and regions than the study by Chen et al., in which the 10–29-year age group and middle regions of the province showed the highest incidence rates (6).

Our study has a few limitations. First, the long, asymptomatic latent period of cysticercosis affects diagnostic efficiency and age-specific incidence estimates. Second, our data were incomplete because of some missing information for cases we identified. Third, independent confirmation might affect incidence estimates from early in the study period. However, our multidiagnostic approach substantially reduced misdiagnosis rates and increased the efficiency of diagnosing cysticercosis (9).

In summary, our analyses show that Shandong Province has been a cysticercosis-endemic area for many years. Improved surveillance and control are needed to address the elevated risk for cysticercosis in western regions of this province.

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References

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**Rickettsia africae** and Novel Rickettsial Strain in *Amblyomma* spp. Ticks, Nicaragua, 2013

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We report molecular detection of *Rickettsia africae* in *Amblyomma ovari* ticks from Nicaragua and a novel rickettsial strain in an *A. triste* tick. Of 146 ticks from dogs, 16.4% were *Rickettsia* PCR positive. The presence of *Rickettsia* spp. in human-biting ticks in Nicaragua may pose a public health concern.

Obligately intracellular *Rickettsia* spp., typically transmitted by ticks, cause a multitude of mild to severe rickettsial diseases in humans and other animals. Novel *Rickettsia* species have been identified through molecular
techniques (1). Rickettsiae in Central America have primarily been reported in ticks, dogs, and humans, with limited data on tick species and rickettsial prevalence in Nicaragua (1). In an earlier study, 87% of 77 dogs in the Bosawás Biosphere Reserve were seropositive for rickettsiae (2); the ticks in that study were collected from 40 of those dogs.

The Bosawás Reserve in remote northern Nicaragua, part of the second largest tropical rainforest in the Western Hemisphere, is inhabited by 2 rapidly growing populations of indigenous people: the Miskito and the Mayagna. These subsistence-based communities use dogs for hunting in the reserve. Increasing connectivity with outside areas, population growth, and interference of dogs with wildlife pose an increased risk for the emergence of zoonotic rickettsioses. We planned to expand information on zoonotic rickettsiosis known as African tick-bite fever and was first described in a patient in the Western Hemisphere in 1998 (1). R. africae has been detected in A. variegatum ticks by using PCR and in humans in Guadeloupe by using serology (6) and more recently in A. loculosum ticks from New Caledonia (7). In Brazil, adult A. ovale ticks bite humans most frequently and are present from the borders of Mexico to those of Argentina (8). A. ovale is a common human-biting tick in Central and South America and poses a public health concern.

Sequences of ompA in 2 of 5 PCR-positive A. mixtum matched 99.6% to Candidatus R. amblyommii in GenBank (ompA of the other samples did not amplify, likely because they were relatively weak on real-time PCR). Candidatus R. amblyommii is common among Amblyomma spp. ticks in the New World and was reported in A. mixtum ticks in Brazil (9). Candidatus R. amblyommii has unknown pathogenicity but has been implicated in rickettsiosis cases in humans (9).

The ompA amplicon from A. triste ticks matched Rickettsia sp. ARAGAOI; sequencing of the rpmB and 17kDa genes was unsuccessful. This rickettsial species was originally described in marsupials in Brazil (10). Further monitoring of tick vectors in this remote area is needed to characterize local risk and detect possibly emerging vector-borne disease.

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Table. Number of dogs and ticks sampled, tick species, and prevalence of rickettsiae in ticks in 3 indigenous communities, northern Nicaragua

<table>
<thead>
<tr>
<th>Category</th>
<th>Amak</th>
<th>Raiti</th>
<th>Arang Dak</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. ticks collected and tested</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. ocale (PCR-positive)</td>
<td>25 (4)</td>
<td>45 (10)</td>
<td>57 (4)</td>
<td>127 (18)</td>
</tr>
<tr>
<td>A. mixtum (PCR-positive)</td>
<td>0</td>
<td>4 (3)</td>
<td>8 (2)</td>
<td>12 (5)</td>
</tr>
<tr>
<td>A. triste (PCR-positive)</td>
<td>0</td>
<td>6 (1)</td>
<td>1 (0)</td>
<td>7 (1)</td>
</tr>
<tr>
<td>Prevalence of rickettsiae in ticks, % (95% CI)</td>
<td>16.0 (5.25–36.9)</td>
<td>25.5 (15.1–39.3)</td>
<td>9.09 (3.75–19.4)</td>
<td>16.4 (11.0–23.7)</td>
</tr>
</tbody>
</table>
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About the Author
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Amebaborne Attilina massiliensis Keratitis, France

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We report a case of Acanthamoeba castellani keratitis in a person who wore contact lenses. The amebae hosted an ameba-resistant bacterial symbiont, provisionally named “Attilina massiliensis,” a yet undescribed α-Proteobacterium.

A mebal keratitis is an aggressive ocular infection that can lead to blindness (1). It is usually associated with wearing soft contact lenses; Dart et al. documented that in countries with a high prevalence of contact lens wear, 85%–88% of Acanthamoeba keratitis cases occurred in contact lens users (1). These ameba host ameba-resistant bacteria, and increase their pathogenicity to the host (2). Ameba hosting intra-amebal microorganisms have been rarely documented in cases originating in contaminated contact lenses (3) and never in mixed keratitis. We report a case of mixed ameba–amebal-resistant bacterial keratitis.

A 17-year-old woman who wore contact lenses consulted the ophthalmology department of the clinic associated with Hôpital de la Timone, Marseille, France, in July 2016, after experiencing 1 month of keratoconjunctivitis symptoms related to an undocumented clinical diagnosis of herpes virus keratitis of the left eye. The patient had been prescribed a 1-week treatment with valacyclovir (3×/d) and a corneal dressing. Examination of the left eye showed 4/10 visual acuity; the right eye was normal. Slit-lamp examination showed a central radial keratoneuritis, central corneal edema, central diffuse infiltrate, and a punctuate superficial keratitis with no predesmecetic precipitates and no satellite lesions (Figure). The patient was admitted to the hospital and was administered hourly topical treatments of polyhexamethylene biguanide eye drops, hexamidine, and 1% atropine. The patient, whose diagnosis was early-stage Acanthamoeba keratitis infection, was discharged after 5 days of treatment; a corneal swab sample at discharge was negative for herpes virus, varicella zoster virus, adenovirus, enterovirus, cytomegalovirus, and Chlamydia trachomatis. Follow-up 7 days later yielded reduced symptoms. We followed up on the patient biweekly and slowly tapered drugs over 4 months; the previously negative...