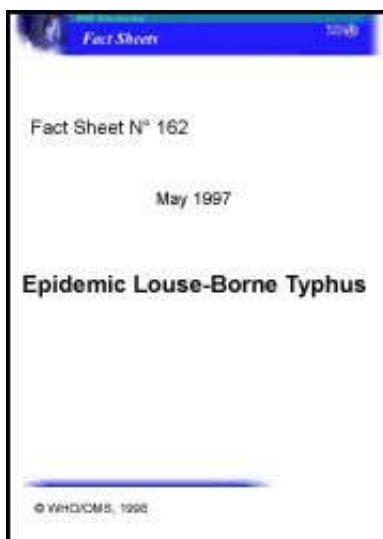






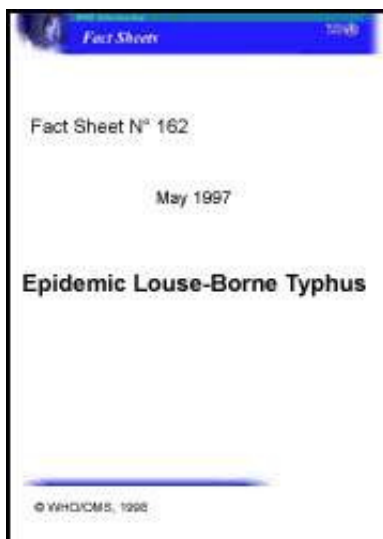
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➔  **Fact sheet No 162: Epidemic Louse-Borne Typhus - May 1997 (WHO, 1997, 2 p.)**

-  **(introduction...)**
-  **What is Louse-borne typhus?**
-  **Treatment**
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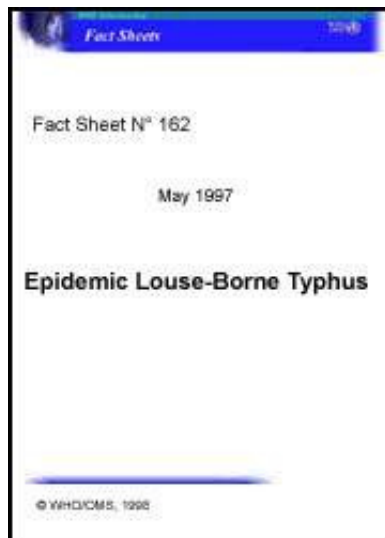
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Louse-borne Typhus is the only rickettsial disease which can cause explosive epidemics in humans. In the past, it was associated with wars and human disasters and it is still endemic in the highlands and cold areas of Africa, Asia and Central and South America.

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What is Louse-borne typhus?

*** It is a rickettsial disease with variable onset, but is often characterised by the sudden appearance of headaches, chills, prostration, high fever, coughing and severe muscular pain. A macular eruption (dark spot on the skin) appears on the fifth to sixth day, initially on the upper trunk, which then spreads to the entire**

body excepting, usually, the face, palms and soles of the feet. The case-fatality rate is between 1% and 20%.

*** Cause: The causative agent, *Rickettsia prowazekii*, is transmitted by the human body louse, *Pediculus humanus corporis*, which is infected while feeding on the blood of patients with acute typhus fever. (Head lice or pubic lice play no role in transmission.) Infected lice excrete rickettsiae when feeding on a second host. People are infected by rubbing louse faecal matter or crushed lice into the bite wound or through scratching.**

*** Prevalence: The body louse lives in clothing and multiplies very rapidly under poor hygienic conditions. Lice proliferate rapidly in refugee camps and other crowded, unsanitary conditions and the risk can be expected to increase in rainy seasons, when more clothing and blankets are used.**

*** Since World War II, large outbreaks of typhus have occurred mainly in Africa, with reported cases coming predominantly from three countries: Burundi, Ethiopia and Rwanda. In Ethiopia, the number of annual cases reported annually has ranged between 7,000 and 17,000 (except in 1979, when a higher number was reported), although most have not been confirmed in a laboratory. In the 1970s, major epidemics which occurred in Burundi and Rwanda were documented by serology and isolation: in 1975 alone, 9,000 cases were reported in Burundi. In 1996, Burundi reported 3,500 cases and that number jumped to 20,000 for the period from January to March 1997.**

*** Warning signals: Louse-borne typhus should be suspected when people in crowded, louse-infected conditions experience sudden onset of high fever, chills,**

headaches, general pain and severe exhaustion alternating with agitation, followed on the fifth or sixth day by a macular eruption. Clinical diagnosis may be confirmed by serology.

*** Latency and recurrence: Humans are the only reservoir and are responsible for maintaining the infection during inter-epidemic periods. Outbreaks occur in colder areas where people live in crowded, unhygienic, louse-infested conditions. Milder symptoms of louse-borne typhus can occur years after the primary attack (Brill-Zinsser disease).**

*** Period of communicability: The disease is not directly transmitted from person to person. Patients are infective for lice during the febrile illness and possibly for two to three days after the temperature returns to normal. Infected lice pass rickettsiae in their faeces within two to six days after the blood meal; it is infective earlier if crushed. The louse invariably dies within two weeks after infection; rickettsiae may remain viable in the dead louse for weeks.**

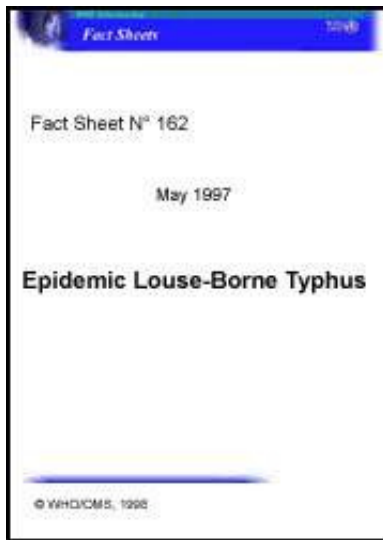
*** Susceptibility and resistance: Susceptibility is general. One attack usually confers long-lasting immunity.**



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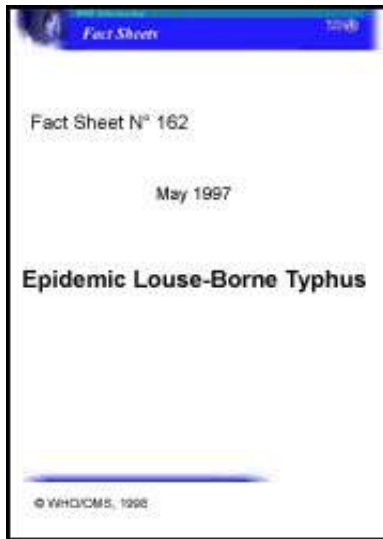
-  **What is Louse-borne typhus?**
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Treatment

*** A single dose of 200 mg of doxycycline (two tablets), irrespective of the patient's age.**

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Control Measures

*** Cleanliness is important in preventing body louse infestations. The easiest control method of occasional infestations is to expose infested clothing to a minimum temperature of 70 degrees C for at least one hour. In emergency situations, it may be impractical or impossible for people to wash properly and fuel for heating water may be in short supply. In general, chemical control is required, especially where louse-borne disease threatens. Two application procedures may be used: the dusting technique (individual and/or mass treatment) and treating clothing. In view of the spread of insecticide resistance in body louse populations, the choice of insecticide for a campaign should be preceded by a survey of insecticide susceptibility status.**

*** Suitable insecticidal dusts for body louse control are permethrin (0.5%), temephos (2%), propoxur (1%) and carbaryl (5%). One thorough treatment of infested clothing with insecticide should be sufficient, although retreatments may**

be required at three to four week intervals if infestations persist or reinfestation is expected. Dusting is not recommended for people with dermatological problems or exposed wounds. The precautions on the insecticide label should be carefully followed. Where infestation is known to be widespread, systematic application of insecticide to all persons in the community is recommended.

*** The process of treating clothing with insecticide is simple, cheap and affords protection for at least six weeks, even with repeated washings. This avoids the problem of repeated treatments in areas difficult to access regularly. The pyrethroid insecticide, permethrin, is recommended for impregnation and should be diluted with water to give an optimal target dose of 0.65-1 g/m² on clothing.**

*** Louse-infested persons exposed to typhus fever should be kept under observation for 15 days after application of an insecticide with residual effect.**

*** All immediate contacts should be kept under surveillance for two weeks.**

*** If death from louse-borne typhus occurs before delousing, the clothing should be deloused by thorough application of an insecticide.**

For further information, please contact Health Communications and Public Relations, WHO, Geneva. Telephone (41 22) 7914458. Fax (41 22) 791 4858.

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