Case Report: First Case of Zika Virus Infection in a Returning Canadian Traveler

Kevin Fonseca,* Bonnie Meatherall, Danielle Zarra, Michael Drebot, Judy MacDonald, Kanti Pabbaraju, Sallene Wong, Patricia Webster, Robbin Lindsay, and Raymond Tellier

Provincial Laboratory for Public Health, Calgary, Alberta, Canada; Alberta Health Services, Calgary, Alberta, Canada; National Microbiology Laboratory; Public Health Agency of Canada, Winnipeg, Manitoba, Canada; University of Calgary, Calgary, Alberta, Canada; University of Manitoba, Winnipeg, Manitoba, Canada

Abstract A woman who recently traveled to Thailand came to a local emergency department with a fever and papular rash. She was tested for measles, malaria, and dengue. Positive finding for IgM antibody against dengue and a failure to seroconvert for IgG against dengue for multiple blood samples suggested an alternate flavivirus etiology. Amplification of a conserved region of the non-structural protein 5 gene of the genus Flavivirus yielded a polymerase chain reaction product with a matching sequence of 99% identity with Zika virus. A urine sample and a nasopharyngeal swab specimen obtained for the measles investigation were also positive for this virus by reverse transcription polymerase chain reaction. Subsequently, the urine sample yielded a Zika virus isolate in cell culture. This case report describes a number of novel clinical and laboratory findings, the first documentation of this virus in Canada, and the second documentation from this region in Thailand.

The tourist industry has successfully promoted and popularized travel to countries, for the average North American traveler, that a few decades ago would not be considered vacation or travel destinations. Many of these locations are in tropical countries where mosquito-borne diseases, such as dengue and malaria, are endemic and highly prevalent. Early signs and symptoms of these travel-related infections can be similar and overlapping, therefore requiring differentiation through laboratory testing. In some regions, where multiple infectious agents co-circulate in mosquito vectors, it is no longer possible to infer with certainty which agent could be causing the disease on the basis of geographic location and clinical signs and symptoms.

We report the detection of Zika virus in a Canadian traveler who was classified as having a case of dengue fever based upon the clinical and epidemiologic history, and preliminary laboratory investigations. However, the atypical dengue serologic results prompted us to reconsider the possibility of another flavivirus infection.

The patient went to Thailand with a party of family and friends to attend a wedding and received travel counseling before her flight. She left Canada on January 20, 2013 and flew to Bangkok via Hong Kong where she stayed for eight days, and recalled being bitten by mosquitoes on a few occasions. She traveled to Kata Beach, Phuket Island, stayed for five days and noted a modest number of bites. She then returned to a hotel in Bangkok located near a river where she stayed for three days and recalled significant mosquito exposure day and night. She did not take medications for malaria, and she did not use a bed net at night. She flew back to Canada via Hong Kong, and noted a few mosquito bites during transit. During her flight she felt irritable, had a backache but no fever or chills, described her bitten areas as itchy, for which she took acetaminophen.

On her return to Canada, she returned to work the next day, and noted the onset of intermittent periods of fever and chills (day one of illness). Two days later, her mouth became sore and oral blisters developed. On day five of illness, a papular rash developed, which spread to her extremities and included her palms. The rash lasted four days, and in conjunction with a retro-orbital headache and fever and mild conjunctivitis, prompted a visit to an emergency department.

Blood, nasopharyngeal swab, and urine samples were collected for investigation of measles and other infectious causes as the differential work-up for travel associated pathogens. On day seven of illness, significant joint and muscle tenderness developed, which lasted for two complete days and then became episodic for an additional four days, followed by a gradual return to her normal well-being, which took an additional three days. The time from the prodromal period, which was marked by intermittent fever and chills, to the resolution of her symptoms, was approximately 16 days.

Initial laboratory investigations showed a hemoglobin level of 131 g/L, a leukocyte count of 4.7 × 10⁹ cells/L, with a normal differential, but low platelet count of 81 × 10⁹ cells/L (reference range = 150–400 × 10⁹ cells/L). Levels of creatinine, electrolytes, alanine aminotransferase, and alkaline phosphatase were within reference ranges. Thick and thin blood smears were negative for malaria and other blood parasites, and blood cultures were negative for bacterial pathogens. Dengue IgM and IgG serologic analysis was performed by using kits from Focus Diagnostics (Cypress, CA) as specified by the manufacturer’s protocol.

A number of blood samples were obtained in February and March to determine if this person had an acute dengue infection; these samples later indicated dengue seroconversion. The positive dengue IgM result from blood collected on day 10 of her illness was considered indicative of an acute infection, which was consistent with her other symptoms and collectively compatible with a clinical picture of acute dengue fever (Table 1). However, blood obtained on day 41, did not show IgG seroconversion, and IgM values for the previous serum sample (obtained on day 10) and this sample were fairly similar (Table 1). This inconsistency prompted us to investigate the possibility of another flavivirus infection.

The decision to use a reverse transcription polymerase chain reaction (RT-PCR) described by Ayers et al,¹ was based upon her onset of illness and availability of archived

*Address correspondence to Kevin Fonseca, Provincial Laboratory of Public Health, 3030 Hospital Drive NW, Calgary, Alberta, Canada. E-mail: kevin.fonseca@albertahealthservices.ca

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serum samples from this period. This gel-based PCR targets the conserved nonstructural protein 5 gene region across numerous species of this genus, but enables subsequent discrimination between them because of characteristic sequence variations within the amplicon.

The results of the RT-PCR are shown in Figure 1 for blood, urine, and nasopharyngeal samples. The urine and nasopharyngeal swab specimen were included because nucleic acid extracts were available from the earlier measles RT-PCR testing, which showed negative results. Significant bands can be seen at the 800–900-base pair range expected for flaviviruses for the samples collected in the acute phase of her illness. The amplicon from each of these bands was sequenced and found to be identical between the various specimen types, and was highly homologous to the Asian lineage of Zika virus (GenBank accession no. JN60885) (Figure 2).

As a result, Zika virus serologic testing was referred to the Centers for Disease Control (CDC) in Fort Collins, Colorado, where IgM testing using an in-house enzyme immunoassay and a plaque-reduction neutralization test (PRNT) were performed; these results are shown in Table 1. Seroconversion to Zika virus was demonstrated by the CDC enzyme immunoassay (from equivocal to positive) and an increase in PRNT titers in acute-phase and convalescent-phase samples, complementing the molecular findings.

The National Microbiology Laboratory in Winnipeg, Manitoba, Canada, successfully isolated Zika virus from the urine sample by using a Vero E6 cell line. Sufficient viral RNA was present in the urine and nasopharyngeal samples to determine most of the genome, segments of which were complemented by sequencing templates from the cultured virus. The complete Zika virus sequence is deposited in GenBank under accession no. KF993678. A phylogenetic tree comparing this virus with other prototype flaviviruses is shown in Figure 2.

This case has a number of interesting features, notwithstanding that this is the first reported detection of Zika virus in Canada and the second reported detection from this part of Thailand. Furthermore, we isolated the virus in culture and determined the complete genome sequence.

The origins of Zika virus date back to its isolation from sentinel rhesus monkeys in the Zika Forest of Uganda. In 2010, during syndromic surveillance of patients with fever in neighboring Cambodia, a case of Zika virus infection in a young child was detected by PCR which indicated its presence in this area of Southeast Asia. An outbreak in Yap Island, Micronesia in 2007 and more recently in French Polynesia in 2013 and 2014 illustrate the global distribution of this agent in Asia and the Pacific region, which in many respects are the same regions where dengue is also endemic. Various species of Aedes mosquitoes, including Aedes aegypti are the permissive vectors of Zika virus, and this mosquito species is also capable of transmitting dengue, making it

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**Table 1**

<table>
<thead>
<tr>
<th>Sample type</th>
<th>No. days after onset†</th>
<th>Dengue EIA (IgM/IgG)</th>
<th>RT-PCR gel-based assay result</th>
<th>CDC results, Zika virus IgM EIA or PRNT‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>6</td>
<td>NT</td>
<td>Positive</td>
<td>IgM EIA: Equivocal</td>
</tr>
<tr>
<td>Urine and nasopharyngeal</td>
<td>6</td>
<td>NT</td>
<td>Positive</td>
<td>IgM EIA: Equivocal, PRNT titer &lt; 10</td>
</tr>
<tr>
<td>swab specimen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td>9</td>
<td>Negative/negative</td>
<td>Positive</td>
<td>IgM EIA: Equivocal</td>
</tr>
<tr>
<td>Blood</td>
<td>10</td>
<td>Positive (2.5)/negative</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td>41</td>
<td>Positive (1.5)/negative</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td>77</td>
<td>Positive (1.5)/negative</td>
<td>NT</td>
<td>IgM EIA: Strongly positive, PRNT titer = 1,280</td>
</tr>
<tr>
<td>Blood</td>
<td>114</td>
<td>Negative/negative</td>
<td>NT</td>
<td></td>
</tr>
</tbody>
</table>

* EIA = enzyme immunoassay; RT-PCR = reverse transcription polymerase chain reaction; CDC = Centers for Disease Control and Prevention; PRNT = plaque reduction neutralization test; NT = not tested; NA = not available.
† Number of days when samples were collected after onset of illness.
‡ See text for description of testing.
plausible that Zika virus can also circulate in areas in which
dengue is endemic.

The incubation period of flaviviruses, such as West Nile
virus and dengue virus, is considered to be from 3 to 7 days
(range = 3–14 days).9 On the basis of the significant mosquito
exposure of the patient in early February and onset of illness
with fever and chills on February 6, the incubation period
would be consistent with the reported range. The appearance
of a rash on her fifth day of illness corresponds to the viremic
phase, which is detectable by the gel-based assay, and her
immune response to infection. Most notably, the presence
of the virus in her nasopharynx and urine, together with cul-
ture of the virus from her urine, indicates significant levels
of viral circulation and shedding and the possibility of person-
to-person transmission in a close setting. There was a reported
case of sexual transmission in a patient who was in the early
stage of his infection.9

From a diagnostic perspective, the collection of urine and
nasopharyngeal swab specimens at the onset of illness could
also be used as alternative or complementary samples to
blood for molecular detection of Zika virus, especially in
persons returning from areas where both flaviviruses are
endemic and for whom clinical signs and symptoms are not
typical for dengue.

The likelihood of transfusion-related transmission has
recently been investigated in mild or asymptomatic cases
because of the brief viremic period (3–5 days) in the acute
phase of the infection. A prevalence of 2.8% of blood donors
were positive for Zika virus in the on-going outbreak in
French Polynesia; furthermore, the sequences of the virus
from these donors were similar to those from the circulating
outbreak strain.10 Similar events of transfusion-associated
transmission have been reported with West Nile virus, another
related flavivirus.11

The clinical signs and symptoms of infection with Zika virus
can be easily confused with dengue, mainly because of the
fever, headache, and generalized rash-like presentation. A
non-purulent conjunctivitis is a unique feature of Zika virus
infections, and was described in 55% of cases in the Yap
Island outbreak,6 and also a finding in our case, although not
often reported for dengue unless it is a severe hemorraghic
presentation. Although speculative, infections with the Asian
lineage of Zika virus are associated with a higher frequency
of conjunctivitis because case reports from Africa make no
reference to this feature.

The serologic tests performed at CDC showed an early IgM
response, whereas the neutralizing antibody response detected
by the PRNT can take somewhat longer. Presently, serologic
assays for Zika virus are not commercially available, and our
case suggests the possibility of using a combination of a positive
IgM response to dengue virus and lack of an IgG seroconver-
sion for convalescent-phase serum samples as a potential sur-
rogate to investigate another flavivirus. However, when the
dengue IgM response is positive, Zika virus is no longer detect-
able, and for our case the cross-reactive IgM response was
detectable for at least one month. Thus, having blood samples
obtained at the onset of illness and stored for molecular testing
is necessary and increases the likelihood of detecting virus in
clinical samples because the viremic period is brief. This find-
ing contrasts with dengue virus infections when the viremic
phase overlaps the period when the IgM is detectable.12 Inter-
estingly, the cross-reactive IgM response to West Nile virus,
another flavivirus, was not seen for samples from this patient.
A similar lack of cross-reactivity to West Nile virus was noted
in the Yap Island outbreak,13 and the case of the recent German
traveler.3 A positive dengue IgM result and the overlapping
features of the infection can reinforce an incorrect classification
of a Zika virus infection as dengue. A recent case report by
Kwong and others14 also commented on this possibility.

The availability of molecular testing using primers to con-
served regions of the flavivirus genus has great merit in detect-
ing a different etiologic agent, as in this particular case.
Although dengue is considered to be the most prevalent agent
causing typical fever and rash-like illness in the returning
traveler, other viruses such as chikungunya15 and possibly Zika
virus, are also now co-circulating in some of these tourist desti-
nations, where the management of the patient may be different.
In chikungunya virus–infected patients, treatment with nonste-
roidal anti-inflammatory drugs and corticosteroids may be con-
considered when these patients have severe and disabling joint
involvement, which can last for extended periods.16 In contrast,
Zika virus infections are, for the most part, self-limiting and
without significant sequelae.5,6

The significant advantage of a positive molecular test result
is that the result is definitive, and thus precludes follow-up
samples to monitor for serologic conversions and multiple
evaluations. Commercial molecular assays for dengue virus
are now available, and it is possible to use these and the gel-
based PCR in a stepwise algorithm to identify other probable
cases of viral agents. One limitation of molecular-based assays
is their dependence upon significant viremia for detection.
Some travelers may be past this period if symptoms occur
while they are in transit or there is a delay in seeking medical
attention and collection of appropriate clinical samples.

In less-developed countries, financial and human resources
to identify these agents through serologic or molecular epidemi-
ology are either unavailable or restricted. Therefore, returning
travelers from developed countries can serve as sentinels for

Figure 2.  Phylogenetic analyses of Zika virus from the patient with representative sequences deposited in Genbank.17 Scale bar indicates nucleotide substitutions per site.
the presence of these emerging agents, especially if their onset of illness is within a few days of their return and the appropriate samples are collected and sent to a laboratory with advanced diagnostics.

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Authors’ addresses: Kevin Fonseca, Danielle Zarra, Kanti Pabbaraju, Sallene Wong, and Raymond Tellier, Provincial Laboratory for Public Health, Calgary, Alberta, Canada, E-mails: kevin.fonseca@albertahealthservices.ca, danielle.zarra@albertahealthservices.ca, kanti.pabbaraju2@albertahealthservices.ca, sallene.wong@albertahealthservices.ca, and raymond.tellier@albertahealthservices.ca. Michael Drebot and Robbin Lindsay, National Microbiology Laboratory, Public Health Agency of Canada, Winnipeg, Manitoba, Canada, and University of Manitoba, Winnipeg, Canada, E-mails: mike.drebot@phac-aspc.gc.ca and robbin.lindsay@phac-aspc.gc.ca. Judy MacDonald, Bonnie Metherall, and Patricia Webster, Alberta Health Services, Calgary, Alberta, Canada, E-mails: judy.macdonald@albertahealthservices.ca, blmcathe@ucalgary.ca, and patricia.webster@albertahealthservices.ca. Bonnie Metherall, Judy Macdonald, Kevin Fonseca, and Raymond Tellier, University of Calgary, Calgary, Alberta, Canada.

REFERENCES