J R Coll Physicians Edinb 2016 46: 100
http://dx.doi.org/10.4997/JRCPE.2016.207

CLINICAL

African tick bite fever

[1]N Rae, [2]D Nathwani
[1]Specialty Registrar, Infectious Diseases and General Medicine, [2]Consultant Physician and Professor of Infection, Infection and Immunodeficiency Unit, Ninewells Hospital, Dundee, UK

DECLARATION OF INTERESTS No conflict of interest declared

CONSENT Written consent was obtained from the patient

Correspondence to** **N Rae
Infection and Immunodeficiency Unit
Ninewells Hospital
Dundee DD1 9SY
UK

e-mail** **nikolas.rae@nhs.net

A 54-year-old man presented with a 4-day history of fever, generalised myalgia, retro-orbital headache and rash. The day prior to the onset of symptoms he had returned to the UK following a four week safari holiday to South Africa and Zambia. He was febrile but haemodynamically stable. Clinical examination revealed a lesion on his back posterior to his right axilla with tender right axillary lymphadenopathy and a generalised vesicular rash.

Rapid antigen testing and thick and thin blood film examination for malaria parasites were negative. Other investigations revealed a mild transaminitis (ALT 104 U/l).

A clinical diagnosis of African tick bite fever was made on the basis of travel history, systemic symptoms and presence of eschar with regional lymphadenopathy and generalised rash. He was treated with doxycycline with complete resolution of symptoms. Although initially negative, subsequent serology two weeks later was positive for rickettsia spotted fever group IgM and IgG

African tick bite fever, caused by *Rickettsia africae*, is transmitted by the *Amblyomma* tick, a common parasite of cattle.[1] It is the most common rickettsial illness in returned travellers, with a particularly high incidence in tourists visiting rural areas of sub-Saharan Africa. While an eschar, regional lymphadenitis and vesicular rash are hallmark features, many patients present with a non-specific febrile illness within 10 days of returning from the endemic area.[2] Thrombocytopenia and mild transaminitis are common. Convalescent serology may be necessary to retrospectively confirm the diagnosis. The treatment of choice for all rickettsial infections is doxycycline.

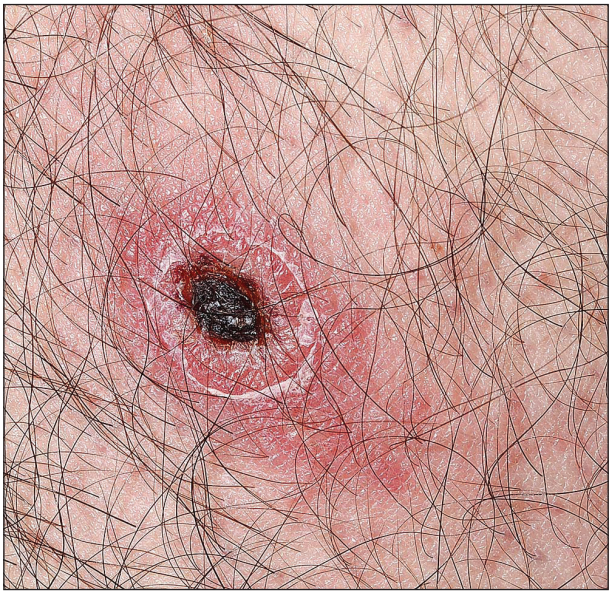

FIGURE 1 Lesion posterior to right axilla

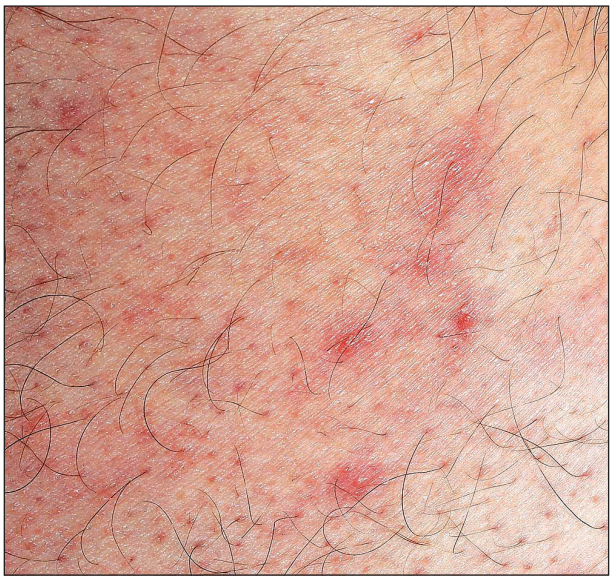

FIGURE 2 Generalised vesicular rash

REFERENCES

1 Jensenius M, Fournier PE, Raoult D. Rickettsioses and the International traveler. *Clin Infect Dis* 2004; 39: 1493–9
2 Johnston V, Stockley JM, Dockrell D et al. Fever in returned travellers presenting in the United Kingdom: recommendations for investigation and initial management. *J Infect* 2009; 59: 1–18. http://dx.doi.org/10.1016/j.jinf.2009.05.005