and clinical findings consistent with the disease. The delay in diagnosis led to a life-threatening condition for the patient. Physicians in areas where scrub typhus is nonendemic should have a high index of suspicion for rickettsial infections in patients with recent travel histories to areas where the disease is endemic and consider treatment with tetracyclines whenever rickettsial infection is suspected. Furthermore, the potential for aerosol transmission of *O. tsutsugamushi* from patients with scrub typhus–associated ARDS to health care workers should be evaluated.

References


Address for correspondence: Didier Raoult, Faculté de Médecine, Université de la Méditerranée, URMITE, UMR CNRS 6236, IRD 198, Centre National de Référence, 27 Blvd Jean Moulin Marseille 13005, France; email: didier.raoult@gmail.com

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The second case-patient was a retired female farmer, 67 years of age, living near Puyloubier, 49 km (≈30 miles) north of Marseille, who reported being stung on the eye by an insect during the morning of July 6. In the afternoon, the eye became painfully inflamed. On the next day, an ophthalmologist performed an excision and extracted *O. ovis* larvae from the eye.

The third case-patient was a 43-year-old female nurse’s aide residing in Meyreuil, which is ≈30 km (≈18 mi) north of Marseille. On July 13, while she was on her terrace, she described ocular trauma by a fly. The next day, she sensed a foreign body in her eye, and she consulted an ophthalmologist. A simple excision led to the identification of an *O. ovis* larva.

The final case-patient was a 28-year-old male mason. On July 22, while working in Miramas, approximately 63 km (≈39 miles) he experienced trauma to his left eye. As the pain persisted, he consulted an ophthalmology facility that same evening. On examination, the presence of an *O. ovis* larva was confirmed, and an ablation was performed. All patients recovered without consequences.

*O. ovis*, also called sheep nasal botfly, is a fly of the class Insecta, order Diptera and family *Oestridae*. It is a cosmopolitan parasite that infects the nasal sinuses of sheep and goats. During the summer and early autumn, the adult female flies are active, laying and retaining eggs until they hatch. The fly then ejects many first-instar larvae onto the nostril of the host. The *O. ovis* larvae grow in the mucus of the nasal sinus until mature; they are then released from the nostrils when the infected host sneezes (8). The larvae pupate in the soil for 4–8 weeks, form a chrysalis, in which they morph into adults, and then emerge. Occasionally, *O. ovis* can infest humans, which become an intermediate accidental host (7). The 4 cases of ophthalmomyiasis described in this report occurred in a restricted area during a 4-week period, which corresponds exactly to the time and location of *la Transhumance*, taking into account the 4- to 8-week time lag required for the maturation of larvae into adults. Three of these cases were directly referred to our laboratory, the regional referent parasitology laboratory. The fourth case was reported by an ophthalmology emergency unit. Note that ophthalmomyiasis is rare in Marseille; during the 5 years before *la Transhumance* of 2013, only a single case had been diagnosed in the area.

Overall, this report reminds us that bringing a large group of livestock into contact with a dense urban population may enhance the risk for transmission of zoonoses. The transmitted zoonosis in this case was oestrosis, a benign condition that can sometimes progress to blindness if untreated. However, other much more severe air-transmitted zoonotic diseases associated with sheep and goats, such as Q fever, could have been transmitted (9). Without questioning
References

Address for correspondence: Renaud Piarroux, Laboratoire de Parasitologie, Centre Hospitalier Universitaire de La Timone, 264 rue Saint Pierre, 13385 Marseille CEDEX 5, France; email: renaud.piarroux@ap-hm.fr

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

Michael P. Broderick, Christopher Phillips, Dennis Faix

Author affiliation: Naval Health Research Center, San Diego, California, USA

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To the Editor: Meningococcal disease in US military personnel is controlled by vaccines, the first of which was developed by the US Army (1–5). In 1985, the quadrivalent polysaccharide vaccine (MPSV-4) was implemented as the military standard. It was replaced during 2006–2008 by the quadrivalent conjugate vaccine (MCV-4). Every person entering US military service is required to receive this vaccine.

Meningococcal disease incidence in active-duty US military personnel, historically far above that in the general population (6), has decreased >90% since the early 1970s, when the first vaccine was introduced (7). Over the last 5 years, incidences in the military and US general populations have become equivalent (8). Here we update previously published data (8) from the Naval Health Research Center’s Laboratory-based Meningococcal Disease Surveillance Program of US military personnel. Data-gathering methods and laboratory analyses of samples from personnel suspected of having meningococcal disease have been previously described (8). Incidences were compared by using the New York State Department of Public Health Assessment Indicator based on the methods of Breslow and Day (9).

During 2006–2013 in US military personnel, only 1 of the 28 meningococcal disease cases for which serogroup data are available was not serogroups C or B (8 cases each) or Y (11 cases). During that period, incidence in US military personnel of 0.271 cases per 100,000 person-years did not differ significantly (p>0.05) from that of 0.238 in the 2006–2012 age-matched US general population (persons 17–64 years of age) (Centers for Disease Control and Prevention [CDC], unpub. data). During 2010–2013, meningococcal disease incidence in military personnel was 0.174 cases per 100,000 person-years, compared with 0.194 in the age-matched 2010–2012 US population. Among military personnel, only 1 case each occurred in 2011 (serogroup Y) and 2012 (serogroup B), and 3 occurred in 2013 (1 each of serogroups B, C, and Y).

To measure the relative success of the 2 vaccines, we compared incidence among military personnel who

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Technical Appendix

**Technical Appendix Figure.** *Oestrus ovis* larva on the eye of case-patient 1 and after collection. A) *Fornix conjunctiva* of case-patient 1 showing chemosis (conjunctival edema) and larva of *Oestrus ovis*. B) Larva collected from *Fornix conjunctiva* on swab.