

## Scrub typhus: a new cause of acute undifferentiated febrile illness in Latin America?

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4 **Keywords:** Scrub typhus, *Orientia*, Latin America, fever, travel  
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9 Classical scrub typhus or tsutsugamushi disease, caused by rickettsial bacteria of the  
10 species *Orientia tsutsugamushi*, is a re-emerging vector-borne infectious disease that affects  
11 more than one million people annually in the Asia-Pacific region, where it is an important cause  
12 of treatable undifferentiated febrile illness [1]. However, if confused with other etiologies and  
13 not adequately treated, case fatality rises significantly and reaches a mean value of 6%, but rates  
14 up to 70% have been reported [2].  
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24 Scrub typhus in countries of Asia, islands of the western Pacific and northern Australia is  
25 transmitted by the larval stage of trombiculid mites, known as chiggers, mainly different species  
26 of *Leptotrombidium*. Chiggers also serve as the reservoir of the pathogen, maintaining *O.*  
27 *tsutsugamushi* through transstadial and transovarial transmission [1]. Outdoor activities, which  
28 predispose humans to be attacked by chiggers (e.g., land clearing, logging, eco-tourism, military  
29 operations, rice farming, collecting firewood), are recognized as risk factors for infection.  
30 Historically, endemic regions of scrub typhus, the so-called “tsutsugamushi triangle,” range from  
31 southeastern Siberia in the North, the Kamchatka Peninsula in the East, and Pakistan in the West,  
32 to the northern Australia in the South [1].  
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45 Clinically, scrub typhus is one of the eschar-associated rickettsioses. After the painless  
46 chigger bite, a necrotic eschar forms at the inoculation site, containing high bacterial loads that  
47 spread regionally through lymphatic vessels and systemically via blood vessels. Shortly after,  
48 generalized infection of endothelial cells causes systemic manifestations such as fever, rash, and  
49 a variety of non-specific symptoms (e.g., headache, myalgia, night sweats), which are  
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4 accompanied by alterations of laboratory parameters such as elevation of C-reactive protein and  
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6 liver enzymes [1]. Severe cases develop respiratory, neurological, and cardiovascular damage.  
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11 *Orientia* genus. However, the global epidemiology of this and possible other *Orientia* species  
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13 remained uncertain due to the lack of studies and insufficient scientific interest in the disease and  
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15 its vectors [3,4]. The existence of scrub typhus outside the tsutsugamushi triangle was initially  
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17 suggested 70 years ago by a study that reported antibody and skin reactivity to *O. tsutsugamushi*  
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19 antigens in febrile patients and healthy controls from Rwanda [5]. Further serological evidence  
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21 derived from three case reports of travelers suffering from scrub typhus after returning from trips  
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23 to Africa (Republic of Congo, Cameroon, and Tanzania) and serosurveys in East Africa (Kenya,  
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25 Djibouti) and West Africa (Sao Tome and Principe) [5,6]. Recent molecular studies detected  
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27 DNA of *Orientia* spp. or closely related bacteria in rodent tissue samples (Senegal), blood from a  
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29 healthy dog (South Africa), and chigger mites (Kenya) [5]. In 2006, the first molecularly  
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31 confirmed scrub typhus case outside the tsutsugamushi triangle was diagnosed in a traveler who  
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33 visited Dubai (United Arab Emirates). The infection was caused by a new species, *Candidatus*  
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35 *Orientia chuto* [7]; nevertheless, no further cases have been detected in this region.  
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43       However, the most significant epidemiological novelty related to scrub typhus came from  
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45 South America, where in 2011, the disease was first suspected in a biologist, who returned from  
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47 fieldwork on Chiloé Island, southern Chile [8]. In the following years, scrub typhus was  
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49 diagnosed in various island inhabitants, confirming the first autochthonous focus of the infection  
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51 outside Asia-Pacific [9]. Since then, further scrub typhus cases were detected in various other  
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53 regions of continental Chile (Los Lagos, Aysén, and Bio Bio) [10], recently extending  
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55 southwards into subantarctic latitudes [11]. The clinical presentation of scrub typhus in Chile is  
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4 similar to the disease in Asia-Pacific. Almost all patients present with fever accompanied by  
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6 cutaneous manifestations (maculopapular rash and eschar) as well as chills, headache, myalgia,  
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8 and night sweats [12]. In contrast to the experiences from Asia-Pacific, scrub typhus in Chile  
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10 frequently affects travelers [13]. Phylogenetic analyses demonstrated that the infection in Chile  
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12 is caused by a novel *Orientia* species, *Candidatus Orientia chiloensis* [14]. In addition, a newly  
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14 identified chigger mite species, *Herpetacarus (Abonnencia) eloisae*, collected from rodents on  
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16 Chiloé Island, was found infected with *Orientia* spp., suggesting its possible role as vector  
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21 [15,16].  
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24 Although studies on scrub typhus in the Americas mainly derive from Chile, this  
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26 rickettsiosis might also occur in other Latin American countries. A retrospective study among  
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28 febrile patients in the Peruvian Amazon (Loreto Department) provided the first serological  
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30 evidence of exposure to *Orientia* species in tropical South America. Although the seroprevalence  
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32 was low (5.3%) and molecular evidence was not found, one febrile patient, stationed in a rural  
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34 military camp near Iquitos, showed IgG seroconversion to *Orientia* spp. [17]. An even broader  
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36 distribution of *Orientia* pathogens was suggested by a recent study in Central America,  
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38 demonstrating a seroreactivity rate of 5.6% (including 4.3% seroconversion) to *O. tsutsugamushi*  
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40 antigens among military personnel returning from long-term deployment to Honduras [18].  
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46 Our knowledge of trombiculid mites in Latin America, including the presumed vectors of  
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48 scrub typhus, is scarce and fragmentary. The countries that are best sampled are those in which  
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50 there were expeditions to discover the local fauna, such as Venezuela [19] and Panama [20], as  
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52 well as those that have or had experts in the taxonomy of chiggers, such as Mexico [21] and  
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54 Brazil [23]. Furthermore, species diversity and exact taxonomy are uncertain since many species  
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56 are only known from the type series. Therefore, many questions on the Neotropical chigger  
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4 fauna, host associations, and vector competence are unanswered. Clinical cases of human  
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6 chigger bite reactions (trombiculiasis) have been reported from different Latin American  
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8 countries, but mostly without correct identification of the involved species [23-28]. Only  
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10 *Apolonia tigipioensis* and *Eutrombicula* spp. have been identified parasitizing humans in South  
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12 America [29-32], while *Herpetacarus* spp., the proposed vector of scrub typhus in Chile, was  
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14 exclusively collected from small mammals [16,33]. However, recent findings from Chile suggest  
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16 that members of this genus are anthropophilic, strengthening their probable role as vector (M.C.  
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18 Silva-de la Fuente and T. Weitzel, unpublished observations).  
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24 In many low- and middle-income countries, causes of febrile disease are incompletely  
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26 understood [34]. The recent discovery of a new *Orientia* species causing scrub typhus in Chile  
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28 and serological evidence in Peru and Honduras suggest that *Orientia* spp. should be considered a  
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30 possible etiology of febrile illness in Latin America especially in rural populations and travelers  
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32 with nature contact. This paradigm shift regarding scrub typhus - formerly a geographically  
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34 limited disease in Asia-Pacific, now more widespread including Latin America - will probably  
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36 expand to regions in Africa and the Middle East [35]. Further studies are necessary to understand  
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38 the global epidemiology of *Orientia* and other neglected *Rickettsia* species and their vectors. In  
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40 the meantime, physicians should maintain a high level of clinical awareness and include scrub  
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42 typhus in the differential diagnosis of febrile patients, including travelers, even if they were  
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44 exposed in countries that are not known to be endemic.  
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21 C. R. Silva-Ramos and Á. A. Faccini-Martínez wrote the draft manuscript; F. C. Jacinavicius, Á.  
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23 A. Faccini-Martínez and T. Weitzel wrote the original manuscript; all authors critically reviewed  
24  
25 the manuscript for relevant intellectual content; all authors have read and approved the final  
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27 version of the manuscript.  
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31 **Declaration of competing interest**  
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34 The authors declare that the manuscript was conducted in the absence of any commercial or  
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