Rickettsia rickettsii in Amblyomma patinoi Ticks, Colombia

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To the Editor: Rickettsia rickettsii is the etiologic agent of Rocky Mountain spotted fever (RMSF), a highly lethal tick-borne rickettsioses restricted to the Western Hemisphere (1,2). In Colombia, R. rickettsii was first reported during the 1930s, when 62 (95%) of 65 affected persons died of RMSF in Tobia town (Cundinamarca Department) (3), from where highly virulent strains of R. rickettsii were isolated through the inoculation of patient blood or of Amblyomma cajennense sensu lato (s.l.) extracts into guinea pigs (4). Thereafter, RMSF remained unnoticed in Colombia until the 21st century, when new outbreaks with high case-fatality rates were reported in different regions, including Villete, a nearby locality of Tobia (1).

Recent studies have shown that A. cajennense s.l. widely distributed from the southern United States to Argentina, is actually a complex of 6 different species: A. cajennense sensu stricto (Amazonian region), A. mixtum (from Texas, USA, to western Ecuador), A. sculptum (northern Argentina, Bolivia, Paraguay, Brazil), A. interandinum (inter-Andean valley of Peru), A. tonelliae (dry areas of northern Argentina, Bolivia, and Paraguay), and A. patinoi (eastern cordillera of Colombia) (5). With this new classification, A. patinoi, originally described from Villete, is the only species of this complex known to occur in the RMSF-endemic area of Cundinamarca, Colombia (5).

In August 2013, we collected 15 A. patinoi adult ticks from cattle in Naranjal village (5°3′31.52″N, 74°26′50.24″W), Villete town, an area of Cundinamarca, Colombia, to which RMSF is endemic. Ticks were taken alive to the laboratory, where they were frozen at –80°C for further analysis. The 15 ticks were defrosted, surface sterilized with iodine alcohol, and processed individually by the shell vial technique for isolation of rickettsiae in Vero cells, as described (6). Infected cells were always incubated at 28°C. Rickettsiae were observed by Gimenez staining within cells (online Technical Appendix Figure 1, http://wwwnc.cdc.gov/EID/article/21/3/14-0721-Techapp1.pdf) from only 1 (inoculated from a female tick) of the 15 inoculated shell vials. This isolate was subjected to at least 7 Vero cell passages, each achieving >90% infected cells.

DNA was extracted from an aliquot of first passage–infected cells and tested by a battery of PCR protocols targeting fragments of the rickettsial genes gltA, ompA, and ompB and the intergenic regions RR0155-rpbB, RR1240-tlc5, and cspA-ksgA (Table). We sequenced 1,106 bp, 512 bp, and 799 bp of the gltA, ompA, and ompB genes, respectively. By BLAST analyses (http://www.ncbi.nlm.nih.gov/blast), these sequences were 100% identical to corresponding sequences of R. rickettsii from Colombia and Brazil (GenBank accession nos. CP003306, CP003305). Generated sequences for 2 intergenic regions, RR0155-rpbB (228 bp) and RR1240-tlc5 (306 bp), were 100% identical to corresponding sequences of the same 2 R. rickettsii isolates from Colombia and Brazil. A 337-bp sequence of the cspA-ksgA intergenic region was 100% (337/337 nt) identical to R. rickettsii from Brazil (CP003305) and 99.7% (336/337) to R. rickettsii from Colombia (CP003306). Partial sequences from R. rickettsii generated in this study were deposited into GenBank and assigned nucleotide accession nos. KJ735644–KJ735649.

Whole-body remnants of the 15 ticks used to inoculate shell vials were also subjected to DNA extraction and processed by PCR for the rickettsial gltA gene (Table); only 1 tick (the one that provided the rickettsial isolate) contained rickettsial DNA, indicating a 6.6% (1/15) infection rate. We confirmed the taxonomic identification of this
Therefore, A. patinoi species of Colombia (which includes Tobia and Villeta) by the spotted fever group rickettsiae species by analysis of restriction fragment length polymorphism. 1991;20:112–24.


To the Editor: Thirty-eight patients with *Mycobacterium bovis* BCG–associated osteomyelitis/osteitis, including 8 who were previously reported (1), were identified during Taiwan’s vaccine injury compensation program during 1989–2012; a total of 30 (79%) patients applied for compensation during 2009–2012 (Figure). In Taiwan, a laboratory program to differentiate BCG from other species of the *M. tuberculosis* complex, using a kit for the *ompB* region of the *M. tuberculosis* genome (2), was established in 2004 (3). Since 2008, the isolated extrapulmonary tuberculosis strains and pathologic specimens collected from children <5 years of age have been sent to the national reference mycobacterial laboratory for BCG detection (2). The detected incidence of BCG osteitis/osteomyelitis increased from 3.68 cases per million vaccinations during 2002–2006 to 30.1 per million during 2008–2012.

Parents or guardians signed written consent forms on behalf of the children when they submitted claims for the vaccine injury compensation program. After consent, children’s hospital information was stored in the Taiwan Centers for Disease Control database and used for research.

Of the 38 compensated BCG osteomyelitis/osteitis patients, 18 were boys. According to chart review, no patients had immunodeficiency or other underlying conditions; however, 3 were premature babies (born at 34–36 weeks of gestation). Eighteen (47%) children had received BCG at ≤1 week of age, 12 (32%) at 1–4 weeks, 7 (18%) at 1–2 months, and 1 at >2 months. The average age at inoculation was 16.2 ± 16.6 days. Symptoms or signs began 3–32 months (average 12.4 ± 6.1 months) after BCG vaccination; for 68%, symptoms or signs developed 7–18 months after vaccination (online Technical Appendix Figure, http://wwwnc.cdc.gov/EID/article/21/3/14-0789-Techapp1.pdf). Time from vaccination to onset of symptoms or signs did not differ for the 3 premature infants.

As in previous reports (3,4), extremity bones were more commonly involved than axial bones. For 30 (79%) children, extremity bones were involved: 14 right lower limbs, 7 left lower limbs, 6 left upper limbs, and 3 right upper limbs. The tibia was the most common site (9 patients), followed by ankle bones (8 patients), femur (4 patients), radius and thumb (3 patients each), humerus and knee (2 patients each), and ulna (1 patient). Of these, 2 patients had 2 bony lesions. In 8 (21%) children, axial bones were involved: 5 sternums, 2 thoracic vertebrae, and 1 right rib. Presentation included a mass (25 [66%] children), tenderness (22 [58%]), limping (19 [50%]), redness (14 [37%]), and heat (7 [18%]). Average time from first clinical visit to final surgical management was 1.6 ± 2.1 months.

Eight (53%) of 15 patients had positive tuberculin skin test results. No specific abnormalities were found with regard to blood cell counts and inflammation markers or to chest radiographs, except for 1 child with rib...
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Technical Appendix

Technical Appendix Figure 1. Rickettsia rickettsii isolated from an Amblyomma patinoi tick, Villeta, Colombia, August 2013. Second passage of infected Vero cells that were inoculated with infected tick extract through the shell vial technique. Gimenez staining, original magnification ×100.
Technical Appendix Figure 2. Scrotal necrosis in a guinea pig that had been inoculated with *Rickettsia rickettsii*–infected Vero cells 14 days previously.