglobulin IgG, IgA, and IgM were within normal ranges. At 60 days after the onset of weakness, she had residual paralysis of the right leg below the knee.

The patient had an immunization history of 3 doses of inactivated poliovirus vaccine (IPV) in the late 1950s and 1 "sugar cube" (not known whether it contained a monovalent [MOPV] or a trivalent oral poliovirus vaccine [OPV]) at a mass clinic in the early 1960s. The patient had travelled previously in Asia and elsewhere, but had not received any doses of poliovirus vaccine before any departures.

MMWR EDITORIAL NOTE: The last cases of paralytic poliomyelitis acquired in the United States and caused by wild poliovirus occurred in 1979. From 1980 through 1985, 4 reported cases of paralytic poliomyelitis caused by wild virus occurred among United States citizens—all persons returning from developing countries. These imported cases represent 7% of the 55 cases of paralytic poliomyelitis reported during the 6-year period 1980-1985. The other 51 cases were vaccine-associated. During the preceding 6-year period (1974-1979), 9 (12%) of 78 reported cases of paralytic poliomyelitis were imported. Of the 13 cases of imported poliomyelitis reported between 1974 and 1985, 6 (46%) were over 18 years of age. The immunization status of the 13 patients was as follows:

- (a) 7 had no history of poliovirus immunization;
- (b) 4 had received 1 or 2 doses of poliovirus vaccine (1 had had 2 doses of OPV; 2, 1 dose of OPV; and 1, 1 dose of IPV); and
- (c) 2 had completed at least a primary series (1 with 3 doses of OPV and the other with 5 doses of IPV, 3 doses of MOPV, and 1 dose of OPV).

In addition, some inappropriately immunized United States residents and others may become infected asymptotically while in an area with endemic poliomyelitis and may excrete wild poliovirus temporarily after entering the United States.

Travellers to countries with endemic or epidemic poliomyelitis should be fully immunized. The only countries currently considered free of endemic wild poliovirus circulation are Australia, Canada, Japan, New Zealand, the United States and most of Eastern and Western Europe. Before visiting other countries, every traveller should have received, at a minimum, a complete primary series of immunizations. In addition, the Immunization Practices Advisory Committee (ACIP) recommends that persons who have previously completed a primary series receive an additional dose of poliovirus vaccine, generally as OPV, before travel.

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