Case Report: Zika Virus Infection Acquired During Brief Travel to Indonesia

Jason C. Kwong,* Julian D. Druce, and Karin Leder

Victorian Infectious Diseases Service, The Royal Melbourne Hospital, Melbourne, Victoria, Australia; Victorian Infectious Diseases Reference Laboratory, Melbourne, Victoria, Australia; Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Victoria, Australia

Abstract. Zika virus infection closely resembles dengue fever. It is possible that many cases are misdiagnosed or missed. We report a case of Zika virus infection in an Australian traveler who returned from Indonesia with fever and rash. Further case identification is required to determine the evolving epidemiology of this disease.

A previously healthy 52-year-old Australian woman had malaise and rash after a 9-day holiday to Jakarta, Indonesia. On arrival in Australia, she initially reported some fatigue and non-specific malaise, followed by a prominent headache. The headache subsequently began to subside, but on day 4 of her symptoms, a maculopapular rash developed that started on her trunk before spreading to her back and limbs, but not her face. This rash was accompanied by generalized myalgia, some loose bowel movements, and an occasional dry cough. She did not experience any significant sweats or rigors.

Examination on day 5 of her illness showed mild bilateral conjunctivitis and a diffuse maculopapular rash, but no evidence of lymphadenopathy or tenosynovitis. Investigations at this time showed a total leukocyte count of 3.6 \( \times 10^9 \) cells/L (reference range = 4.0–11.0 \( \times 10^9 \) cells/L), a hemoglobin level of 137 g/L (reference range = 115–150 g/L), a hematocrit of 39%, and platelet count of 230 \( \times 10^9 \) cells/L (reference range = 140–400 \( \times 10^9 \) cells/L). Reactive lymphocytes were present on a blood film. Baseline liver and renal function test results were normal.

Dengue serologic analysis on day 5 of her illness showed a positive result for IgG, a weakly positive result for IgM, but no evidence of lymphadenopathy or tenosynovitis. Investigations at this time showed a total leukocyte count of 3.6 \( \times 10^9 \) cells/L (reference range = 4.0–11.0 \( \times 10^9 \) cells/L), a hemoglobin level of 137 g/L (reference range = 115–150 g/L), a hematocrit of 39%, and platelet count of 230 \( \times 10^9 \) cells/L (reference range = 140–400 \( \times 10^9 \) cells/L). Reactive lymphocytes were present on a blood film. Baseline liver and renal function test results were normal.

Examination on day 5 of her illness showed mild bilateral conjunctivitis and a diffuse maculopapular rash, but no evidence of lymphadenopathy or tenosynovitis. Investigations at this time showed a total leukocyte count of 3.6 \( \times 10^9 \) cells/L (reference range = 4.0–11.0 \( \times 10^9 \) cells/L), a hemoglobin level of 137 g/L (reference range = 115–150 g/L), a hematocrit of 39%, and platelet count of 230 \( \times 10^9 \) cells/L (reference range = 140–400 \( \times 10^9 \) cells/L). Reactive lymphocytes were present on a blood film. Baseline liver and renal function test results were normal.

Dengue serologic analysis on day 5 of her illness showed a positive result for IgG, a weakly positive result for IgM, but no evidence of lymphadenopathy or tenosynovitis. Investigations at this time showed a total leukocyte count of 3.6 \( \times 10^9 \) cells/L (reference range = 4.0–11.0 \( \times 10^9 \) cells/L), a hemoglobin level of 137 g/L (reference range = 115–150 g/L), a hematocrit of 39%, and platelet count of 230 \( \times 10^9 \) cells/L (reference range = 140–400 \( \times 10^9 \) cells/L). Reactive lymphocytes were present on a blood film. Baseline liver and renal function test results were normal.

Examination on day 5 of her illness showed mild bilateral conjunctivitis and a diffuse maculopapular rash, but no evidence of lymphadenopathy or tenosynovitis. Investigations at this time showed a total leukocyte count of 3.6 \( \times 10^9 \) cells/L (reference range = 4.0–11.0 \( \times 10^9 \) cells/L), a hemoglobin level of 137 g/L (reference range = 115–150 g/L), a hematocrit of 39%, and platelet count of 230 \( \times 10^9 \) cells/L (reference range = 140–400 \( \times 10^9 \) cells/L). Reactive lymphocytes were present on a blood film. Baseline liver and renal function test results were normal.

Examination on day 5 of her illness showed mild bilateral conjunctivitis and a diffuse maculopapular rash, but no evidence of lymphadenopathy or tenosynovitis. Investigations at this time showed a total leukocyte count of 3.6 \( \times 10^9 \) cells/L (reference range = 4.0–11.0 \( \times 10^9 \) cells/L), a hemoglobin level of 137 g/L (reference range = 115–150 g/L), a hematocrit of 39%, and platelet count of 230 \( \times 10^9 \) cells/L (reference range = 140–400 \( \times 10^9 \) cells/L). Reactive lymphocytes were present on a blood film. Baseline liver and renal function test results were normal.

Examination on day 5 of her illness showed mild bilateral conjunctivitis and a diffuse maculopapular rash, but no evidence of lymphadenopathy or tenosynovitis. Investigations at this time showed a total leukocyte count of 3.6 \( \times 10^9 \) cells/L (reference range = 4.0–11.0 \( \times 10^9 \) cells/L), a hemoglobin level of 137 g/L (reference range = 115–150 g/L), a hematocrit of 39%, and platelet count of 230 \( \times 10^9 \) cells/L (reference range = 140–400 \( \times 10^9 \) cells/L). Reactive lymphocytes were present on a blood film. Baseline liver and renal function test results were normal.
REFERENCES


