

Chikungunya Virus – An Emerging Threat to the Americas

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Chikungunya virus disease

- ❑ Mosquito-borne viral disease characterized by acute onset of fever and severe polyarthralgia
- ❑ Often occurs in large outbreaks with high attack rates
- ❑ Outbreaks have occurred in countries in Africa, Asia, Europe, and the Indian and Pacific Oceans
- ❑ In 2013, first locally-acquired cases in the Americas reported on islands in the Caribbean

Chikungunya virus in the Americas*

- Nine Caribbean countries or territories and one country in South America have reported locally-acquired cases
- >40,000 suspected and laboratory-confirmed cases reported
- Virus expected to spread to new areas

*As of March 28, 2014



Chikungunya virus in the United States

- ❑ Chikungunya virus is not currently found in U.S.
- ❑ From 2006-2009, 106 laboratory-confirmed chikungunya cases identified in travelers visiting or returning to U.S.
 - None triggered a local outbreak in U.S.
- ❑ With outbreaks in Caribbean, number of chikungunya cases among U.S. travelers will likely increase
- ❑ Imported cases may result in virus introduction and local spread in some areas of U.S.

Chikungunya virus

- ❑ Single-stranded RNA virus
- ❑ Genus *Alphavirus*
- ❑ Family *Togaviridae*
- ❑ Closely related to Mayaro, O'nyong-nyong, and Ross River viruses

Mosquito vectors

- ❑ Predominantly *Aedes aegypti* and *Aedes albopictus*
- ❑ Same mosquitoes that transmit dengue
- ❑ Widely distributed throughout Americas
- ❑ Aggressive daytime biters



Aedes aegypti



Aedes albopictus

Primary transmission cycle



Anthroponotic transmission
(person to mosquito to person)



Other modes of transmission

- ❑ Documented rarely
 - *In utero* transmission resulting in abortion
 - Intrapartum from viremic mother to child
 - Percutaneous needle stick
 - Laboratory exposure
- ❑ Theoretical concern
 - Blood transfusion
 - Organ or tissue transplantation
- ❑ No evidence of virus in breast milk

Chikungunya virus infection

- ❑ Majority (72%–97%) of infected people develop clinical symptoms
- ❑ Incubation period usually 3–7 days (range 1–12 days)
- ❑ Primary clinical symptoms are fever and polyarthralgia

Fever and polyarthralgia

□ Fever

- Abrupt onset
- Typically $\geq 39.0^{\circ}\text{C}$ ($\geq 102.2^{\circ}\text{F}$)

□ Joint pain

- Often severe and debilitating
- Involves multiple joints
- Usually bilateral and symmetric
- Most common in hands and feet

Other clinical signs and symptoms

- ❑ Headache
- ❑ Myalgia
- ❑ Arthritis
- ❑ Conjunctivitis
- ❑ Nausea/vomiting
- ❑ Maculopapular rash

Clinical laboratory findings

- ❑ Lymphopenia
- ❑ Thrombocytopenia
- ❑ Elevated creatinine
- ❑ Elevated hepatic transaminases

Atypical disease manifestations

- Uveitis
- Retinitis
- Hepatitis
- Nephritis
- Myocarditis
- Hemorrhage
- Myelitis
- Cranial nerve palsies
- Guillain-Barre syndrome
- Meningoencephalitis
- Bullous skin lesions*

*Primarily described in neonates

Risk factors for hospitalization or atypical disease

- ❑ Neonates exposed intrapartum
- ❑ Older age (e.g., >65 years)
- ❑ Underlying medical conditions (e.g., diabetes, hypertension, or cardiovascular disease)

Clinical outcomes

- ❑ Acute symptoms typically resolve in 7–10 days
- ❑ Mortality is rare; occurs mostly in older adults
- ❑ Some patients have relapse of rheumatologic symptoms* in the months following acute illness
- ❑ Studies report variable proportions of patients with persistent joint pains for months or years

*Polyarthralgia, polyarthritis, tenosynovitis, Raynaud's syndrome

Diagnostic testing

- ❑ Culture for virus*
- ❑ Reverse transcriptase-polymerase chain reaction (RT-PCR) for viral RNA
- ❑ Serology for IgM and confirmatory neutralizing antibodies
- ❑ Serology for ≥ 4 -fold rise in virus-specific quantitative antibody titers on paired sera†

*Virus should be handled under biosafety level (BSL) 3 conditions

†Determined by plaque reduction neutralization test (PRNT) or immunofluorescence assay (IFA)

Optimal timing for diagnostic assays

Diagnostic assay	Days post-illness onset
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Viral culture	≤ 3 days
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RT-PCR	≤ 8 days
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IgM antibody tests	≥ 4 days
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Laboratories for diagnostic testing*

- ❑ Testing performed at:
 - Florida DOH BPHL
 - Two other state health departments (CA and NY)
 - CDC Arboviral Diseases Branch
 - One commercial laboratory (Focus Diagnostics)†
- ❑ Contact your county or state health department for information or to facilitate testing

*As of March 2014

†Testing may be ordered through other commercial laboratories and will be forwarded to Focus Diagnostics for testing

Distinguishing dengue from chikungunya

- ❑ Viruses transmitted by same mosquitoes
- ❑ Diseases have similar clinical features
- ❑ Viruses can circulate in same areas and cause co-infections
- ❑ Important to rule out dengue, as proper clinical management can improve outcome*

*WHO dengue clinical management guidelines:

http://whqlibdoc.who.int/publications/2009/9789241547871_eng.pdf

Clinical features of chikungunya virus infections compared with dengue virus infections

	Chikungunya	Dengue
Fever (>39°C)	+++	++
Arthralgia	+++	+/-
Arthritis	+	-
Headache	++	++
Rash	++	+
Myalgia	+	++
Hemorrhage	+/-	++
Shock	-	+

Laboratory features of chikungunya virus infections compared with dengue virus infections

	Chikungunya	Dengue
Lymphopenia	+++	++
Neutropenia	+	+++
Thrombocytopenia	+	+++
Hemoconcentration	-	++

Differential diagnosis for chikungunya

- Dengue
- Leptospirosis
- Malaria
- Rickettsia
- Parvovirus
- Enterovirus
- Other alphavirus infections (e.g., Mayaro, Ross River, Barmah Forest, O'nyong-nyong, and Sindbis viruses)
- Group A streptococcus
- Rubella
- Measles
- Adenovirus
- Post-infectious arthritis
- Rheumatologic conditions

Treatment

- ❑ No specific antiviral therapy
- ❑ Supportive care with rest and fluids
- ❑ Non-steroidal anti-inflammatory drugs (NSAIDs) for acute fever and pain
 - In dengue endemic areas (or travelers returning from endemic areas), use acetaminophen until dengue can be ruled out
- ❑ Persistent joint pain may benefit from use of NSAIDs, corticosteroids, or physiotherapy

Surveillance

- ❑ Inform travelers going to areas with known virus transmission about risk of disease
- ❑ Consider chikungunya in patients with acute onset of fever and polyarthralgia
- ❑ Be aware of possible local transmission in areas where *Aedes* species mosquitoes are active

Reporting of chikungunya cases

- ❑ Suspected cases should be reported to state or local health departments to
 - Facilitate diagnosis
 - Mitigate risk of local transmission
- ❑ State health departments encouraged to report laboratory-confirmed cases to CDC

Preventive measures

- ❑ No vaccine or medication available to prevent infection or disease
- ❑ Primary prevention measure is to reduce mosquito exposure
- ❑ Advise persons at risk for severe disease to avoid travel to areas with ongoing outbreaks
- ❑ Protect infected people from further mosquito exposure during first week of illness

Mosquito prevention and control

- ❑ Use air conditioning or window/door screens
- ❑ Use mosquito repellents on exposed skin
- ❑ Wear long-sleeved shirts and long pants
- ❑ Empty standing water from outdoor containers
- ❑ Support local vector control programs

Selected references

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- ❑ Staples JE, et al. Chikungunya fever: an epidemiological review of a re-emerging infectious disease. *Clin Infect Dis* 2009; 49(6): 942–948.
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Additional resources

- ❑ General information about chikungunya virus and disease:
<http://www.cdc.gov/chikungunya/>
- ❑ Protection against mosquitoes:
<http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-2-the-pre-travel-consultation/protection-against-mosquitoes-ticks-and-other-insects-and-arthropods>
- ❑ Travel notices: <http://wwwnc.cdc.gov/travel/notices>
- ❑ Information for travelers and travel health providers:
<http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-3-infectious-diseases-related-to-travel/chikungunya>
- ❑ Chikungunya preparedness and response guidelines:
http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=16984&Itemid