

(dengue and possibly RVF) have been reported in recent years in Somalia: RVF outbreaks occurred during 1997–1998 and 2006–2007 (6,7), and a dengue outbreak occurred during 1992–1993 (8).

The current outbreak in Somalia could have been triggered by several factors, including circulation of CHIKV in neighboring Kenya (references 8,9 in online Technical Appendix) and heavy rains that led to flooding in southern and central Somalia beginning in January 2016 (reference 1 in online Technical Appendix). CHIKV has the potential to provoke explosive outbreaks in naive populations (9), so the current outbreak may greatly affect the economy and public health in Somalia.

Systematic studies to understand the magnitude of the ongoing epidemic are needed. In the meantime, local public health stakeholders in Somalia and healthcare workers worldwide caring for travelers returning from Somalia should be aware that CHIKV is circulating in the country. This report confirms the importance of travel medicine services in performing early diagnosis of imported arboviral diseases, not only to thwart secondary transmission during periods of competent vector activity but also to help to detect or confirm virus circulation in previously unaffected countries.

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Meningococcal Disease in US Military Personnel before and after Adoption of Conjugate Vaccine

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To the Editor: In their recent letter (1), Broderick et al. provided useful information about the remarkable declines in incidence of meningococcal disease among active-duty US military personnel since the early 1970s, when meningococcal vaccination began within that population. The authors reported that the incidence of meningococcal disease from vaccine-covered serogroups was 0.183 cases/100,000 persons during 2006–2013 among persons vaccinated with quadrivalent conjugate meningococcal vaccine (MCV-4), compared with 0.307 cases/100,000 persons during 2000–2013 among persons vaccinated with quadrivalent polysaccharide meningococcal vaccine (MPSV-4). They stated that, because these rates did not differ significantly, case rates were similar in personnel vaccinated with MCV-4 and MPSV-4. Although statistically correct, this comment might mislead the unwary reader.

The absence of a significant difference does not necessarily mean that the 2 vaccines have similar effectiveness. The incidence rate of meningococcal disease was 68% higher $([0.307-0.183] \times 100/0.183)$ during the period of MPSV-4 use than during the period of MCV-4 use. If the same findings arose in a study of sufficient size to achieve statistical significance, this difference would be considered of substantial clinical importance. A happy consequence of the long-term temporal trends in meningococcal incidence and the success of these vaccines is that the incidence of meningococcal disease is now sufficiently reduced that even the very large active-duty population is too small to provide the statistical power to declare these 2 different incidence rates as being statistically different.

The trends reported by Broderick et al. have continued. During 2006–2014, the incidence of meningococcal disease caused by vaccine-covered serogroups among US military recipients of MCV-4 fell to 0.146 per 100,000 person-years, whereas MPVS-4–related incidence did not change (M.P. Broderick, pers. comm.). Furthermore, through July 2016, the US military has not seen a case from a covered serogroup since 2011 among recipients of MCV-4. Even with these additional data, however, the difference between MCV-4 and MPSV-4 does not achieve statistical significance (M.P. Broderick, pers. comm.).

The author is an employee of a company that manufactures both conjugate and polysaccharide meningococcal vaccines.

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Correction: Vol. 22, No. 8

The name of author Natalie Witek was misspelled in *Baylisascaris procyonis*–Associated Meningoencephalitis in a Previously Healthy Adult, California, USA (C. Langelier et al.). The article has been corrected online (http://wwwnc.cdc.gov/eid/article/22/8/15-1939_article).

Corrections: Vol. 22, No. 9

Some descriptions of tickborne transmission of bacteria were unclear in Large-Scale Survey for Tickborne Bacteria, Khammouan Province, Laos (A.J. Taylor et al.). The article has been corrected online (http://wwwnc.cdc.gov/eid/article/22/9/15-1969_article).

A second affiliation for author Martie L. van der Walt was omitted in Treatment Outcomes for Patients with Extensively Drug-Resistant Tuberculosis, KwaZulu-Natal and Eastern Cape Provinces, South Africa (C.L. Kvasnovsky et al.). The article has been corrected online (http://wwwnc.cdc.gov/eid/article/22/9/16-0084_article).

EID Podcast: Nipah Virus Transmission from Bats to Humans Associated with Drinking Traditional Liquor Made from Date Palm Sap, Bangladesh, 2011–2014

Nipah virus (NiV) is a paramyxovirus, and *Pteropus* spp. bats are the natural reservoir. From December 2010 through March 2014, hospital-based encephalitis surveillance in Bangladesh identified 18 clusters of NiV infection. A team of epidemiologists and anthropologists investigated and found that among the 14 case-patients, 8 drank fermented date palm sap (*tari*) regularly before their illness, and 6 provided care to a person infected with NiV. The process of preparing date palm trees for *tari* production was similar to the process of collecting date palm sap for fresh consumption. Bat excreta was reportedly found inside pots used to make *tari*. These findings suggest that drinking *tari* is a potential pathway of NiV transmission.



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