WEEKLY EPIDEMIOLOGICAL REPORT

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Invasive Meningococcal Disease: Current Outbreak in the UK and the Sri Lankan Context - I

This is the first article of two in a series on "Invasive Meningococcal Disease: Current Outbreak in the UK and the Sri Lankan Context - I"

Introduction

Infectious diseases often remind us of their presence in quiet, expected ways such as seasonal patterns, predictable outbreaks and familiar surveillance trends. Yet, every so often, a disease that is considered rare re-emerges with an urgency that captures both clinical attention and public concern.

In March 2026, such a moment unfolded in Kent, United Kingdom, where a cluster of severe infections among young people rapidly escalated into an outbreak of invasive meningococcal disease (IMD). Within days, what began as a handful of cases evolved into a high-profile public health event marked by hospitalizations, fatalities, and widespread preventive interventions.

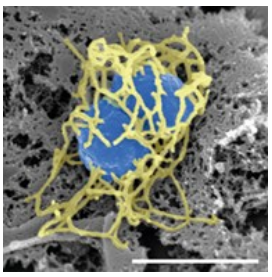
What makes this outbreak especially noteworthy is not only its severity but also the context in which it occurred – within a country with a well-established immunization programme and advanced surveillance systems. It serves as a powerful reminder that even rare diseases can exploit gaps in population immunity and social mixing patterns to spread rapidly.

For Sri Lanka, where meningococcal disease is infrequently reported and remains largely under-characterized, this outbreak provides an opportunity to reflect, not with alarm but with preparedness. It invites us to consider what is known, what remains unseen and how best to strengthen our systems in anticipation of the unexpected.

The United Kingdom Outbreak: A Rapidly Evolving Cluster

In March 2026, the UK Health Security Agency (UKHSA) reported an outbreak of invasive meningococcal disease (IMD) in Canterbury, Kent, involving a cluster of cases occurring within a short time period.

- Total cases (as of 18 March 2026): 20 (confirmed and probable)
- Deaths: 2
- Primary group affected: adolescents and university students
- Identified strain: predominantly Neisseria meningitidis group B



A notable epidemiological feature was the linkage of several cases to shared social environments, including attendance at crowded venues. This reflects the well-established mode of transmission of Neisseria meningitidis, which spreads through respiratory droplets and close interpersonal contact.

Unlike many communicable diseases, meningococcal transmission does not require prolonged exposure. Short close interactions may be sufficient, especially in crowded settings.

Understanding the Drivers of the Outbreak

The occurrence of this outbreak in a high-income setting highlights an important epidemiological concept: heterogeneity in population immunity. Although the United Kingdom has established meningococcal vaccination programme, including:

- MenB vaccine introduced in 2015 for infants
- MenACWY vaccine for adolescents

Many individuals within the affected age group had not received the MenB vaccine, as they were born prior to its introduction. This created a cohort-specific immunity gap, allowing transmission within a susceptible population, especially in environments characterized by close contact and intense social interaction.

Clinical & Public Health Significance
Invasive meningococcal disease is characterized by:

- Rapid onset and progression
- High case fatality (approximately 8-15%)
- Potential for severe complications among survivors.

Clinical manifestations include meningitis, septicaemia, or a combination of both. Early symptoms are often non-specific, which may delay diagnosis. However, deterioration can occur rapidly within hours, emphasizing the importance of early recognition and treatment.

The severity of the Kent outbreak was evident from:

- Universal need for hospitalization among confirmed cases
- Occurrence of fatalities
- Rapid increase in case numbers within a short time period

Public Health Response in the United Kingdom
The response to the outbreak was swift and comprehensive, demonstrating key principles of outbreak control. These include:

1. **Case detection and surveillance**: Enhanced surveillance and laboratory confirmation were rapidly implemented
2. **Contact tracing**: close contacts were identified and risk-assessed.
3. **Chemoprophylaxis:** Over 2,500 individuals received antibiotics to prevent secondary transmission
4. **Targeted vaccination:** MenB vaccination was offered to high-risk groups, especially students in residential settings.
5. **Risk communication:** Clear public health messaging was disseminated to clinicians, institutions, and the general public.

This coordinated approach reflects established best practices in the management of meningococcal outbreaks.

Relevance to Sri Lanka
While the events in the United Kingdom may seem geographically distant, the epidemiological questions they raise are highly relevant to our own setting. In Sri Lanka, meningococcal disease is rarely reported, and its true burden remains uncertain.

Current Situation in Sri Lanka
Surveillance data from the Epidemiology Unit indicate that approximately 1000 suspected cases of meningitis are notified annually and these include both bacterial and viral causes. However, meningococcal disease represents only a small proportion of these cases (around 10-12 cases usually reported each year).

Evidence from Sri Lankan literature
A case series of 11 cases of invasive meningococcal sepsis that occurred during a period of eight months was documented. suggesting possible localized clustering. Age of presentation ranged from 1.5 to 67 years, with 7 of these males (63.6%). Four patients were found to be associated with inmates of two prisons. The majority of the patients were from urban, crowded areas in Colombo and the adult working population. All were promptly treated with antibiotics on suspicion, and chemoprophylaxis to contacts of these sporadic cases was prescribed. Four patients (36.3%) died, while the others recovered without any complication (Galappaththi et al, 2021).

Individual case reports describing severe presentations, including septic shock and meningitis have also been documented such as the case reports of meningococcaemia with meningitis in a 9 year old child who had high grade fever with acute confusion, vomiting, loose stools, purpuric rash over the limbs, and features of shock. The child recovered with supportive care and early treatment with appropriate antibiotics (Srinekethan, Niruba, Rajeevan et al, 2025).

No major meningococcal meningitis outbreaks have been reported in Sri Lanka, but sporadic cases among prison inmates and a few isolated cases among children have been reported by the Epidemiology Unit in past years. In these instances, immediate quarantining of those exhibiting symptoms, limiting movement of close contacts and chemoprophylaxis being administered for all who were in contact with the index cases are conducted (Special investigation reports - Epidemiology Unit).

Reviews conducted in the region (Vyse, Wolter, Chen et al, 2011) indicate minimal national level data on meningococcal disease.

These findings suggest that while meningococcal disease does occur in Sri Lanka, it is likely under-recognized and under-documented.

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 To be Continued….

Table 1: Distribution of Notified Diseases reported by Medical Officers of Health 23rd – 29th Mar 2026 (13th Week)

RDHS	Dengue Fever		Dysentery		Encephalitis		En. Fever		F. Poison-		Leptospirosis		Typhus		Viral Hep.		H. Rabies		Chickenpox		Meningitis		Leishman.		Tuberculosis		Leprosy		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	316	5181	0	3	0	1	0	4	1	11	4	115	0	0	0	3	0	0	12	173	3	17	0	1	38	481	5	58	**92**	**96**
Gampaha	194	2994	0	13	1	11	0	0	0	8	8	168	0	3	0	3	0	0	24	253	4	73	1	6	25	279	2	23	**91**	**93**
Kalutara	122	1198	2	14	0	2	2	6	1	6	16	143	0	1	0	2	0	0	18	247	0	17	0	0	7	160	2	29	**90**	**98**
Kandy	68	834	2	20	1	1	0	3	1	9	3	65	2	17	1	9	0	0	17	191	0	11	2	23	14	155	0	5	**100**	**100**
Matale	17	344	0	3	0	1	0	0	0	0	2	66	0	2	0	5	0	0	8	65	3	12	18	160	1	41	1	6	**80**	**98**
Nuwara Eliya	4	113	1	20	0	1	0	2	0	6	5	87	1	19	1	8	0	0	13	141	1	34	0	0	3	63	0	2	**96**	**100**
Galle	114	1457	2	8	0	2	0	3	5	35	11	171	0	11	0	7	0	0	34	298	3	47	0	1	10	103	2	10	**70**	**100**
Hambantota	29	642	1	23	0	0	0	0	1	6	0	60	0	10	1	8	0	0	5	87	2	12	11	80	1	34	0	6	**11**	**100**
Matara	83	1521	0	3	0	1	0	0	0	11	11	100	0	4	0	7	0	0	21	206	0	13	3	48	7	46	0	6	**4**	**91**
Jaffna	30	468	2	16	0	3	3	14	0	5	2	38	17	165	0	0	0	0	23	169	0	11	0	0	1	50	1	7	**95**	**100**
Kilinochchi	4	36	0	1	0	0	0	3	0	0	2	17	0	8	0	2	0	1	0	52	0	1	0	0	0	9	0	1	**87**	**100**
Mannar	1	26	0	0	0	1	0	0	0	0	1	18	0	1	0	0	0	0	0	26	0	2	0	2	0	10	0	1	**100**	**100**
Vavuniya	5	49	0	5	0	1	0	1	4	6	1	25	0	3	0	0	0	0	2	35	0	7	0	9	3	20	0	1	**100**	**100**
Mullaitivu	1	33	0	3	0	0	0	0	0	1	1	20	0	0	0	1	0	0	1	3	0	2	0	3	0	10	0	4	**100**	**100**
Batticaloa	40	588	0	26	0	3	0	1	0	15	2	62	0	0	1	6	0	0	5	96	2	10	0	0	0	48	3	37	**18**	**100**
Ampara	7	165	2	20	0	1	0	1	0	6	2	55	0	1	0	3	0	0	6	126	2	15	1	5	2	16	2	13	**90**	**100**
Trincomalee	30	247	1	9	0	2	0	2	1	6	1	31	0	7	1	2	0	0	8	55	0	14	0	5	2	43	0	2	**100**	**100**
Kurunegala	26	491	0	4	0	7	1	3	0	55	4	116	0	20	0	4	0	0	21	236	3	44	7	128	1	81	0	17	**44**	**100**
Puttalam	14	322	0	9	0	5	0	0	0	1	1	93	0	14	0	2	1	2	6	59	2	27	0	6	2	48	0	10	**23**	**67**
Anuradhapura	12	245	0	8	0	3	0	0	2	33	6	113	1	16	2	6	0	0	19	145	6	22	12	251	8	67	4	19	**91**	**58**
Polonnaruwa	14	145	0	7	0	2	0	0	0	19	13	93	1	3	0	13	0	0	11	167	0	12	5	188	3	22	3	22	**88**	**99**
Badulla	21	312	0	13	1	5	1	3	0	5	5	79	1	11	3	47	0	0	12	117	0	19	0	30	6	69	0	5	**73**	**100**
Monaragala	16	258	0	9	0	3	1	1	0	0	11	100	1	16	1	20	0	0	2	94	2	16	3	61	2	24	0	9	**65**	**100**
Ratnapura	90	1173	2	15	0	4	0	3	2	9	20	259	1	15	0	5	0	0	15	144	4	15	7	62	13	115	0	10	**99**	**100**
Kegalle	37	549	1	13	0	2	0	2	0	14	5	107	0	5	0	3	0	0	23	221	2	22	1	6	8	86	0	2	**99**	**100**
Kalmunai	36	350	0	16	0	0	0	0	0	12	1	30	0	1	0	1	0	0	19	169	1	16	0	0	5	35	1	15	**92**	**100**
SRILANKA	**1331**	**19741**	**16**	**281**	**3**	**62**	**8**	**52**	**18**	**279**	**138**	**2231**	**25**	**353**	**11**	**167**	**1**	**3**	**325**	**3575**	**40**	**491**	**71**	**1075**	**162**	**2115**	**26**	**320**	**77**	**96**

Source: WRCD module of the EPINET.
A = Cases reported during the current week;
T*=Timeliness refers to returns received on or before 29th Mar, 2026.
B = Cumulative cases for the year.
Total number of reporting units 360.
C**-Completeness;

Table 2: Selected Vaccine Preventable Diseases & AFP 23rd – 29th Mar 2026 (13th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2026	Number of cases during same week in 2025	Total number of cases to date in 2026	Total number of cases to date in 2025	Difference between the number of cases to date in 2026 & 2025
	W	C	S	N	E	NW	NC	U	Sab					
AFP[1]	00	00	00	00	00	00	00	00	00	00	04	22	19	15.7%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps[2]	04	00	00	00	00	01	00	01	00	06	04	47	39	20.5 %
Measles[3]	01	00	00	00	00	00	00	00	00	01	00	01	01	0 %
Rubella[3]	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
CRS[2]	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Tetanus[2]	00	00	00	00	00	00	00	00	00	00	00	01	02	-50 %
Neonatal Tetanus[2]	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis[3]	00	00	00	00	00	00	00	00	00	00	00	00	04	-100 %
Whooping Cough[2]	00	00	00	00	00	00	00	00	01	01	00	07	07	0 %

Key to Table 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

Data Sources:
Weekly Return of Communicable Diseases: Diphtheria, Mumps, Tetanus, Neonatal Tetanus, Whooping Cough.
Special Surveillance: AFP, Measles, Rubella, CRS.

AFP[1] = No Polio cases
Mumps[2], CRS[2], Tetanus[2], Neonatal Tetanus[2], Whooping Cough[2]—Clinically and/ or laboratory confirmed cases
Measles[3], Rubella[3], Japanese Encephalitis[3]— Laboratory Confirmed cases

AFP—Acute Flaccid Paralysis
CRS = Congenital Rubella Syndrome
NA = Not Available

AFP and all Vaccine Preventable Diseases except Mumps should be investigated by the MOH Personally.

Take prophylaxis medications for Leptospirosis during the paddy cultivation and harvesting seasons.
It is provided free by the MOH office / Public Health Inspectors.

Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiology Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk.** The Epidemiology Unit should be formally acknowledged in all resulting publications as the primary data source.

ON STATE SERVICE

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