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NH DIVISION OF Public Health Services
Department of Health and Human Services

Oropouche Virus and Risk of Vertical Transmission During Pregnancy

Key Points and Recommendations:

- Review the CDC HAN (1st attachment) about risk of travel-associated Oropouche virus in the Americas, particularly for pregnant women because of the potential for vertical transmission during pregnancy with reports of congenital abnormalities.
    - Refer also to CDC's interim clinical considerations for pregnant persons with Oropouche virus.
- Review the attached NH Division of Public Health Services' (DPHS) Healthcare Provider Frequently Asked Questions (2nd attachment).
- Consider Oropouche virus infection in people who travel to affected areas and develop compatible signs and symptoms within 2 weeks of returning (consider also dengue, Zika, and chikungunya viruses).
    - Currently in 2024, Oropouche virus has been detected in Bolivia, Brazil, Colombia, Peru, and Cuba, but this list may change.
- Report patients with suspected or confirmed Oropouche virus infection to NH DPHS at 603-271-4496 (after hours 603-271-5300), and send a completed arboviral case report form (Fax: 603-696-3017).
- Following the initial report, contact the NH Public Health Laboratories (NH PHL) at 603-271-4661 to request diagnostic testing for Oropouche virus. The NH PHL will facilitate testing which will occur at the CDC.
    - See below for more details on specimen collection and laboratory testing.
    - Currently the CDC is only testing patients who meet their suspect case definition and accepting serum and cerebrospinal fluid (CSF) specimens for testing.
- NH DPHS continues to host healthcare provider webinars on the 2nd Thursday of each month from 12:00–1:00 pm. We will provide updates on Oropouche virus during our next webinar on **Thursday, September 12th**:
    - Click Here to Join the Meeting (via Microsoft Teams)
    - Meeting ID: 278 434 186 837
    - Passcode: Bvfiah
    - Dial-In By Phone: 603-931-4944
    - Phone Conference ID: 902 201 066#

Additional Information on Specimen Collection and Laboratory Testing:

Currently diagnostic testing is conducted at the U.S. Centers for Disease Control and Prevention (CDC) on serum and/or cerebrospinal fluid (CSF) specimens. It is recommended that paired acute and convalescent specimens be obtained ≥2 weeks apart to confirm infection using a plaque reduction neutralization test (PRNT), although a single test may still be useful for clinical diagnosis. The CDC is also currently validating a PCR assay, but CDC's PCR testing is not currently able to be reported back to a patient or provider until test validation has occurred.

Refer to CDC's specimen requirements for information about specimen collection, which should include ≥1mL of serum and/or ≥1mL of CSF. Refrigerate specimens at 2-8°C after collection. When packaging specimens, refrigerated or frozen cold packs should be used to ensure the specimens are at 2-8°C during transport. Submit specimens to the NH PHL with a completed Clinical Laboratory Test Requisition form. Contact the NH PHL (603-271-4661) if courier service is needed for specimen pickup.

Additional Resources:

CDC clinical overview of Oropouche virus: https://www.cdc.gov/oropouche/hcp/clinical-overview/index.html

Attachments:

1. CDC HAN
2. NH DPHS Healthcare Provider Frequently Asked Questions (FAQs)

- For any questions regarding this notification, please call the NH DHHS, DPHS, Bureau of Infectious Disease Control at (603) 271-4496 during business hours (8:00 a.m. – 4:30 p.m.).
- If you are calling after hours or on the weekend, please call the New Hampshire Hospital switchboard at (603) 271-5300 and request the Public Health Professional on-call.
- To change your contact information in the NH Health Alert Network, please send an email to DHHS.Health.Alert@dhhs.nh.gov or visit www.nhhan.org.

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From:	Dr. Benjamin P. Chan, MD, MPH – NH State Epidemiologist
Originating Agency:	NH Department of Health and Human Services, Division of Public Health Services

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CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
August 16, 2024, 4:00 PM ET
CDCHAN-00515

Increased Oropouche Virus Activity and Associated Risk to Travelers

Summary
The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory to notify clinicians and public health authorities of an increase in Oropouche virus disease in the Americas region, originating from endemic areas in the Amazon basin and new areas in South America and the Caribbean. Between January 1 and August 1, 2024, more than 8,000 cases of Oropouche virus disease were reported, including two deaths and five cases of vertical transmission associated with fetal death or congenital abnormalities. Countries reporting cases include Brazil, Bolivia, Peru, Colombia, and Cuba. In the United States and Europe in 2024, travel-associated cases have been identified in travelers returning from Cuba and Brazil. As testing and surveillance for Oropouche virus disease increase in the Americas, reports of cases from additional countries are expected. This Health Advisory advises on evaluating and testing travelers who have been in impacted areas with signs and symptoms consistent with Oropouche virus infection. It also raises awareness of the possible risk of vertical transmission (e.g., from gestational parent to fetus during pregnancy) and associated adverse effects on pregnancy and highlights prevention measures to mitigate additional spread of the virus and potential importation into unaffected areas, including the United States.

Background
Oropouche virus belongs to the Simbu serogroup of the genus *Orthobunyavirus* in the *Peribunyaviridae* family. The virus was first detected in 1955 in Trinidad and Tobago and is endemic in the Amazon basin. Previous outbreaks have been described in Bolivia, Brazil, Colombia, Ecuador, French Guiana, Panama, and Peru. One child was infected in Haiti in 2014. The current 2024 outbreak is occurring in endemic areas and new areas outside the Amazon basin; countries reporting locally acquired (autochthonous) cases include Brazil, Bolivia, Peru, Colombia, and Cuba. Although travel-associated cases have been identified in the United States (n=11), no evidence of local transmission currently exists within the United States or its territories.

Sylvatic (enzootic) transmission of Oropouche virus occurs in forested areas between mosquitoes and non-human vertebrate hosts (e.g., sloths, non-human primates, domestic and wild birds, and rodents). Humans can become infected while visiting forested areas and are likely responsible for introducing the virus into urban environments. Humans contribute to the transmission cycle in urban environments since infected humans develop sufficient viremia to serve as amplifying hosts. Biting midges (*Culicoides paraensis*) and possibly certain mosquitoes (*Culex quinquefasciatus)* are responsible for transmitting the virus from an infected person to an uninfected person in urban areas.

Approximately 60% of people infected with Oropouche virus become symptomatic. The incubation period is typically 3–10 days. Initial clinical presentation is similar to diseases caused by dengue, Zika, and chikungunya viruses, with acute onset of fever, chills, headache, myalgia, and arthralgia. Other symptoms can include retroorbital (eye) pain, photophobia (light sensitivity), nausea, vomiting, diarrhea, fatigue, maculopapular rash, conjunctival injection, and abdominal pain. Clinical laboratory findings can include lymphopenia and leukopenia, elevated C-reactive protein (CRP), and slightly elevated liver enzymes. Initial symptoms typically resolve after a few days, but a high proportion (about 70%) experience recurrent symptoms days to weeks after resolution of their initial illness. Although illness is typically mild, it is estimated less than 5% of patients can develop hemorrhagic manifestations (e.g., epistaxis, gingival bleeding, melena, menorrhagia, petechiae) or neuroinvasive disease (e.g., meningitis, meningoencephalitis). Neuroinvasive disease symptoms may include intense occipital pain, dizziness,

confusion, lethargy, photophobia, nausea, vomiting, nuchal rigidity, and nystagmus. Clinical laboratory findings for patients with neuroinvasive disease include pleocytosis and elevated protein in cerebrospinal fluid (CSF).

Although people exposed to biting midges or mosquitoes infected with the virus are most at risk for developing disease, the risk factors for more severe Oropouche virus disease are not well-defined. People at risk for more severe disease likely include those at risk for severe disease with other viral infections transmitted by vectors (e.g., people aged 65 years or older, or those with underlying medical conditions, such as immune suppression, hypertension, diabetes, or cardiovascular disease). Earlier this year, Brazil reported two deaths in otherwise healthy non-pregnant women, and five cases in pregnant people with evidence of vertical transmission of the virus to the fetus associated with fetal death or congenital abnormalities, including microcephaly. This was the first report of deaths and Oropouche virus vertical transmission and associated adverse birth outcomes.

Laboratory diagnosis is generally accomplished by testing serum. Cerebrospinal fluid can also be tested in patients with signs and symptoms of neuroinvasive disease. Diagnostic testing is available at some public health laboratories (e.g., Wadsworth Center, NYS Department of Health) and at CDC. CDC and other public health laboratories are currently working to validate additional diagnostic assays. Contact your state, tribal, local, or territorial health department for more information and to facilitate testing. For current testing and case reporting guidance, visit CDC's website. In many countries, outbreaks of dengue are occurring in areas with reported Oropouche virus transmission. For patients with suspected Oropouche virus disease, it is important to rule out dengue virus infection because proper clinical management of dengue can improve health outcomes. Other diagnostic considerations include chikungunya, Zika, leptospirosis, malaria, or infections caused by various other bacterial or viral pathogens (e.g., rickettsia, group A streptococcus, rubella, measles, parvovirus, enteroviruses, adenovirus, Mayaro virus).

No specific antiviral treatments or vaccines are available for Oropouche virus disease. Treatment for symptoms can include rest, fluids, and use of analgesics and antipyretics. Acetaminophen is the preferred first-line treatment for fever and pain. Aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs) should not be used to reduce the risk of hemorrhage. Patients who develop more severe symptoms should be hospitalized for close observation and supportive treatment. Pregnant people with laboratory evidence of Oropouche virus infection should be monitored during pregnancy and live-born infants should be carefully evaluated.

Travelers to areas with Oropouche virus transmission should use prevention measures to avoid biting midge and mosquito exposure during travel and for 3 weeks after travel, or if infected during the first week of illness, to mitigate additional spread of the virus and potential importation into unaffected areas in the United States. Oropouche virus disease is not a nationally notifiable condition. However, CDC encourages jurisdictions to report voluntarily to ArboNET, the national arboviral disease surveillance system.

Recommendations for Healthcare Providers

- Consider Oropouche virus infection in a patient who has been in an area with documented or suspected Oropouche virus circulation within 2 weeks of *initial* symptom onset (as patients may experience recurrent symptoms), and the following:
    - Abrupt onset of reported fever, headache, and one or more of the following: myalgia, arthralgia, photophobia, retroorbital/eye pain, or signs and symptoms of neuroinvasive disease (e.g., stiff neck, altered mental status, seizures, limb weakness, or cerebrospinal fluid pleocytosis); AND
    - No respiratory symptoms (e.g., cough, rhinorrhea, shortness of breath); AND
    - Tested negative for other possible diseases, in particular dengue. If strong suspicion of Oropouche virus disease exists based on the patient's clinical features and history of travel to an area with virus circulation, do not wait for negative testing for other infections before contacting your state, tribal, local, or territorial health department.
- Contact your state, tribal, local, or territorial health department to facilitate diagnostic testing.

- Rule out dengue virus infection in travelers with suspect Oropouche virus infection because these viruses often cocirculate and cause similar clinical presentations during acute illness. Early clinical management of dengue can improve health outcomes.
- Be aware that a high proportion of patients (about 70%) with Oropouche virus disease may experience recurrent symptoms days to weeks after resolution of their initial illness.
- Be aware of the risk of vertical transmission and possible adverse impacts on the fetus, including fetal death or congenital abnormalities. Monitor pregnancies in people with laboratory evidence of Oropouche virus infection and provide thorough infant evaluations.
- Inform pregnant people of the possible risks to the fetus when considering travel to areas with reported Oropouche virus transmission. Counsel these patients to consider the destination, reason for traveling, and their ability to prevent insect bites.
- Pregnant people are currently recommended to reconsider non-essential travel to areas with an Oropouche virus Level 2 Travel Health Notice. If a pregnant person decides to travel, counsel them to strictly prevent insect bites during travel.
- Manage travelers with suspect Oropouche virus disease with acetaminophen as the preferred first-line treatment for fever and pain. Aspirin and other NSAIDS should not be used to reduce the risk of hemorrhage.
- Be aware that people who may be at higher risk for complications or severe disease include pregnant people, older adults (e.g., aged 65 years or older), and people with underlying medical conditions (e.g., immune suppression, hypertension, diabetes, or cardiovascular disease).
- Direct all travelers going to areas with Oropouche virus transmission to use measures to prevent insect bites during travel and for 3 weeks after travel, or if infected, during the first week of illness to mitigate additional spread of the virus and potential importation into unaffected areas in the United States.
- Report all suspected Oropouche virus disease infections to your state, tribal, local, or territorial health department to facilitate diagnosis and mitigate risk of local transmission. For after-hours contact information for health departments please visit: https://www.cste.org/page/EpiOnCall. Please follow standard procedures for reporting during normal business hours.

Recommendations for Health Departments

- Share Oropouche virus prevention messages for travelers and pregnant persons with healthcare providers, travel health clinics and the public.
- Perform surveillance for Oropouche virus disease cases in travelers who have been in areas with Oropouche virus transmission and be aware of risk of possible local transmission in areas where biting midges (*Culicoides paraensis)* and mosquitoes (*Culex quinquefasciatus)* are currently active.
- Keep current on CDC's evolving testing and case reporting guidance.
- Assist healthcare providers with obtaining appropriate testing for diagnosing Oropouche virus infection.
- Voluntarily report confirmed and probable Oropouche virus infections to CDC via ArboNET, the national surveillance system for arthropod-borne viruses.
- Contact CDC (eocevent495@cdc.gov) if concern exists for local transmission in a non-endemic area. Consider if the patient had contact with a person with confirmed Oropouche virus infection, lives in an area where travel-related cases have been identified, or has known vector exposure (e.g., mosquitoes or biting midges).

Recommendations for Travelers

- All travelers can protect themselves from Oropouche, dengue, Zika, and other viruses transmitted by insects by preventing insect bites, including using an Environmental Protection Agency (EPA)-registered insect repellent; wearing long-sleeved shirts and pants; and staying in places with air conditioning or that use window and door screens.
- Pregnant travelers should discuss travel plans, reasons for travel, steps to prevent insect bites, and potential risk with their healthcare provider.

- Pregnant people considering travel to countries with an Oropouche virus Level 2 Travel Health Notice should reconsider non-essential travel. If travel is unavoidable, pregnant travelers should strictly follow Oropouche virus prevention recommendations to prevent insect bites during travel.
- Travelers should be aware that the most common symptoms of Oropouche virus are fever and headache and that symptoms usually begin 3-10 days after being bitten by an infected midge or mosquito. Most people infected with Oropouche virus feel better within a week, but symptoms often come back.
- Travelers who have been in areas with Oropouche virus transmission should prevent insect bites for 3 weeks after travel.
- Travelers to areas with Oropouche virus transmission, including South America or the Caribbean, who develop fever, chills, headache, joint pain, or muscle pain during or within 2 weeks after travel, should:
    - Seek medical care and tell their healthcare provider when and where they traveled.
    - Not take aspirin or other NSAIDS (e.g., ibuprofen) to reduce the risk of bleeding.
    - Continue to prevent insect bites during the first week of illness to avoid further spread, especially in areas where mosquitoes or biting midges are active.

For More Information

- About Oropouche | CDC
- Travel Health Notices | CDC
- Preventing Mosquito Bites | CDC
- Find the Repellent that is Right for You | EPA
- Dengue: Guidelines for Diagnosis, Treatment, Prevention and Control | WHO

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The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages

Health Alert	Requires immediate action or attention. Conveys the highest level of importance about a public health event.
Health Advisory	Requires immediate action. Provides important information about a public health event.
Health Update	May require immediate action. Provides updated information about a public health event.
HAN Info Service	Does not require immediate action. Provides general information about a public health event.

Healthcare Provider Oropouche Virus Frequently Asked Questions (FAQs)

What is Oropouche virus?

Oropouche is a virus that was first identified in 1955 in a village near the Oropouche River in Trinidad and Tobago. The virus is endemic to the Amazon basin, with infections historically identified in Bolivia, Brazil, Colombia, Ecuador, French Guiana, and Peru. Infections and outbreaks have also previously been identified in Panama. In 2024, Oropouche virus has been identified to be causing outbreaks in both endemic countries (Bolivia, Brazil, Colombia, and Peru) and new countries, including Cuba.

How is Oropouche virus transmitted?

Oropouche virus is an arthropod-transmitted virus (i.e., arbovirus) that circulates in certain animal hosts. People can become infected when they visit forested areas and are bitten by midges or mosquitoes that have picked up the virus from other animals (e.g., sloths, non-human primates, birds, rodents). Once a person is infected, they develop viremia and can serve as amplifying hosts able to transmit the virus to other people through biting midges or certain mosquitos, which can establish outbreaks in urban areas.

What are the symptoms of Oropouche virus infection?

Most people develop symptoms within 3-10 days after being infected with Oropouche virus. Illness usually starts with the abrupt onset of a fever often with a severe headache, chills, myalgia, and arthralgia. Other symptoms can include photophobia, retroorbital eye pain, dizziness, nausea and vomiting, and maculopapular rash. Symptoms will typically resolve within a week, but many patients (~70%) will have recurring symptoms days or weeks later. The Oropouche virus can also cause neuroinvasive disease (e.g., meningitis, encephalitis) and hemorrhagic manifestations (e.g., epistaxis, melena, menorrhagia). Symptoms can look similar to dengue, chikungunya, and Zika, which should also be considered in a differential diagnosis.

Can Oropouche virus infection be acquired or transmitted in NH?

Travel-associated cases have been identified in the United States, but there has been no evidence of local transmission within the U.S., and no infections with Oropouche virus have been identified to date in New Hampshire. New Hampshire is not known to have the primary mosquito vector or biting midges that are known to transmit Oropouche virus, however, it is possible that other mosquito species may also be able to transmit the virus, which is being investigated.

Who should be tested for Oropouche virus infection?

Currently, testing for Oropouche virus is conducted at the U.S. Centers for Disease Control and Prevention (CDC), but testing capacity is limited, and CDC is still working to validate some of their Oropouche virus tests (including PCR testing). For this reason, CDC is only testing patients who meet their suspect case definition. This means that a patient needs to be symptomatic and have developed symptoms within 14 days after travel to an area with documented or suspected Oropouche virus circulation. Testing is NOT being conducted on asymptomatic persons at this time, but this may change in the future as testing capacity improves.

How do I test for Oropouche virus?

CDC is currently only accepting serum and cerebrospinal fluid (CSF) specimens for Oropouche virus testing. See specimen requirements for more details and to stay up-to-date on currently accepted and requested specimens.

Testing can only currently be obtained by calling the NH Division of Public Health Services (DPHS) at 603-271-4496, to report a person suspected of having Oropouche virus infection. NH DPHS will then work with our Public Health Laboratories (PHL) to facilitate transport of the appropriate specimens to the CDC for testing. The requested specimens include serum and/or cerebrospinal fluid (CSF). It is recommended that paired acute and convalescent specimens be obtained ≥2 weeks apart to confirm infection using a plaque reduction neutralization test (PRNT), although a single test may still be clinically useful. The CDC is also currently validating a PCR assay, but PCR results are not able to be reported back to a patient or provider until validation has occurred.

Should I test a patient for Oropouche virus who develops symptoms after traveling to a country in Central/South American that has NOT yet identified Oropouche virus?

CDC is only testing patients who meet their suspect case definition. This means that in order to be tested a patient needs to have traveled to an area with documented or suspected Oropouche virus circulation within 14 days before their symptom onset. This may change in the future as testing capacity increases.

Should I test a pregnant patient for Oropouche virus who is asymptomatic, but traveled to an affected country in Central/South America during their pregnancy?

CDC is only testing patients who meet their suspect case definition, which requires a person to be symptomatic to be eligible for testing. Testing is not validated or approved for asymptomatic persons at this time. But this may change in the future as testing capacity increases.

Should I test a pregnant patient whose fetus has evidence of congenital abnormalities or suffered fetal demise after traveling to an affected country while pregnant?

If you're concerned that a pregnant patient has experienced adverse fetal outcomes that might be due to Oropouche virus infection, please contact NH DPHS at 603-271-4496, so we can discuss and consider maternal testing.

Can fetal tissue, placental tissue, or amniotic fluid be tested for Oropouche virus?

CDC is currently only accepting serum and/or cerebrospinal fluid (CSF) specimens for Oropouche virus testing. They cannot perform testing on fetal tissue, placental tissue, or amniotic fluid. As testing capacity increases and test validation occurs, additional specimens may be accepted by the CDC in the future. See specimen requirements for more details and to stay up-to-date on currently accepted and requested specimens.