Rickettsia felis Infection, Tunisia

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We report, for the first time, serologic evidence of Rickettsia felis and R. aeschlimannii infections acquired in Tunisia from 1998 to 2003. We found that most patients with antibodies against both R. conorii and R. typhi had serologic evidence of R. felis infection.

Rickettsioses are arthropod-borne zoonoses with geographic distributions determined by the ecology of their vectors. The genus Rickettsia is divided into 2 groups, the spotted fever group (SFG) and the typhus group (TG), mainly based on their intracellular positions, optimal growth temperatures, gas chromatographic proportion (%), DNA content, clinical features, epidemiologic aspects, and antigenic characteristics. Recently, a new species of Rickettsia that infected humans, R. felis, was reported (1), and the whole genome of this species has recently been sequenced (2). The pathogenic role of R. felis in humans was demonstrated first in Texas (1), with subsequent reports of this “fleaborne spotted fever” confirmed in patients from Europe and South/Central America (3–5) by polymerase chain reaction (PCR), serologic tests, or both. In Tunisia, North Africa, the epidemiology of rickettsial diseases has not been documented and only 1 study concerning these diseases has been conducted. The study, conducted in 1995, confirmed that R. conorii and TG rickettsia were endemic in Tunisia, with estimated antibody prevalences of 9% and 3.6%, respectively (6). The aim of our study was to investigate the diversity of rickettsioses in Tunisia through the use of serologic assays.

The Study

Serum samples obtained from patients suspected to have clinical rickettsial infection (fever associated with an eschar or cutaneous rash) were collected from 1998 to 2003 at the Laboratory of Microbiology CHU Habib Bourguiba, Sfax, Tunisia. Acute- and convalescent-phase serum samples, when available, were stored at −80°C until they were tested in a multiple-antigen immunofluorescence assay (IFA) at the Unité des Rickettsies Marseille (7). Ten SFG rickettsial antigens were used: R. conorii conorii strain 7, R. africae strain ESF-5, R. sibirica mon-
Conclusions

Second patient. Cervical and inguinal in the first patient and axillary and inguinal in the second patient. Clinical data were available for only 1 patient with R. aeschlimannii infection. This patient had fever with meningitis without inoculation eschar or cutaneous rash. Serologic and clinical characteristics were available for 8 patients with R. felis infection (Table); most of the patients lived in urban areas, and 1 came from Libya. All 8 patients had fever and a maculopapular rash, and none reported a history of flea or tick bite or had an eschar. Two patients had peripheral adenopathy on admission: cervical and inguinal in the first patient and axillary and inguinal in the second patient.

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Conclusions

In this study, IFA and WB identified R. felis infection in patients from Tunisia. Serologic cross-reactions are common among Rickettsia species in both the SFG and TG. A difference in specific IgG or IgM antibody titers has been useful for distinguishing murine typhus from epidemic typhus (8). More sophisticated serologic methods are needed to identify the causative agent at the species level (9). WB performed on 7 of 18 serum samples with cross-reactions between SFG, R. felis, and R. typhi confirmed the diagnosis of R. felis in 5 patients and TG rickettsia in 1 patient; the diagnosis remained undetermined in 1 patient. Recently, the whole genome of R. felis has been sequenced and demonstrated genetic similarity with R. typhi but showed some genes missing from the R. conorii genome (2). Thus, R. felis may be the major cause of cross-reactions between R. typhi and R. conorii or other tick-borne spotted fever agents. Cross-reactions between the 2 groups of Rickettsia have been puzzling because this activity is not reported in experimentally infected guinea pigs and mice (10). In fact, we speculate that many of the reactions with both R. typhi and R. conorii are caused by R. felis infection. This hypothesis is supported by our findings of cross-reactivity in serum specimens from 5 of 7 patients with confirmed R. felis infection. Indeed, when antigens are not available, this cross-reactivity should be a good screening method for R. felis infection. Alternatively, all serum specimens exhibiting cross-reactivity between R. typhi and R. felis only were considered to be TG rickettsia infection after WB.

To the best of our knowledge, this is the first report of patients with R. felis and R. aeschlimannii infections in Tunisia. In Morocco, similar results have been reported (11). Several cases of SFG rickettsioses have been reported from North Africa, including 1 patient with R. aeschlimannii infection from Morocco (12) and 1 patient with R. sibirica mongolitimonae infection from Algeria (13). These results are not surprising since vectors of R. felis and R. aeschlimannii are present in North Africa (14). Indeed, R. aeschlimannii has been isolated from Hyalomma marginatus ticks collected from camels in Morocco (15), and R. felis–infected fleas in Algeria have been recently reported (14). Since R. felis has a worldwide distribution and infestation with these fleas is very common, R. felis and fleaborne spotted fever may occur worldwide.

Only a few human cases of R. felis infection diagnosed by serologic tests or PCR have been reported: 1 case from the United States (Texas) (1), 3 from Mexico (3), 2 from France, 2 from Brazil (4), and 2 from Germany (5). In the
Texas case (1), the patient had clinical features similar to those associated with murine typhus. However, patients with *R. felis* and central nervous system and pulmonary involvement have been reported from Mexico (3). In our study, 1 of the patients with *R. felis* infection had pulmonary involvement and 2 had adenopathy. Although none had an eschar or a history of flea bite, 3 patients had contact with animals.

Our findings indicate the need for further studies to determine the distribution of *R. felis* and the prevalence of this agent and associated infection. These results suggest that fleaborne spotted fever, as well as other SFG rickettsioses, are common in Tunisia.

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**References**


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