Q Fever

1. DISEASE REPORTING

A. Purpose of Reporting and Surveillance

1. To identify the source of infection (e.g., an outbreak at a rendering plant or farm) and prevent further transmission from that source to others.

2. To educate potentially exposed persons about signs and symptoms of disease, thereby facilitating early diagnosis.

3. To raise the index of suspicion of a possible bioterrorism event if no natural exposure source is identified.

B. Legal Reporting Requirements

1. Health care providers: notifiable to local health jurisdiction within 24 hours.

2. Health care facilities: notifiable to local health jurisdiction within 24 hours.

3. Laboratories: *Coxiella burnetii* notifiable to local health jurisdiction within 24 hours; specimen submission is required – culture (2 business days).


5. Local health jurisdictions: notifiable to Department of Health (DOH) Office of Communicable Disease Epidemiology (OCDE) within 7 days of case investigation completion or summary information required within 21 days.

C. Local Health Jurisdiction Investigation Responsibilities

1. If bioterrorism is suspected, notify OCDE immediately (24/7): 1-877-539-4344.

2. Facilitate the transport of specimens to Washington State Public Health Laboratories (PHL) for confirmatory testing.

3. Identify potentially exposed persons and make appropriate recommendations.

4. Report all *confirmed* and *probable* cases (see definitions below) to OCDE. Use the Q fever case report form (http://www.doh.wa.gov/Portals/1/Documents/5100/210-043-ReportForm-Qfever.pdf) and enter the data in the Public Health Issues Management System (PHIMS).

2. THE DISEASE AND ITS EPIDEMIOLOGY

A. Etiologic Agent

Q fever is caused by *Coxiella burnetii*, a gram negative bacterium with two antigenic phases. The organism is highly resistant to heat and many disinfectants and can survive long periods under harsh environmental conditions. *C. burnetii* can reach high concentrations in animal tissues, particularly placentas and birthing fluids, and can be spread by wind and stirred up dust. A few organisms can cause infection.
B. Description of Illness

Human infections with *C. burnetii* range from asymptomatic seroconversion (~50%) to severe disease. Acute Q fever is characterized by sudden onset of fever, chills, headache, myalgia, nausea, vomiting, diarrhea, and sometimes non-productive cough and severe sweats. Untreated, the fever can persist for up to 9 to 14 days. It is most often a self-limited febrile illness, though atypical pneumonia is a major clinical presentation, occurring in 30% to 50% of patients. Acute hepatitis is also a frequent presentation, though may be mild. Other severe but rare manifestations include meningoencephalitis, pericarditis, myocarditis, or cholecystitis. Clinical laboratory findings commonly include elevated liver enzyme levels. Pregnant women are at risk for miscarriage, stillbirth, and premature birth. Acute Q fever has a low mortality rate (<2%).

Although the majority of people with acute Q fever recover completely, a post-Q fever fatigue syndrome has been reported in 10% to 25% of acute cases. This syndrome is characterized by constant or recurring fatigue, night sweats, severe headaches, photophobia, myalgia, mood changes, and difficulty sleeping.

Chronic Q fever is rare (<5% of acute cases), occurs weeks to years after acute infection, and manifests primarily as endocarditis. Other manifestations include chronic hepatitis, chronic vascular infections, osteomyelitis, osteoarthritis, or pneumonitis. Pregnant women, immunosuppressed persons, and patients with pre-existing valvulopathy, aneurysm, prosthetic heart valve, vascular prosthesis, or renal insufficiency are at highest risk for chronic Q fever. Untreated it is often fatal; mortality rates may be as high as 65%.

C. Q Fever in Washington State

Typically 0 to 3 cases of Q fever are reported per year. In 2011, an outbreak associated with goats occurred in Washington and Montana, resulting in 21 infected persons; of these 8 symptomatic cases and 4 asymptomatic infections were Washington residents.

D. Reservoirs

The most common reservoirs are sheep, cattle, and goats. Cats, dogs, and some wild animals and birds can also be infected. Infected animals are usually asymptomatic, but fertility issues such as abortion can occur. The organism is shed in urine, feces, milk, and especially birth products (e.g., placental tissue and amniotic fluid).

E. Modes of Transmission

The disease is most commonly acquired by inhalation of aerosols containing *C. burnetii*. This can occur through inhalation of dust from premises contaminated by placental tissues, birth fluids and excreta of infected animals; in establishments processing infected animal products; in necropsy rooms; or during direct contact with infected animals, placentas, or other contaminated materials such as wool, straw, fertilizer and laundry. Less common routes include ingestion of contaminated raw milk, tick bites, receipt of contaminated blood or bone marrow, and handling of cultures in the laboratory. A recent report from the New York State Department of Health described four cases of Q fever in persons treated with fresh sheep cell injections in Germany. Alternative therapies involving fresh cell injections are controversial and not available in the US, however, patients may travel overseas to receive fresh cell injections.
F. Incubation Period

The incubation period depends on the size of the infecting dose, but is typically around 20 days, with a range of 3 to 30 days.

G. Period of Communicability

Direct person-to-person transmission occurs rarely, but sexual transmission may occur. Fomites such as contaminated clothing may be a source of infection.

H. Treatment

Doxycycline is the treatment of choice for acute *C. burnetii* infection and should be started promptly; monitor for relapses requiring retreatment. Chronic infections may require extended treatment with multiple antibiotics and may require surgery.

3. CASE DEFINITIONS

A. Acute Q Fever

1. Clinical Evidence

Acute fever and one or more of the following: rigors, severe retrobulbar headache, acute hepatitis, pneumonia, or elevated liver enzyme levels.

2. Laboratory Evidence

Confirmatory:

- Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific titer to *C. burnetii* phase II antigen by indirect immunofluorescence assay (IFA) between paired serum samples (CDC suggests one taken during the first week of illness and a second 3–6 weeks later; phase I may be elevated or rise as well); or

- Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay; or

- Demonstration of *C. burnetii* in a clinical specimen by immunohistochemical methods (IHC); or

- Isolation of *C. burnetii* from a clinical specimen by culture.

Supportive:

- Single supportive IFA IgG titer of ≥1:128 to phase II antigen (phase I titers may be elevated as well); or

- Elevated phase II IgG or IgM antibody reactive with *C. burnetii* antigen by enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination.

Note: Serologic profiles of pregnant women infected during gestation may progress rapidly to those characteristic of chronic infection.

Note: For acute testing, CDC uses in-house IFA IgG testing (cutoff of ≥1:128), preferring simultaneous testing of paired specimens, and does not use IgM results for routine diagnostic testing.

3. Case Classification for Acute Q Fever (2009)

**Confirmed:** A laboratory confirmed case that either meets clinical case criteria or is epidemiologically linked to a lab confirmed case.
**Probable:** A clinically compatible case of acute illness (meets clinical evidence criteria for acute Q fever illness) that has laboratory supportive results for past or present acute disease (antibody to Phase II antigen) but is not lab confirmed.

### B. Chronic Q Fever

1. **Clinical Evidence**

   Newly recognized, culture-negative endocarditis, particularly in a patient with previous valvulopathy or compromised immune system, suspected infection of a vascular aneurysm or vascular prosthesis, or chronic hepatitis, osteomyelitis, osteoarthritis, or pneumonitis in the absence of other known etiology.

2. **Laboratory Evidence**

   **Confirmed:**
   
   - Serological evidence of IgG antibody to *C. burnetii* phase I antigen ≥ 1:800 by IFA (phase I titer is higher than the phase II titer), or
   
   - Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by PCR assay, or
   
   - Demonstration of *C. burnetii* antigen in a clinical specimen by IHC, or
   
   - Isolation of *C. burnetii* from a clinical specimen by culture.

   **Supportive:**

   - Antibody titer to *C. burnetii* phase I IgG antigen ≥1:128 and < 1:800 by IFA.

   Note: Samples from suspected chronic patients should be evaluated for IgG titers to both phase I and phase II antigens. Current commercially available ELISA tests (which test only for phase II) are not quantitative, cannot be used to evaluate changes in antibody titer, and hence are not useful for serological confirmation. IgM tests are not strongly supported for use in serodiagnosis of acute disease, as the response may not be specific for the agent (resulting in false positives) and the IgM response may be persistent. Complement fixation (CF) tests and other older tests are not readily available.

   Serologic test results must be interpreted with caution, because baseline antibodies acquired as a result of historical exposure to Q fever may exist, especially in rural and farming areas.

3. **Case Classification for Chronic Q Fever (2009)**

   **Confirmed:** A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic disease) that is laboratory confirmed for chronic infection.

   **Probable:** A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic Q fever) that has laboratory supportive results for past or present chronic infection (antibody to Phase I antigen).

### C. Exposure

Exposure is usually via aerosol and may be unknown (especially for chronic infection), but often includes the presence of goats, sheep, or other livestock, especially during periods of parturition. Direct contact with animals is not required, and variable incubation periods may be dose dependent.
4. DIAGNOSIS AND LABORATORY SERVICES

A. Laboratory Diagnosis

Laboratory diagnosis is commonly made by demonstration of a rise in specific antibodies in acute and convalescent specimens. High antibody titers to Phase I antigen indicate chronic infection; whereas high Phase II antibody titers occur during acute infection. The diagnosis can also be made by isolation or identification of the organism in blood, sputum or tissue (e.g., liver biopsy or heart valve) by culture, immunohistochemical methods, or polymerase chain reaction (PCR). These latter tests are less convenient than serologic tests because they require processing in a biosafety level 3 laboratory.

**Confirmatory laboratory testing by a reference laboratory such as Centers for Disease Control and Prevention (CDC) or Washington State Public Health Laboratories is recommended**, though may not be necessary when a 4-fold rise in Q fever titer has been documented. Substantial variability exists between clinical laboratories, so titers should only be compared if specimens are tested at the same laboratory. Acute and convalescent sera should be collected 2-6 weeks apart, ideally, during the first week of illness and 2-4 weeks after. Detectable antibody titers are not typically present until 7-10 days after illness onset; therefore, if Q fever is suspected, a convalescent specimen is necessary for confirmation. Negative or very low titers are expected during the first week of illness and do not rule out Q fever. PCR on blood has highest diagnostic yield in the first week of illness onset, prior to antibiotic administration; but may be performed on tissues for chronic illness. Although a positive PCR result is diagnostic, a negative result does not rule out Q fever, and treatment should not be withheld due to a negative result.

B. Tests Available at the Washington State Public Health Laboratories (PHL)

The PHL perform PCR testing only. Specimens for serology, culture, or immunohistochemistry will be forwarded to the CDC. Contact the Office of Communicable Disease Epidemiology for approval prior to submitting specimens.

Note that PHL require all clinical specimens have two patient identifiers, a name and a second identifier (e.g., date of birth) both on the specimen label and on the submission form. Due to laboratory accreditation standards, specimens will be rejected for testing if not properly identified. Also include specimen source and collection date.

C. Specimen Collection

Clinical laboratories should call PHL prior to shipping specimens (206-418-5400) for shipping instructions. Serum should be submitted with a completed PHL Serology submission form (http://www.doh.wa.gov/Portals/1/Documents/5230/302-017-SerVirHIV.pdf); all other specimens require a completed PHL Microbiology submission form (http://www.doh.wa.gov/Portals/1/Documents/5230/302-013-Micro.pdf)

5. ROUTINE CASE INVESTIGATION

Since Q fever is an uncommon disease, call DOH Office of Communicable Disease Epidemiology (OCDE) to discuss the case investigation. Interview the case and others who may be able to provide pertinent information.
A. Evaluate the Diagnosis

Collect copies of laboratory results. Confirmatory laboratory testing by a reference laboratory is recommended, unless a 4-fold titer rise was documented (see Section 4). Single serum positives must be interpreted with caution. IgM antibodies may persist for months or longer and IgM has a much lower specificity for *C. burnetii* than IgG. Cross reactions with *Legionella* and *Bartonella* species have been reported. Facilitate collection of additional specimens and/or facilitate submission to PHL as needed. Proceed with investigation upon receipt of preliminary lab results for sporadic cases. During an outbreak or potential bioterrorism situation, start investigation before results are available.

B. Manage the Case

Hospitalized patients should be cared for in accordance with standard precautions. No special precautions are necessary for routine care. However, if surgeries or autopsies for Q fever patients are planned, advise staff to wear extra respiratory protection (e.g., N95 masks) and use negative pressure rooms if performing any aerosol-generating procedures (e.g., bone saw use). During obstetrical procedures on infected women, contact and droplet precautions should be used; aerosolization of birth fluids should be avoided.

Chronic Q fever patients should be referred to an infectious disease specialist for management. These patients require long-term antibiotic therapy, periodic diagnostics, and long-term monitoring.

Healthy patients with acute Q fever and no identified risk factor for development of Chronic Q fever should be clinically evaluated and serologically tested 6 months following acute infection. Patients with cardiac or other risk factors for development of chronic disease should be clinically evaluated and serologically tested at 3, 6, 12, 18, and 24 months following acute infection. Pregnant women should be clinically evaluated and serologically tested at 3, 6, 12, 18, and 24 months following delivery.

C. Identify Potential Sources of Infection

Investigate possible exposures during the 2-3 weeks prior to onset of acute disease. For chronic disease, inquire about previous diagnosis of or illness consistent with acute Q fever. Ask about history of:

1. Travel;
2. Contact with potentially infected animals or their tissues, particularly postpartum fluid or tissues;
3. Consumption of unpasteurized milk products;
4. Work with sheep, goats, cattle;
5. Work in a laboratory (especially animal necropsy); and
6. Possible exposure to dust or other aerosols associated with livestock.
7. Medical procedures or alternative therapies conducted outside of the US

D. Identify Contacts/Others Potentially Exposed

1. Identify and contact persons who participated with the case in any of the activities above.
2. Identify laboratory workers who handled infected tissue or laboratory isolates. (Note that
culture requires special methods and facilities so exposure to isolates is unlikely at most
hospital and diagnostic laboratories; for instance, there is no risk for standard blood
cultures handled using normal precautions).

3. Identify surgeons, pathologists, and other staff present in surgical or autopsy rooms
during aerosol-generating procedures, e.g., use of bone saws.

4. Identify veterinarians, veterinary pathologists, and livestock owners who handled
infected animal specimens (especially placentas or stillborn animals) or who were present
during the delivery of infected animals.

5. Inform all identified persons of their possible exposure and symptoms of Q fever. See
“Management of Other Exposed Persons” below.

6. Determine if the case donated blood or tissue and notify the appropriate agency.

7. Consider alerting healthcare providers in the surrounding area if widespread exposure is
suspected

E. Management of Other Exposed Persons

Persons potentially exposed should be educated regarding symptoms to facilitate early
diagnosis. In general, no specific management is recommended for asymptomatic people
who have been exposed. For high-risk exposures, call the Office of Communicable
Disease Epidemiology to discuss circumstances.

F. Environmental Evaluation/Measures

Surgical/autopsy areas can be decontaminated with 70% ethanol, MicroChem-Plus®, or
quaternary ammonia solution. Contact time should be 30 minutes.

If the suspected source is farm animals or unpasteurized dairy products, contact OCDE
who will contact the Washington State Department of Agriculture.

6. MANAGING SPECIAL SITUATIONS

A. Bioterrorist Event

*C. burnetii* has been classified as a potential bioterrorism agent because of its very low
infectious dose, its ability to survive in the environment, and the fact that it can
potentially be disseminated by aerosol. One should suspect bioterrorist spread of Q fever
if there is a cluster of patients with a non-specific febrile illness and pulmonary
symptoms in about one quarter of the cases. Chemoprophylaxis with tetracycline or
doxycline may be appropriate for people exposed in a bioterrorism event. *If
bioterrorism is suspected, call the Office of Communicable Disease Epidemiology
immediately (24/7) at 1-877-539-4344.*

7. ROUTINE PREVENTION

A. Immunization Recommendations

There is currently no licensed vaccine against Q fever in the United States.

B. Prevention Recommendations (available at: [http://www.cdc.gov/qfever/#prevention](http://www.cdc.gov/qfever/#prevention))

1. Educate the public on sources of infection.
2. Recommend use of personal protective equipment (PPE) while assisting with birthing and handling aborted fetuses, placentas, and other birth products. PPE may include a properly fitted respirator mask (N95 or higher rated), eye protection, disposable gloves, protective clothing, and rubber boots.


4. Follow good hygiene practices after animal contact, including washing hands and arms and removing coveralls and footwear used during farm work prior to entering homes.

5. Restrict access to barns and laboratories used in housing potentially infected animals.

6. Consume only pasteurized milk and milk products.

7. Use appropriate procedures for bagging, autoclaving, and washing of laboratory clothing.

8. Quarantine imported animals.

9. Ensure that holding facilities for sheep are located away from populated areas. Research animals should be routinely tested for antibodies to C. burnetii, and measures should be implemented to prevent airflow to other occupied areas.

10. Counsel exposed persons at highest risk for developing chronic Q fever, especially pregnant women, persons with pre-existing cardiac valvular disease or vascular grafts, or immunocompromised individuals.

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UPDATES

December 2008: Minor wording changes were made to the case definition (Section 3). The link to the PHL microbiology form was updated (Section 4).

January 2011: The Legal Reporting Requirements section has been revised to reflect the 2011 Notifiable Conditions Rule revision. Section 4 was updated to reflect current lab submission requirements.

December 2012: Illness description and occurrence in Washington (Sections 2 B & C) were revised. Additional laboratory detail was added in Section 4. The Routine Case Investigation and Controlling Further Spread sections were combined into a single Section 5, with additional detail added to parts B, D and F.

January 2015: Sections 2, 4, 5, and 7 were updated in accordance with the 2013 NASPHV guidelines for prevention and control of Coxiella burnetii infection and updated CDC guidelines.