

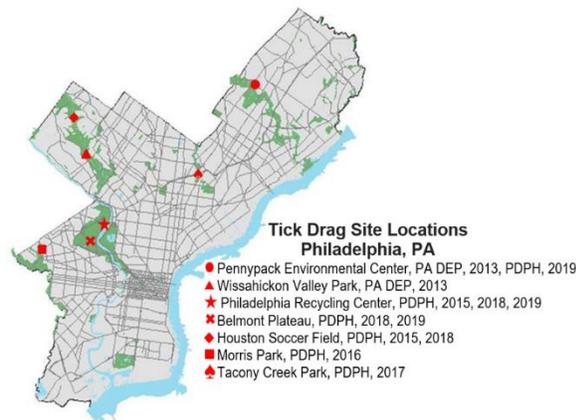
Health Advisory

Tickborne Diseases in Philadelphia: Recognition, Reporting, and Prevention

July 2, 2020

The height of the 2020 season for tickborne infections in Philadelphia and surrounding areas is upon us. While Lyme disease is the most frequently diagnosed tickborne illness in Philadelphia residents, cases of babesiosis, anaplasmosis, ehrlichiosis, and Rocky Mountain spotted fever (RMSF) are reported every year. Highlighting the potential for tickborne infections in Philadelphia, 57.8% of blacklegged ticks collected in City parks since 2013 have tested positive for Lyme disease, while 8.6% and 5.7% tested positive for anaplasmosis and babesiosis, respectively.

Providers should also be aware of emerging tickborne infections, like Powassan virus and *Borrelia miyamotoi*, that are transmitted by blacklegged ticks. In Philadelphia, Powassan was first identified in ticks collected in November 2019. In May 2020, the first Powassan virus infection was diagnosed in a resident of the City. This resident was likely infected in another PA county, was hospitalized with meningoencephalitis and has since been discharged to recover at home. *B. miyamotoi* has been detected in ticks in PA and causes a relapsing febrile illness. Providers should obtain a travel history when an emerging tickborne infection is suspected.



Many tickborne diseases have symptoms similar to COVID-19. During months of increased tick activity (now through October), patients presenting with rash, “flu-like” symptoms, including fever, fatigue, and lymphadenopathy, or altered mental status should also be evaluated for tickborne illnesses. See Table 1 for further details on tickborne disease symptoms and diagnostic testing. Please remember to report all suspected or confirmed cases of babesiosis, anaplasmosis, ehrlichiosis, RMSF, and Lyme disease (including clinically-diagnosed erythema migrans) within 5 days to PDPH by telephone at (215) 685-6748 or fax at (215) 238-6947. For uninsured and underinsured patients, free Lyme disease testing is available through the Pennsylvania Department of Health’s Bureau of Laboratories. For tickborne disease testing inquiries, call PDPH at (215) 685-6742.

Tick Bite Prevention

In addition to COVID-19 prevention measures (e.g., masking, distancing), providers should advise patients to take the following tick bite prevention tips when spending time outdoors:

- Wear insect repellent that contains DEET (≥20%) or another EPA-approved repellent and reapply as directed. Wearing clothing and gear that have been treated with permethrin will also help repel ticks.
- Walk in the center of trails and stay away from wooded or brushy areas with high grass and leaf litter.
- Conduct a full-body tick check and shower or bathe within two hours of returning indoors. Remove attached ticks with fine-tipped tweezers.
- Place clothes in a dryer on high heat for 10 minutes to kill ticks.
- Check pets for ticks daily, especially after spending time outdoors, and use tick repellent products.

Provider Resources

- Tickborne diseases of the United States. *A Reference Manual for Health Care Providers*: <https://www.cdc.gov/ticks/tickbornediseases/TickborneDiseases-P.pdf>
- Free prevention education materials for patients from the CDC: <https://www.cdc.gov/lyme/toolkit/>
- Philadelphia-specific tickborne disease surveillance updates on PDPH’s Health Information Portal: <https://hip.phila.gov/DataReports/TickborneDiseases>

Table 1. Epidemiologic and Clinical Characteristics of Tickborne Infections

	LYME DISEASE	BABESIOSIS	ANAPLASMOSIS	EHRlichiosis	RMSF	POWASSAN VIRUS	B. MIYAMOTOI
Main Vector	Blacklegged (deer) tick	Blacklegged (deer) tick	Blacklegged (deer) tick	Lone Star Tick	American Dog Tick	Blacklegged (deer) tick	Blacklegged (deer) tick
Incubation Period	3-30 days (from tick bite to rash development, if rash develops)	1–3 weeks	1–2 weeks	1–2 weeks	2–14 days	1-4 weeks	Days to weeks, range unknown
Rash	Erythema migrans in 70-80% of patients	--	Rare	30%	Spotted rash ~ 90% of patients	--	<10%
Complications	Early-disseminated disease: A-V block, Bell's palsy, cranial neuritis, lymphocytic meningitis/ encephalitis/ encephalomyelitis, multiple erythema migrans Late-onset: arthritis, radiculoneuropathy	Hepatospleno-megaly, thrombocytopenia, hemolytic anemia, death (5% in untreated cases infected with <i>B. microti</i>)	Difficulty breathing, hemorrhage, thrombocytopenia, leukopenia, LFT increases, renal failure, neurological problems, death (<1% in untreated cases)	Difficulty breathing, bleeding disorders, thrombocytopenia, leukopenia, LFT increases, death (1% in untreated cases)	Hearing loss, thrombocytopenia, leukopenia, mild LFT increases, amputation of extremities or limbs, paralysis, mental disability, death (30% in untreated cases)	Meningitis, confusion, loss of coordination, seizures, death (10% of cases with severe disease)	Fever, chills, and headache lasting 3 days, followed by 7 days without fever, followed by another 3 days of fever. If left untreated, this process can repeat several times
Laboratory Tests	A positive two-tier test. (This is defined as a positive or equivocal enzyme immunoassay (EIA) or immunofluorescent assay (IFA) followed by a positive Immunoglobulin M1 (IgM) or Immunoglobulin G 2 (IgG) western immunoblot (WB) for Lyme disease)	Microscopy PCR in whole blood	PCR IgG antibody titer to <i>A. phagocytophilum</i> antigen by IFA demonstrating a four-fold changes in paired serum samples Identification of morulae in the cytoplasm of monocytes or macrophages by microscopic examination	PCR IgG antibody titer to <i>E. chaffeensis</i> antigen by IFA demonstrating a four-fold changes in paired serum samples Identification of morulae in the cytoplasm of monocytes or macrophages by microscopic examination	PCR in whole blood during first week of illness onset AND IgG antibody testing by IFA demonstrating a four-fold changes in paired serum samples	PCR IHC IgM and neutralizing antibody testing (<i>neutralizing antibody testing only available at CDC</i>)	PCR Serologies <i>Testing only available at CDC</i>
Treatment	Doxycycline Cefuroxime axetil Amoxicillin	Atovaquone PLUS azithromycin; OR clindamycin PLUS quinine	Doxycycline*	Doxycycline*	Doxycycline*	None, Supportive Care	Doxycycline*

*Clinical suspicion is sufficient to begin treatment. Delay in treatment may result in severe illness and death.