

The dominant features may be fever, abdominal pain, proteinuria, mild oliguria, and sometimes blurred vision or glaucoma, followed by polyuria and hyposthenuria in recovery. Lethality is <1%.

HFRS should be suspected in patients with rural exposure in an endemic area. Prompt recognition of the disease permits rapid hospitalization and expectant management of shock and renal failure. Useful clinical laboratory parameters include leukocytosis, which may be leukemoid and is associated with a left shift; thrombocytopenia; and proteinuria. HFRS is readily diagnosed by an IgM-capture ELISA that is positive at admission or within 24–48 h thereafter. The isolation of orthohantaviruses is difficult, but RT-PCR of a blood clot collected early in the clinical course or of tissues obtained postmortem should give positive results. Such testing is usually undertaken if definitive identification of the infecting virus is required.

Mainstays of therapy are management of shock, reliance on vasopressors, modest crystalloid infusion, IV human serum albumin administration, timely renal replacement therapy to prevent overhydration that may result in pulmonary edema, and control of hypertension that increases the possibility of intracranial hemorrhage. Use of IV ribavirin has reduced lethality and morbidity in severe cases, provided treatment is begun within the first 4 days of illness. Lethality may be as high as 15% but, with proper therapy, lethality should be lower than 5%. Sequelae have not been definitively established.

CRIMEAN-CONGO HEMORRHAGIC FEVER (CCHF) This severe VHF has a wide geographic distribution, potentially emerging wherever virus-bearing ticks occur. Because of the propensity of CCHF virus-transmitting ticks to feed on domestic livestock and certain wild mammals, veterinary serosurveys are the most effective mechanism for the monitoring of virus circulation in a particular region. Human infections are acquired via tick bites or during the crushing of infected ticks. Domestic animals do not become ill but do develop viremia. Thus, risk of acquiring CCHF occurs during sheep shearing, animal slaughter, or contact with infected hides or carcasses from recently slaughtered infected animals. Nosocomial epidemics are