

travelers returning from Cuba with a rash, similarly to patients returning from other countries in which dengue fever, chikungunya fever, and Zika virus infection are endemic. Preventive measures, including advice to travelers on proper use of insect repellents, are critical for preventing CHIKV infection.

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### References

1. Burt FJ, Rolph MS, Rulli NE, Mahalingam S, Heise MT. Chikungunya: a re-emerging virus. *Lancet*. 2012;379:662–71. [http://dx.doi.org/10.1016/S0140-6736\(11\)60281-X](http://dx.doi.org/10.1016/S0140-6736(11)60281-X)
2. Taubitz W, Cramer JP, Kapaun A, Pfeiffer M, Drosten C, Dobler G, et al. Chikungunya fever in travelers: clinical presentation and course. *Clin Infect Dis*. 2007;45:e1–4. <http://dx.doi.org/10.1086/518701>
3. Weaver SC, Lecuit M. Chikungunya virus and the global spread of a mosquito-borne disease. *N Engl J Med*. 2015;372:1231–9. <http://dx.doi.org/10.1056/NEJMra1406035>
4. Pan American Health Organization. Countries/territories with autochthonous transmission or imported cases of Chikungunya in the Americas, EW 49, 2013–EW 10, 2016 [cited 2016 Apr 7]. [http://www.paho.org/hq/images/stories/AD/HSD/IR/Viral\\_Diseases/Chikungunya/CHIKV-Data-Caribbean-2016-EW-10.jpg](http://www.paho.org/hq/images/stories/AD/HSD/IR/Viral_Diseases/Chikungunya/CHIKV-Data-Caribbean-2016-EW-10.jpg)
5. Tamura K, Stecher G, Peterson D, Filipski A, Kumar S. MEGA6: molecular evolutionary genetics analysis version 6.0. *Mol Biol Evol*. 2013;30:2725–9. <http://dx.doi.org/10.1093/molbev/mst197>
6. Ross RW. The Newala epidemic. III. The virus: isolation, pathogenic properties and relationship to the epidemic. *J Hyg (Lond)*. 1956;54:177–91. <http://dx.doi.org/10.1017/S0022172400044442>
7. Valdés L, Guzmán MG, Kouri G, Delgado J, Carbonell I, Cabrera MV, et al. Epidemiology of dengue and hemorrhagic dengue in Santiago, Cuba 1997 [in Spanish]. *Rev Panam Salud Publica*. 1999;6:16–25. <http://dx.doi.org/10.1590/S1020-49891999000600003>
8. Peláez O, Guzmán MG, Kouri G, Pérez R, San Martín JL, Vázquez S, et al. Dengue 3 epidemic, Havana, 2001. *Emerg Infect Dis*. 2004;10:719–22. <http://dx.doi.org/10.3201/eid1004.030271>
9. Pan American Health Organization. Zika virus (ZIKV)—incidence and trends. Regional Zika epidemiological update (Americas). 2016 Apr 8 [cited 2016 Apr 9]. [http://www.paho.org/hq/index.php?option=com\\_content&view=article&id=11599&Itemid=41691&lang=en](http://www.paho.org/hq/index.php?option=com_content&view=article&id=11599&Itemid=41691&lang=en)
10. Duffy MR, Chen TH, Hancock WT, Powers AM, Kool JL, Lanciotti RS, et al. Zika virus outbreak on Yap Island, Federated States of Micronesia. *N Engl J Med*. 2009;360:2536–43. <http://dx.doi.org/10.1056/NEJMoa0805715>

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## Inactivation and Environmental Stability of Zika Virus

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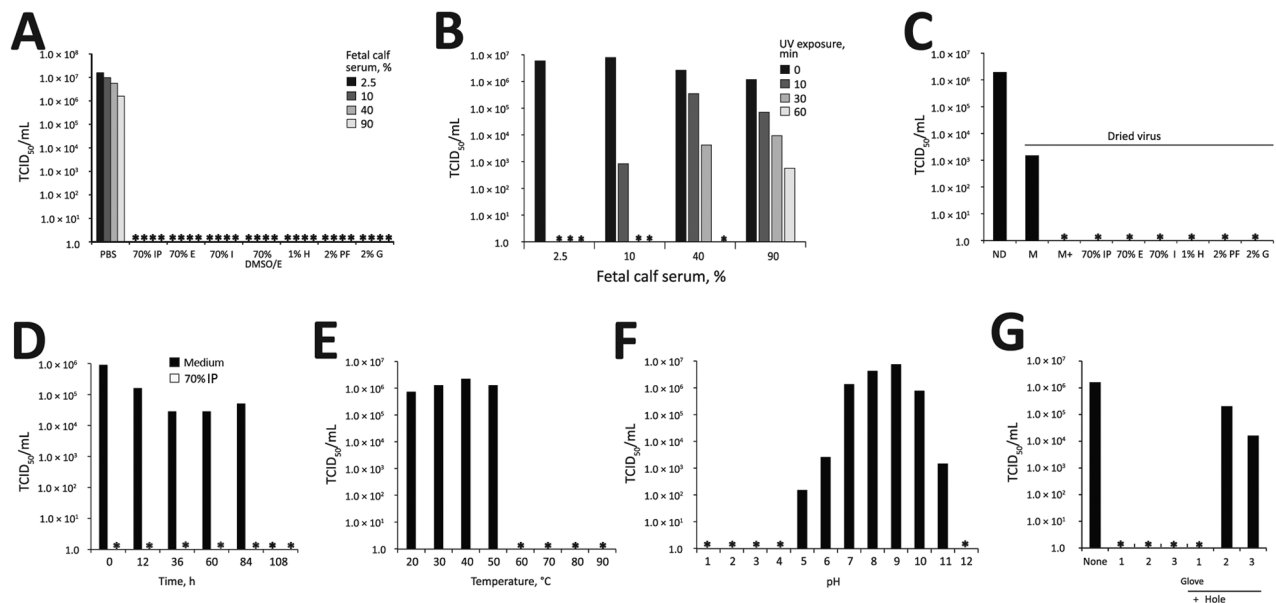
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**To the Editor:** Zika virus is an emerging virus that has spread to most countries in Latin America and the Caribbean (1,2). It is transmitted by mosquitoes and through sexual intercourse (3). Most persons infected with Zika virus are asymptomatic or experience mild symptoms (4). However, in a pregnant woman, infection may cause severe pregnancy and birth complications, most notably microcephaly in children infected in utero (5–7). Zika virus infection might also be associated with an increased incidence of Guillain-Barré syndrome (8). Thus, the virus represents a threat to healthcare workers who manage infected patients or diagnostic samples and researchers who work with infectious virus in laboratories.

Working with Zika virus, a Biosafety Level 2 (BSL-2) pathogen in the European Union, except for the United Kingdom (where it is BSL-3), requires specific safety precautions (9). No inactivation data specific for Zika virus are available (9); consequently, disinfection guidelines are based on protocols to inactivate other flaviviruses. To gain experimental evidence regarding inactivation and disinfection for Zika virus, we determined its susceptibility to various disinfectants and inactivation methods.

To test susceptibilities, we determined the 50% tissue cell infectious dose per milliliter (TCID<sub>50</sub>/mL) (10) of the Zika virus MR766 strain (1) before and after the virus was exposed to disinfectants or other inactivation procedures (online Technical Appendix, <http://wwwnc.cdc.gov/EID/article/22/9/16-0664-Techapp1.pdf>). We then determined the effect of alcohol-based disinfectants on viral infectivity. Using Zika virus stock containing 2.5% fetal calf serum (FCS) mixed 3:10 (vol/vol) with indicated alcohols, we incubated the mixture for 1 minute and then used it for infection (Figure, panel A). All alcohols entirely inactivated



**Figure.** Inactivation and environmental stability of Zika virus. Asterisks (\*) indicate lack of infection. A) Virus stocks containing 2.5%, 10%, 40%, or 90% fetal calf serum were incubated with alcohol-based disinfectants for 1 min. All disinfectants inactivated the virus. B) Virus stocks containing indicated concentrations of fetal calf serum were exposed to the ultraviolet (UV) light of a laminar flow hood. Higher concentrations of serum required more time to inactivate the virus. C) Virus stock was dried for 18 h and was then reconstituted in medium or the indicated disinfectants for 5 min or exposed to 10 min UV light before reconstitution. All disinfectants inactivated the virus. D) Virus was dried and incubated for indicated periods of time. Thereafter, dried virus was reconstituted in medium or 70% (vol/vol) isopropanol. Isopropanol inactivated the virus, but dried virus in medium remained infectious even after 84 h of incubation. E) Zika virus was incubated for 5 min at indicated temperatures. Temperatures  $\geq 60^{\circ}\text{C}$  inactivated the virus. F) Stocks were adjusted to indicated pH values and incubated for 10 min. pH levels  $\leq 4$  or  $> 11$  deactivated the virus. G) Finger tips of laboratory gloves were cut off, with or without introducing a hole by pinching with a needle, and put into medium. Glove tips were filled with virus stock and incubated for 90 min at room temperature. All gloves without needle holes were protective against transmission; 2 of 3 gloves with needle holes allowed virus transmission. For detailed experimental description, see online Technical Appendix (<http://wwwnc.cdc.gov/EID/article/22/9/16-0664-Techapp1.pdf>). DMSO, dimethyl sulfoxide; E, ethanol; G, glutaraldehyde; H, hypochlorite; I, incindin, IP, isopropanol; M, medium, M+, medium plus 10 min UV; ND, not dried; PBS, phosphate-buffered saline; PF, paraformaldehyde; TCID<sub>50</sub>, 50% tissue culture infective dose; UV, ultraviolet.

the virus. Complete loss of infectivity was also observed after virus exposure to 1% hypochlorite (often used to inactivate virus in liquid wastes in BSL-2/3 laboratories), 2% paraformaldehyde (used to inactivate virus for subsequent flow cytometry), and 2% glutaraldehyde (often applied to fix virus for subsequent electron microscopy analysis) (Figure, panel A). Thus, routinely used disinfectants and inactivation procedures are sufficient to inactivate Zika virus in laboratory virus stocks. Next, we repeated these experiments in the presence of a high protein load using Zika virus preparations supplemented with FCS in increasing concentrations (10%, 40%, 90%), to mimic virus found in clinically relevant material. Again, all treatments entirely disrupted Zika virus infectivity (Figure, panel A).

Ultraviolet (UV) radiation inactivates viruses by chemically modifying the genome. We exposed 200  $\mu\text{L}$  of Zika virus preparations containing increasing concentrations of serum to UV light of a laminar flow for up to 60 minutes. Exposure for 10 minutes entirely inactivated Zika virus in the presence of 2.5% FCS serum; increasing concentrations

of serum reduced the antiviral effects of UV light (Figure, panel B). When Zika virus containing 90% serum was exposed for 60 min to UV light, infectivity was reduced by 99.95%; however, some residual infectivity was detected (Figure, panel B).

Next, we evaluated environmental stability by drying 100  $\mu\text{L}$  of Zika virus stock for 18 hours. Thereafter, dried virus was reconstituted in the same volume of medium or disinfectants. Endpoint titrations showed that the reconstituted virus remained infectious, although TCID<sub>50</sub> was reduced by  $\approx 3$  orders of magnitude (Figure, panel C). All disinfectants and UV radiation entirely inactivated dried Zika virus (Figure, panel C). Additional experiments demonstrated that dried Zika virus remained infectious for  $> 3$  days (Figure, panel D) suggesting, for example, that dried droplets can be infectious, confirming that proper surface disinfection is essential.

We also assessed the environmental stability of Zika virus to heat and change in pH. The virus was stable at temperatures up to  $50^{\circ}\text{C}$  but lost all infectivity at temperatures

of  $\geq 60^{\circ}\text{C}$  (Figure, panel E). Thus, virus-contaminated materials such as surgical instruments can be decontaminated by heat. We also found that Zika virus infectivity was highest after adjusting the stock to a pH of  $\approx 9$  (Figure, panel F). In contrast, adjusting Zika virus to pH 12 or to  $\leq \text{pH } 4$  abrogated infectivity (Figure, panel F).

Finally, we analyzed whether gloves routinely used in BSL-2 laboratories protect against Zika virus. For this, we cut off fingertips of nitrile and latex gloves, filled tips with a Zika virus suspension, and placed them into cell culture plates containing medium. Virus-containing fingertips were inserted in such a way that diffusion would only occur if the virus passed through the nitrile/latex barrier. As a control, we made a hole of  $< 1$  mm in the fingertips. All 3 tested gloves prevented virus diffusion (Figure, panel G). However, if glove integrity was disrupted by a pin, the virus passed through in 2 of 3 cases (Figure, panel G).

We demonstrated that Zika virus is destroyed by classical disinfectants and inactivation methods and that nitrile and latex gloves are protective. We also showed that UV light of a laminar flow hood inactivates Zika virus, but particularly if the virus is in a protein-rich environment, the exposure time range should be in hours rather than in minutes. Although we expected that Zika virus would be inactivated by alcohol and disinfectants, we conducted a thorough experimental verification to exclude uncertainties surrounding work with this emerging pathogen.

## References

- Dick GWA, Kitchen SF, Haddock AJ. Zika virus. I. Isolations and serological specificity. *Trans R Soc Trop Med Hyg.* 1952;46:509–20. [http://dx.doi.org/10.1016/0035-9203\(52\)90042-4](http://dx.doi.org/10.1016/0035-9203(52)90042-4)
- Zamarchi L, Tappe D, Fortuna C, Remoli ME, Günther S, Venturi G, et al. Zika virus infection in a traveller returning to Europe from Brazil, March 2015. *Euro Surveill.* 2015;20:pii=21153. <http://dx.doi.org/10.2807/1560-7917.ES2015.20.23.21153>
- D'Ortenzio E, Matheron S, Yazdanpanah Y, de Lamballerie X, Hubert B, Piorkowski G, et al. Evidence of sexual transmission of Zika virus. *N Engl J Med.* 2016;374:2195–8. <http://dx.doi.org/10.1056/NEJMc1604449>
- Ginier M, Neumayr A, Günther S, et al. Zika without symptoms in returning travellers: what are the implications? *Travel Med Infect Dis.* 2016;14:16–20. <http://dx.doi.org/10.1016/j.tmaid.2016.01.012>
- Driggers RW, Ho C-Y, Korhonen EM, Kuivaniemi S1, Jääskeläinen AJ1, Smura T, et al. Zika virus infection with prolonged maternal viremia and fetal brain abnormalities. *N Engl J Med.* 2016;374:2142–51. <http://dx.doi.org/10.1056/NEJMoa1601824>
- Rasmussen SA, Jamieson DJ, Honein MA, et al. Zika virus and birth defects—reviewing the evidence for causality. *N Engl J Med.* 2016;374:1981–7. <http://dx.doi.org/10.1056/NEJMs1604338>
- Mlakar J, Korva M, Tul N, Petersen LR, et al. Zika virus associated with microcephaly. *N Engl J Med.* 2016;374:951–8. <http://dx.doi.org/10.1056/NEJMoa1600651>
- Rozé B, Najjioullah F, Fergé J-L, Apetse K, Brouste Y, Cesaire R, et al. Zika virus detection in urine from patients with Guillain-Barré syndrome on Martinique, January 2016. *Eurosurveillance.* 2016;21:pii=30154. <http://dx.doi.org/10.2807/1560-7917.ES.2016.21.9.30154>
- Charrel RN, Leparco-Goffart I, Pas S, de Lamballerie X, Koopmans M, Reusken C. State of knowledge on Zika virus for an adequate laboratory response. *Bull World Health Organ.* E-pub 2016 Feb 10. <http://dx.doi.org/10.2471/BLT.16.171207>
- Reed LJ, Muench H. A simple method of estimating fifty percent endpoints. *Am J Hyg.* 1938;27:493–7.

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## ESBL-Producing Strain of Hypervirulent *Klebsiella pneumoniae* K2, France

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**To the Editor:** *Klebsiella pneumoniae* is mainly responsible for hospital-acquired urinary tract infections, bacteremia, pneumonia and intra-abdominal infections. However, since the mid-1980s, *K. pneumoniae* has also been described as the cause of highly invasive community-acquired infections (1,2). The *K. pneumoniae* isolates associated with such infections are often hypermucoviscous and frequently belong to the capsular serotypes K1 or K2. Two of the most extensively studied genes associated with invasive infections are a mucoviscosity-associated gene A (*magA*) in serotype K1 and a regulator of mucoid phenotype A (*rmpA*). These strains of hypervirulent *K. pneumoniae* (hvKP) are now circulating worldwide (1,2).

At the same time, a substantial increase of high-level antimicrobial resistance acquired by non-hvKP strains has also been observed. Clonal complexes of hvKP and multi-drug-resistant (MDR) strains had been considered independent (3) until 2014, when extended-spectrum  $\beta$ -lactamase (ESBL)— or carbapenemase-producing hvKP were first identified in China (4). Here we report an ESBL-producing strain of hvKP isolated from a patient in France.

The patient was a 56-year-old woman, born in Algeria, who alternately resided in France and Algeria for several years without travel to any other country. She underwent liver transplant in 2007 for primary biliary cirrhosis. In 2012, she had a routine posttransplant liver biopsy indicating