Powassan Virus Encephalitis, Minnesota, USA

To the Editor: Birge and Sonnesyn report the first death of a Minnesota resident caused by Powassan virus (POWV) (1). However, they provide an inaccurate description of several critical diagnostic and surveillance issues concerning POWV.

The 17 POWV infections detected in Minnesota residents from 2008 through 2011 (6 cases were identified through 2010, not 8 as reported by Birge and Sonnesyn) (Minnesota Department of Health [MDH], unpub. data) were found through enhanced surveillance. Health alerts to Minnesota medical providers described POWV as a possible etiologic agent for viral meningitis and encephalitis. Providers consulted with MDH on suspected cases and submitted serum and cerebrospinal fluid specimens to MDH. MDH conducted serologic testing for endemic arboviruses (including POWV) and reverse transcription PCR (RT-PCR) for flaviviruses and POWV. MDH would not have detected any POWV infections without enhanced surveillance. Limited field studies also identified POWV-infected ticks in 4 Minnesota counties (not 2 as reported [1]) (MDH, unpub. data).

Commercial laboratories do not provide testing for POWV, and only a few state health department laboratories and the Centers for Disease Control and Prevention offer testing. Serologic testing (enzyme immunoassay with plaque-reduction neutralization testing confirmation) is preferred (2) because POWV RT-PCRs are not validated, and the short viremic periods of flaviviruses limit their usefulness (3).

Few POWV infections are identified by lineage (prototype vs. deer tick virus); Minnesota’s first case in 2008 was identified as a deer tick virus infection, but the lineage was unknown for the other 16 cases. However, many case-patients had likely exposure to *Ixodes scapularis* ticks (blacklegged ticks), the tick species associated with deer tick virus transmission, and viruses from all POWV-positive tick pools were confirmed as deer tick virus by sequencing. The distribution of the 2 lineages in North America is poorly understood, and most cases likely go undetected without specific POWV surveillance efforts.

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Hepatitis E Virus and Porcine-derived Heparin

To the Editor: Cases of sporadic, locally acquired hepatitis E have been increasingly identified in industrialized countries over the last few years (1). In this setting, hepatitis E is thought to be a zoonotic infection, with pigs as the primary host. Consumption of uncooked or lightly cooked pork meat products is thought to be a key route of infection, but other routes of transmission have been documented (2). For example, there have been several iatrogenic cases after transfusion of hepatitis E virus (HEV)–contaminated blood products (3) and transplantation of an HEV–infected donor liver (4). However, in most cases the source and route of infection are uncertain.

In May 2011, a 42-year-old woman sought care at the Royal Cornwall Hospital in Truro, United Kingdom, for a 1-week history of malaise, diarrhea, nausea, and vomiting. Physical examination results were normal. Her liver function test results, however, indicated hepatitis: alanine aminotransferase 2,785 IU/L (reference range 10–36 IU/L), aspartate aminotransferase 2,785 IU/L (reference range 10–36 IU/L), alkaline phosphatase 319 IU/L (reference range 30–130 IU/L), and bilirubin 30 µmol/L (reference range <21 µmol/L). HEV IgM and IgG serologic test results for the patient were positive, and HEV genotype 3 was identified in her blood by reverse transcription PCR and sequencing. Other causes of viral hepatitis and hepatocellular jaundice, including hepatitis viruses A, B, and C; Epstein-Barr virus; and autoimmune hepatitis, were excluded by testing. As with most immunocompetent persons with HEV, the patient made an uneventful clinical recovery after 12 weeks, and her liver function tests returned to normal after 8 weeks.
The source and route of infection in this case was uncertain. A detailed in-person assessment of potential risk factors was undertaken with the patient. She had not traveled outside the United Kingdom in the previous 3 months. She rarely ate pork products (well cooked bacon only); ate no shellfish; and had no workplace, domestic, or recreational exposure to pigs or their effluent. However, 4 weeks before symptom onset, the patient had...
acute appendicitis for which she underwent an uneventful laparoscopic appendectomy and was hospitalized for 2 days. During hospitalization she received no blood products, but, as prophylaxis for thromboembolic disease, she received 2 doses (5,000 IU each) of low–molecular weight heparin (Fragmin [dalteparin sodium]; Pfizer, Sandwich, UK) by subcutaneous injection. All heparins used in Europe and North America are isolated from porcine intestinal mucosa (5). The exact purification methods used by heparin manufacturers are deemed commercially sensitive and not in the public domain, so it is impossible to evaluate whether the isolation process would be sufficient to remove or inactivate any contaminating HEV. The virus is known to be acid and alkaline stable; heat sensitivity varies, depending on strain and heating conditions, although heating at 60°C for 1 hour is generally sufficient to achieve 96% inactivation (6). To our knowledge, no investigation has determined whether clinical-grade heparin could contain viral contaminants. Thus, we hypothesized that the heparin the patient received might have been the source of her HEV infection.

To examine this possibility, we screened multiple batches of hospital pharmacy–grade heparin for the presence of HEV, including batches of dalteparin sodium that were in use at the hospital when the patient received treatment for appendicitis. Before testing, the samples were ultracentrifuged to concentrate any contaminating virus and enable the removal of excipients, which could inhibit the assay. We tested samples by quantitative reverse transcription PCR (7) in parallel with positive World Health Organization HEV RNA standard spiked controls, which showed the limit of detection (LOD) to be 500 IU/mL, regardless of the heparin’s excipient or concentration. This LOD is within the range used by collaborating laboratories in the establishment of the World Health Organization HEV RNA standard (http://whqlibdoc.who.int/hq/2011/WHO_BS_2011.2175_eng.pdf). In addition, we tested the heparin samples for porcine circovirus 2 (PCV2), an identified adventitious agent of several rotavirus vaccines (8) and porcine parvovirus (PPV) (9), a known contaminant of porcine clotting factor hyate:C (10). Although samples were tested in parallel with PCV2- and PPV-positive spiked controls, we were unable to calculate the LOD for these assays because international standards are not available for these viruses.

All samples tested negative for HEV, PCV2, and PPV (Table), which would indicate the patient’s source of HEV infection is unlikely to have been the heparin. However, we cannot rule out low-level viral contamination below the sensitivity of the assay. We also cannot exclude that the negative test results were related to the Poisson effect. Given that all samples analyzed were negative for all 3 viruses tested, it seems likely that the heparin manufacturing process is sufficient to remove viral contaminants. However, this may not necessarily be the case for other porcine-derived products, such as porcine insulin, factor VIII C, pancreatic, and poractant alfa. Further investigation is warranted to exclude these products as potential sources of HEV infection.

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