in Yucatan State. It also shows that a shell vial alternative method for \textit{R. typhi} isolation is simple and effective.

**Acknowledgments**

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We dedicate this article to the memory of Jorge Zavala Velázquez, who pioneered \textit{Rickettsia} research in Mexico and Latin America.

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**References**


**Zika Virus Infection after Travel to Tahiti, December 2013**

To the Editor: Zika virus (ZIKV), a member of the family \textit{Flaviviridae}, is a mosquito-borne virus that is endemic to Africa and Southeast Asia. ZIKV causes illness that is similar to dengue fever, characterized by joint pain, myalgia, headache, and rash (1). ZIKV has caused several recent outbreaks, including one in Micronesia in 2007 (2) and one in French Polynesia (≈30,000 cases) ongoing since October 2013 (3) and spreading to New Caledonia and Easter Island (4). We report the clinical and laboratory findings for a patient with ZIKV infection imported from Tahiti, French Polynesia.

The previously healthy 31-year-old woman from Norway was admitted to the Oslo University Hospital, Norway, on December 13, 2013. Six days earlier, she had returned from a 14-day vacation to Tahiti, where she mainly stayed in the capital, Pape’ete, and took a short trip to the island of Moorea. One day after her return to Norway, she experienced fever, intense joint pain, and myalgia. Subsequently, a maculopapular rash developed. At the time of admission, her temperature was 37.7°C, and she had enlarged nuchal lymph nodes; injected conjunctivae; and a maculopapular rash on her trunk, extremities, and face (online Technical Appendix, http://wwwnc.cdc.gov/EID/article/20/8/14-0302-Techapp1.pdf). Clinical examination findings were otherwise unremarkable. Laboratory tests showed leukopenia of $2.7 \times 10^9$ cells/L (reference range $3.5–10 \times 10^9$/L), with mild lymphopenia of $1.0 \times 10^9$ cells/L (reference range $1.5–4.0 \times 10^9$/L) and neutropenia of $1.4 \times 10^9$ cells/L (reference range $1.5–7.3 \times 10^9$/L). No thrombocytopenia or elevated liver enzyme levels were detected. C-reactive protein levels (1.4 mg/L) were within reference range.

Because of the patient’s clinical picture and travel history, an acute ZIKV infection was suspected and several diagnostic tests were ordered. In a serum sample taken 5 days after symptom onset, no IgM or IgG against ZIKV, dengue virus (DENV), Japanese encephalitis virus, yellow fever virus, or chikungunya virus was detected by in-house indirect immunofluorescence (5,6). Only a weak IgG titer of 1:20 (and no IgM) against tick-borne encephalitis virus was found (cutoff <1:20). Test results for DENV nonstructural protein 1 antigen (Plate; Bio-Rad, Hercules, CA, USA) and generic flavivirus reverse transcription PCR (RT-PCR) (6) were negative. Thus, for increased sensitivity, quantitative ZIKV-specific real-time RT-PCR (6) with the AgPath-ID One-Step RT-PCR Kit (Life Technologies, Carlsbad, CA, USA) was performed according to the manufacturer’s instructions, and results were positive. ZIKV RNA load was $1.6 \times 10^5$ copies/mL; in vitro–transcribed RNA from a
Attempts to isolate ZIKV in cell culture failed. Therefore, the serum sample was used to obtain the partial ZIKV genome sequence with primers designed from multiple alignments of partial ZIKV genomes retrieved from databases. Primer sequences used for partial genome amplification of ZIKV are available on request (to J. S.-C.). The partial ZIKV genome (strain Tahiti, GenBank accession no. KJ461621) was successfully amplified from the serum sample, and phylogenetic analysis of an ≈200-bp long genomic fragment of the nonstructural protein 3 gene demonstrated that strain Tahiti clusters within the Asian ZIKV lineages and is closely related to a strain from Malaysia (Figure).

In a follow-up serum sample collected 36 days after symptom onset, IgG and IgM seroconversion against ZIKV was demonstrated; IgM titer was 1:1,280 and IgG titer was 1:2,560 (cutoff <1:20). In the same sample, low IgG titers against tick-borne encephalitis virus and DENV (1:40 and 1:80, respectively) were noted (cutoffs <1:20). Real-time RT-PCR for ZIKV in this serum sample was negative.

Travel-related imported ZIKV infections have been reported after travel from Thailand to Germany (6) and Canada (7), from Indonesia to Australia (8), and from Senegal to the United States (9). Linked to the current outbreak in French Polynesia, infections in 2 travelers who had returned from Bora Bora to Japan have recently been described (10). The clinical findings for the patient reported here (fever, rash, arthralgia, myalgia) were similar to those previously reported for patients with imported cases (6,10).

Available laboratory data are meager, but mild thrombocytopenia has been reported for some patients with Zika fever (10), but not for others (6,8). Outbreaks of dengue fever also occur in French Polynesia (10), making dengue fever clinically and epidemiologically the most important differential diagnosis. Elevated liver enzymes, which are found in patients with acute dengue fever, are found in some, but not all, patients with Zika fever (6,8).

The measured viral load for the patient reported here (5 days after symptom onset) would not be high enough for efficient transmission of ZIKV to susceptible vectors such as *Aedes aegypti* or *Ae. albopictus* mosquitoes (S. Becker, pers. comm.). This finding is consistent with previously reported findings of ZIKV RNA loads of 930–728,800 copies/mL (2). However, *Ae. aegypti* and *Ae. albopictus* mosquitoes are not present in Norway; thus, transmission in Norway seems unlikely. ZIKV infection should be considered as a differential diagnosis for febrile dengue–like syndromes in travelers who have returned from Southeast Asia and the Pacific region.

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This letter is dedicated to the late Ursula Herrmann (1927–2014), who made this study possible.

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These authors contributed equally to this article.
Yersinia pestis in Pulex irritans Fleas during Plague Outbreak, Madagascar

To the Editor: Yersinia pestis (family Enterobacteriaceae) is a bacterium that can cause high rates of death in susceptible mammals and can provoke septicemic, pneumonic, and bubonic plague in humans (1). This zoonotic pathogen can be transmitted directly by infectious droplets or by contact with contaminated fluid or tissue or indirectly through flea bites (1).

Plague was introduced into Madagascar in 1898 from rat-infested steamships that had sailed from affected areas (2). Now, Madagascar is 1 of 2 countries in Africa that have reported cases of human plague every year since 1991 (3). During January 2008–January 2013, the number of human plague cases reported in Madagascar ranged from 312 to 648 per year. Of these, 61.8%–75.5% were laboratory confirmed (National Plague Laboratory and Control. Zika virus—Pacific (07). ProMed. 2014 Mar 16. http://www.promedmail.org, archive no. 20140316.2335754.


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Table. Fleas collected inside and outside houses in Soavana, Madagascar, January 2013

<table>
<thead>
<tr>
<th>Species</th>
<th>Total no. (%)</th>
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<th>No. (%), outside</th>
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<td>Xenopsylla cheopis</td>
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<td>13 (17.3)</td>
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<tr>
<td>Total</td>
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<td>75 (100)</td>
</tr>
</tbody>
</table>
Zika Virus Infection after Travel to Tahiti, December 2013

Technical Appendix

Technical Appendix legend. Maculopapular rash on the trunk and extremities of a patient with Zika virus infection imported from Tahiti, French Polynesia, December 2013.