2026 FIFA World Cup

Summary of Biological Threats: June-July 2026

Department of Public Health
CITY OF PHILADELPHIA

Clues to a possible bioterrorist attack:

- **Single cases of disease due to uncommon, non-indigenous agents in patients with no history suggesting an explanation for illness**
- **Clusters of patients with similar syndrome with unusual characteristics (e.g., unusual age distribution) or unusually high morbidity and mortality**
- **Unexplained increase in the incidence of a common syndrome above seasonally expected levels (e.g., increase in influenza-like illness during summer, or with negative tests for influenza and other respiratory viruses).**

To report suspected cases, access diagnostic testing, or to obtain more information contact the Division of Disease Control at 215-685-6741 during business hours (8:30am-5:00pm). After hours and on weekends and holidays call 215-686-4514, press 1 for Unified Dispatch, and ask for DDC On-Call staff.

Disease	Clinical Syndrome	Incubation Period	Diagnostic Samples	Diagnostic Assay	Patient Isolation Precautions	Treatment	Post-Exposure Prophylaxis	Comments
Anthrax	• Inhalational: febrile prodrome, respiratory distress, bacteremia, meningitis. • CXR: wide mediastinum • Cutaneous: ulcer • GI syndrome: less likely	1-5 days (up to 42 days described)	Sputum, blood, CSF; stool, ulcer swab or biopsy (BSL-2)	Gram stain, culture, PCR	Standard (no person-to-person transmission).	Cipro 400 mg IV q 8-12 or doxycycline 100 mg IV q 12; plus 1 or 2 additional abx (e.g., rifampin, vancomycin, penicillin, chloramphenicol, clindamycin, imipenem, clarithromycin); switch to po to complete 60 days (1 agent)	Cipro 500 BID or doxycycline 100 mg BID for 60 days, plus 3-dose regimen of anthrax vaccine (available through CDC, IND protocol)	If organism susceptible to penicillin, PEP for pregnant women and children can be changed to oral amoxicillin
Brucellosis	• Febrile prodrome • Osteoarticular disease, • Genitourinary infection • Hepatitis • Endocarditis and CNS involvement rarely	5-60 days, occasionally months	Serum; blood, bone marrow (BSL-2)	Serology; culture	Standard precautions; contact isolation if draining lesions	Doxycycline 200 mg/d po plus rifampin 600-900 mg/d po x 6wk	Doxycycline and rifampin for 3 wks. if inadvertently inoculated	Trimethoprim-sulfamethoxazole can be substituted for rifampin, although 30% relapse rate

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Plague	• Pneumonic: fulminant pneumonia, septicemia • Bubonic less likely	2-3 days	Blood, sputum, lymph node aspirate; serum (BSL-2/3)	Gram, Wright, Giemsa or FA stain; culture; Serology	Pneumonic: droplet precautions until patient treated for 3 days	Streptomycin 1gIM twice daily x 10 days, or gentamicin, doxycycline, ciprofloxacin, chloramphenicol	Doxycycline 100 mg po q 12 h x 7 days; ciprofloxacin 500 mg po BID x 7 days	Vaccine not protective against pneumonic infection
Q Fever	• Fever, • Systemic symptoms • Pneumonia • Hepatosplenomegaly	10-40 days	Serum (BSL-2)	Serology	Standard	Tetracycline 500 mg po QID x 5-7 days; doxycycline 100 mg po BID x 5-7 days	Doxycycline or tetracycline: start 8-12 d postexposure x 5 days	Vaccine available - investigational
Tularemia	• Ulceroglandular • Typhoidal (septicemic): fever, weight loss, pneumonia	2-10 days	Serum; Blood, sputum, ulcer swab, lymph node aspirate (BSL-2/3)	Serology; Gram stain, culture (PCR and DFA if available)	Standard	Streptomycin 1g IM twice daily, or gentamicin 5 mg/kg IM or IV daily or ciprofloxacin x 10 days; OR doxycycline or chloramphenicol x 14 days	Doxycycline 100 mg po q 12hrs x 14 days; Ciprofloxacin 500 mg po twice daily X 14 days	Transfer culture to BSL-3 after initial isolation of organism
Smallpox	• Fever • Systemic toxicity • Vesicular rash with centrifugal distribution • Lesions synchronous in stage of development	7-17 days	Pharyngeal swab, vesicular fluid, scab material (BSL-4)	ELISA, PCR, viral isolation	Airborne	None (cidofovir effective in vitro	Vaccine within 4 days of exposure, VIG (0.6 ml/kg IM within 3 days) if vaccine contraindicated	Preexposure and post-exposure vaccination recommended if > 3 yrs since last vaccination
Viral encephalitis	• VEE: fever, headache, malaise, photophobia, vomiting • WEE/EEE: febrile prodrome, somnolence, delirium	• VEE 2-6 days • WEE/EEE 7-14 days	Serum; CSF (BSL-2)	Serology; Viral isolation	Standard	Supportive	None	Vaccines available, although poorly immunogenic
Viral hemorrhagic fevers	• Fever, • myalgia, • hypotension, • hemorrhagic features	4-21 days	Serum; blood, formalin-fixed tissue biopsy (BSL-4)	Serology; Viral isolation, PCR, immunobiological detection of antigen in tissue	Contact precautions (consider additional precautions if massive hemorrhage)	Supportive; ribavirin for CCHF/arenaviruses; antibody passive for AHF, BHF, Lassa, CCHF	None	Aggressive management of hypotension, secondary infections

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Botulinum	• Ocular symptoms • Skeletal muscle paralysis – symmetric, descending • Respiratory failure	1-5 days	Serum, stool (BSL-2), gastric aspirate, vomitus	Mouse bioassay for toxin detection; culture	Standard	DOD heptavalent antitoxin serotypes A-G; CDC trivalent equine antitoxin serotypes A, B, E	None	Skin testing for hypersensitivity before equine antitoxin administration
Staphylococcal enterotoxin B	• Fever • Headache • Cough • Respiratory distress • GI symptoms	1-6 hours	Nasal swab, serum, urine (BSL-2)	Antigen detection (toxin) – ELISA; serology	Standard precautions	Supportive	None	Vomiting and diarrhea may occur if toxin is swallowed

Important contact information:

Philadelphia Department of Public Health…….215-685-6741; After-hours on-call: 215-686-4514
Philadelphia Police/Fire/Emergency……………..911
Poison Control Center………………………………….800-222-1222
Pennsylvania Department of Health……………..1-877-PA-HEALTH

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