**Virginia Department of Health**  
**Tularemia: Overview for Healthcare Providers**

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<tr>
<th><strong>Organism</strong></th>
<th><em>Francisella tularensis</em>: gram-negative bacteria that are small, aerobic, nonspore-forming coccobacilli. Multiple strains have been recognized.</th>
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<tr>
<td><strong>Infectious Dose</strong></td>
<td>Very low: 10 bacteria when injected subcutaneously and 25 when aerosolized</td>
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<td><strong>Occurrence</strong></td>
<td>Occurs throughout North America and in many parts of continental Europe, Russia, China and Japan. Approximately 165 cases in the United States and 2 cases in Virginia are reported annually. Tularemia is more common during May-September. Males are affected more frequently than females, and children are affected more than adults.</td>
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<td><strong>Natural Reservoir</strong></td>
<td>Small mammals (including voles, rodents, squirrels, rabbits, hares, muskrats, beavers) and various hard ticks. Numerous other wild and domestic animals, including cats, dogs, hamsters, can be affected.</td>
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| **Route of Infection** | • Inhalation of dust with infective aerosols (from contaminated soil, grain or hay), or inhalation of organisms from animal carcasses  
• Bite of infected arthropods (wood, dog and lone star ticks; less commonly in deer flies; and, in other countries, mosquitoes)  
• Ingestion of contaminated meat, water, soil or vegetation  
• Contact with contaminated water, soil, vegetation or infectious animal tissues or fluids  
• Handling sick pet animals or exotic animals |
| **Communicability** | • No person-to-person transmission  
• *F. tularensis* can be found in blood during first 2 weeks of disease and in lesions for a month or more; flies are infective for 14 days and ticks are infective throughout their lifetime (~2 years) |
| **Risk factors** | Risk is higher if hunting, trapping, butchering, farming, landscaping, or handling infectious laboratory specimens |
| **Case-fatality Rate** | Range <2%–24%, depending upon the strain |
| **Incubation Period** | Related to the size of the inoculum; average is 3–5 days (range 1–14 days) |
| **Clinical Description** | • There are multiple clinical forms that depend on the transmission route.  
• Ulceroglandular: most common syndrome; cutaneous ulcer with regional lymphadenopathy; occurs through contact with an infected animal carcass or through an arthropod bite  
• Glandular: common syndrome; regional lymphadenopathy with no ulcer; occurs through contact with an infected animal carcass or through an arthropod bite  
• Oculoglandular: uncommon syndrome; conjunctivitis with preauricular lymphadenopathy; occurs with direct contamination of eye  
• Oropharyngeal: uncommon syndrome; stomatitis, pharyngitis, tonsillitis, cervical lymphadenopathy; occurs through ingestion of contaminated food or water or inhalation of contaminated droplets  
• Intestinal: intestinal pain, vomiting and diarrhea; occurs rarely, through ingestion of contaminated food or water |
Typhoidal: uncommon syndrome; febrile illness without early localizing signs and symptoms; used to describe illness in patients with systemic infections without cutaneous or mucosal membrane lesions

Pneumonic: most serious syndrome, typical after intentional aerosol release of organism; primary pleuropulmonary disease; occurs through inhalation of infectious aerosols or secondary to spread in the blood

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<th>Differential Diagnosis</th>
<th>Depends upon the clinical manifestations and transmission route</th>
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**Radiography**

- Radiographic findings include patchy subsegmental air space opacities, hilar lymphadenopathy, and pleural effusion.
- Earliest findings might be peribronchial infiltrates advancing to bronchopneumonia.

**Specimen Collection and Laboratory Testing**

- Appropriate specimens include swabs or scrapping of skin lesions, lymph node aspirates or biopsies, pharyngeal washings, sputum specimens, or gastric aspirates, depending on the form of illness. Blood cultures are often negative.
- A presumptive diagnosis can be made by direct fluorescent antibody, immunohistochemical staining, or PCR.
- A diagnosis can also be established serologically by demonstrating a 4-fold change in specific antibody titers between acute and convalescent sera. Convalescent sera are best drawn at least 4 weeks after illness onset; hence this method is not useful for clinical management.
- If tularemia is suspected, notify LHD immediately to discuss the case and laboratory testing. Specimens may be sent to the Division of Consolidated Laboratory Services (DCLS) after VDH has been approved testing. For questions about specimen collection, the DCLS Emergency Officer can be reached 24/7 at 804-335-4617.

**Treatment**

- Streptomycin is the drug of choice for sporadic cases and gentamicin is an acceptable alternative. During a mass casualty situation (i.e., when intramuscular or intravenous treatment is not available), doxycycline or ciprofloxacin are the preferred choices for treatment.

**Postexposure Prophylaxis**

- Doxycycline or ciprofloxacin are the preferred choices for postexposure prophylaxis during a mass casualty situation.

**Vaccine**

- No vaccine available

**Infection Control**

- Standard Precautions should be used when caring for patients
- Laboratory personnel should be alerted when tularemia is suspected
- Bodies of patients who die of tularemia should be handled using standard precautions. Autopsy procedures likely to produce aerosols or droplets should be avoided.