# *TERRESTRIAL MANUAL* REVISION: ADVICE FOR MEMBER COUNTRY COMMENTS

Chapter Number and Title: Chapter 3.1.22 Tularemia

Country making the comments:

Date:

It would be appreciated if the following guidance is followed when making a reply:

1. Comments may be general or specific, but specific comments are more valuable. General comments should be such that some conclusion and action can be taken in response to them. For example, instead of stating “This test is no longer used in our laboratory”, indicate the reasons the test is no longer used and what test is used instead.

2. Specific comments should be identified by indicating the line number in the text, to facilitate the editorial process.

3. Highlighting typing or technical errors is welcome, but the correct word or figure should be indicated in its place. For example, instead of indicating simply “0.8 M is too high”, the preferred value should also be indicated.

4. Bear in mind that the introductory chapters (Part 1 of the *Terrestrial Manual*) set general standards for the management of veterinary diagnostic laboratories and vaccine facilities and are not intended to be exhaustive, and indeed none of the chapters can give a completely comprehensive cover of the subject, otherwise the *Terrestrial Manual* would be too long. However, assistance in indicating priorities is always helpful.

5. The *Terrestrial Manual* is intended for world-wide use. The chapters need to reflect the development of new technology, while maintaining the established methods, usually requiring less sophisticated apparatus. New technology should not be described in detail until it has gained wide acceptance as a reliable method.

6. We recommend that if you have no specific comments, please respond to the OIE to that effect.

7. Any comments, proposed changes or revisions should be supported by clear evidence (the scientific rationale) such that some conclusion and action can be taken in response to them.

*Your participation in the OIE Standard-setting process is valued. Thank you for your engagement in the process!*

*General Comments*

*Specific Comments* (*add continuation sheets if required*)

*line:*

Chapter 3.1.22.

tularemia

SUMMARY

**Description of the disease:** Tularemia is a zoonosis caused by Francisella tularensis. The causative bacterium is a Gram-negative coccoid rod, 0.2–0.5 µm × 0.7–1.0 µm, non-motile and non-spore-forming organism that is an obligate aerobe with optimal growth at 37°C. It is oxidase-negative, weakly catalase-positive, and cysteine is required for growth. Tularemia is primarily a disease of the orders Lagomorpha and Rodentia, but a wide range of other mammals and several species of birds have also been reported to be infected. Haematophagous arthropods have a substantial role both in the maintenance of F. tularensis in nature and in disease transmission.

The disease is characterised by fever, depression and often septicaemia. In humans, there may be ulcers or abscesses at the site of ~~inoculation~~ exposure (this is rarely seen in animals) and swelling of the regional lymph nodes. On post-mortem examination, lesions may include caseous necrosis of lymph nodes and multiple greyish-white foci of necrosis in the spleen, liver, lungs, pericardium, kidneys and other organs. The spleen is usually enlarged in septicaemic cases.

It is important to ~~understand that there is a~~ recognise the high risk of direct infection of humans ~~by~~ via aerosols and direct contact with the organism or infected tissue. ~~Special precautions, including the wearing of gloves, masks and eye-shields, are therefore recommended when handling infective materials.~~ Infection control precautions (including personal protective equipment) based on an assessment of the risks should be in place when handling infective materials. All laboratory manipulations with live cultures or potentially infected or contaminated material must be performed at an appropriate biosafety and containment level as determined by biological risk analysis (see Chapter 1.1.4 Biosafety and biosecurity: Standard for managing biological risk in the veterinary laboratory and animal facilities).

**Detection of the agent:** Polymerase chain reaction is a safe and convenient ~~way for the~~ method of detection and identification of F. tularensis in clinical ~~samples~~ specimens. The bacterium can be demonstrated in impression smears or in fixed specimens of organs ~~by the~~ using a specific fluorescent antibody test or immunohistochemistry. With Gram staining, the bacteria appear as very small punctiform Gram-negative rods, often difficult to distinguish as bacteria.

The organism is highly fastidious. For growth it is necessary to use Francis medium, McCoy and Chapin medium, or Modified Thayer-Martin agar. In certain cases, e.g. isolation from tissues or carcasses, the use of selective medium containing antibiotics or mouse inoculation is needed to aid successful isolation. The colonies are small, round and transparent, and do not appear before 48 hours incubation at 37°C. If transportation is necessary, samples should be inoculated into sterile nutrient broth and stored at 4–10°C for a few hours or on dry ice if transit is likely to be prolonged.

**Serological tests:** Serological tests are useful ~~diagnostic aids in~~ for diagnosing human infection, but are of limited value in the more susceptible animal species that usually die before developing antibodies. ~~Epidemiological~~ Serological surveys can be conducted in ~~domestic animals, in~~ relatively resistant species that survive the infection and develop antibodies, such as sheep, cattle, pigs, dogs, cats, wild ungulates, foxes and wild boars ~~as these species develop antibodies~~. Relatively resistant species of rodents and lagomorphs (e.g. European brown hare in Central Europe) can also be ~~used~~ included in epidemiological surveys.

**Requirements for vaccines:** The attenuated F. holarctica live vaccine strain (LVS, NCTC 10857) ~~has been~~ was used for decades as a tularemia vaccine, especially in laboratory workers handling large volumes of F. tularensis cultures. This vaccine is no longer used because of its overall limited efficacy and concern about reversion to virulence~~, although a derivative of LVS is still used to immunise people in endemic regions of Russia~~. Novel vaccines against tularemia are under development ~~but not yet of writing licensed~~ for human or animal use.

A. introduction

Tularemia is a zoonosis caused by *Francisella tularensis.* It occurs naturally in lagomorphs (rabbits and hares) and rodents, especially microtine rodents such as voles, vole rats and muskrats, ~~as well as~~ and also in beavers. In addition, a wide variety of other mammals~~, birds, amphibians and invertebrates~~ have been reported to be infected, and the organism has been isolated from birds, fishes, amphibians, arthropods, and protozoa (Gyuranecz, 2012; Morner & Addison, 2001; Yeni *et al.,* 2020). Tularemia occurs endemically in the northern hemisphere. The disease can occur as epizootic outbreaks in many countries in North America and Europe, while it occurs only as sporadic cases in some other countries in Europe and Asia. It is rarely reported from the tropics or the southern hemisphere.

The two clinically most relevant ~~two~~ types of *F. tularensis* are recognised on the basis of culture characteristics, epidemiology, and virulence. *Francisella tularensis* subsp. *tularensis* (Type A) is mainly associated with lagomorphs in North America~~. It~~ and is primarily transmitted by ticks or biting flies or by direct contact with infected ~~lagomorphs~~ animals. It is highly virulent for humans and domestic rabbits, and most isolates ferment glycerol. *Francisella tularensis* subsp. *holarctica* (Type B) occurs mainly in aquatic rodents (beavers, muskrats) and voles in North America, and in lagomorphs (hares) and rodents in Eurasia. It is primarily transmitted by direct contact or by arthropods (primarily ticks and mosquitoes) but may also be transmitted through inhalation or through infected water or food. It is less virulent for humans and domestic rabbits, and does not ferment glycerol ([Ellis *et*](http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=Search&Term=%22Ellis%20J%22%5BAuthor%5D&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVAbstractPlus) *al.*, 2002; Keim *et al.*, 2007; Morner & Addison, 2001).

In sensitive animals, clinical signs of severe depression are followed by a fatal septicaemia (Morner & Addison, 2001). The course of the disease ~~is~~ lasts approximately 2–10 days ~~in susceptible species~~, and animals are usually dead when presented for diagnosis. Most domestic species do not usually manifest signs of tularemia infection, but they do develop specific antibodies to the organism following infection. Outbreaks with high mortality caused by the Type A organism have occurred in sheep (Morner & Addison, 2001). Among domestic ~~animals, the cat has~~ pets, *F. tularensis* infection can result in clinical illness in cats but less commonly in dogs (Feldman, 2003). Both have been ~~reported to be able to act as a carrier~~ implicated in transmission of the ~~bacterium and the~~ disease ~~is occasionally spread~~ to humans. Transmission from cats to humans occurs most commonly via bites or scratches and from dogs via close facial contact, ticks, and retrieved carcasses, as well as bites (Kwit *et al.,* 2019).

At necropsy, animals that have died from acute tularemia are usually in good body condition~~. There are~~, but signs of septicaemia characterised by whitish foci of necrosis randomly distributed in the liver, bone marrow and spleen, are evident (Morner & Addison, 2001). In addition, the spleen is usually enlarged. Necrotic foci vary in size, ~~and in~~ with some ~~cases may be~~ barely visible to the naked eye. The lungs are usually congested and oedematous, and ~~there may be~~ areas of consolidation and fibrinous pneumonia or pleuritis may be present. Fibrin may be present in the abdominal cavity. Foci of caseous necrosis are often present in one or more lymph node(s)~~. The lymph nodes that are~~; those most often affected are ~~those~~ lymph nodes in the abdominal and pleural cavities and lymph nodes draining the extremities. In less sensitive species, the macroscopic picture can resemble that of tuberculosis with subacute or chronic granulomas in the lungs, pericardium, kidneys, spleen and liver. Macrophages are the dominant constituent cell type in the granulomas, but other cells including lymphocytes, heterophil granulocytes, multinucleated giant cells and fibrocytes are also found occasionally. Focal or multifocal necrosis is often observed in the centre of these lesions (Gyuranecz, 2012; Gyuranecz *et al.*, 2010).

There is a high risk of human infection from *F. tularensis*, as the infective dose is extremely low and infected animals excrete bacteria in urine and faeces. Infection can occur by simple contact and via inhalation of infective aerosols. Suitable ~~precautions, such as the wearing of~~ personal protective equipment (e.g. gloves, particulate-filtering masks or respirators, and eye-shields) must be worn during any manipulation of pathological specimens or cultures~~, must be taken in order~~ to avoid human infection. All laboratory manipulations with live cultures or potentially infected or contaminated material must be performed at an appropriate biosafety and containment level as determined by biological risk analysis (see Chapter 1.1.4 *Biosafety and biosecurity: Standard for managing biological risk in the veterinary laboratory and animal facilities*). Countries lacking access to a specialised national or regional laboratory should send specimens to the OIE Reference Laboratory. Experimentally inoculated animals and their excreta are especially hazardous to humans.

b. DIAGNOSTIC TECHNIQUES

Table 1. Test methods available for the diagnosis of tularemia and their purpose

| Method | **Purpose** | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Population freedom from infection | Individual animal freedom from infection prior to movement | Contribute to eradication policies | Confirmation of clinical cases | Prevalence of infection – surveillance | Immune status in individual animals or populations post-vaccination |
| **Detection of the agent[[1]](#footnote-2)** | | | | | | |
| **Bacterial isolation** | – | – | – | ++ ~~+~~ | – | – |
| **Antigen detection** | – | – | – | +++ | – | – |
| **Real-timePCR(a)** | +++ | – | – | +++ | +++ | – |
| **Conventional PCR(b)** | ++ | – | – | – | + | – |
| **Detection of immune response** | | | | | | |
| **SAT** | +++ | +++ | +++ | ++ | +++ | – |
| **TAT** | ++ | +++ | ++ | +++ | +++ | – |
| **MAT** | ++ | +++ | ++ | +++ | +++ | – |
| **ELISA** | ++ | +++ | ++ | ++ | +++ | – |

Key: +++ = recommended for this purpose; ++ recommended but has limitations;   
+ = suitable in very limited circumstances; – = not appropriate for this purpose.   
PCR = polymerase chain reaction; SAT = slide agglutination test; TAT = tube agglutination test;   
MAT = microagglutination test; ELISA = enzyme-linked immunosorbent assay.   
(a)Versage *et al.,* 2003; (b)Barns *et al.,* 2005.

1. Detection of the agent

*Francisella tularensis* can be demonstrated in smear preparations or in histological sections~~. As the post-mortem picture is variable, diagnosis is sometimes difficult and~~ using specific immunological or immunohistochemical methods ~~are preferable, although~~ of identification. If reagents ~~may be difficult to obtain. It can sometimes be recommended, therefore, that~~ are not readily available, fixed specimens can be analysed at laboratories equipped with proper reagents ~~or~~ and methods. ~~It can~~ Bacterial isolation followed by identification via immunological or molecular methods is also ~~be identified by culture. However~~ used, however, *F. tularensis* may be difficult to isolate from dead animals and carcasses due to overgrowth of other bacteria. ~~In these cases~~ Selective culture media or animal inoculation can be used to enhance recovery of the organism. Polymerase chain reaction (PCR) is a safe and convenient way ~~for the detection~~ to detect and ~~identification of~~ identify *F. tularensis* in clinical samples.

1.1. Smear preparations for antigen detection

~~Smear preparations are made on microscope slides as~~ Impression smears of organs, such as the liver, spleen, bone marrow, kidney, lung or blood, are made on microscope slides. The bacteria are abundant in such smears, but may be overlooked because of their very small size (0.2–0.7 µm). The bacteria can be demonstrated by direct or indirect fluorescent antibody staining. This is a safe, rapid and specific diagnostic tool (Karlsson *et al*., 1970; Morner, 1981).

Gram staining of smears reveals a scattering of small, punctiform Gram-negative bacteria near the limit of visibility. The use of oil microscopy increases the visibility of the bacteria. The bacteria may be difficult to distinguish from precipitates of stain.

1.2. Histological sections for antigen detection

Bacteria can be demonstrated in sections using immunohistochemical methods, such as the fluorescent antibody test (FAT) (Morner, 1981) or immunohistochemistry (Gyuranecz *et al.,* 2010). The tests are performed on organ samples fixed in neutral buffered formalin and paraffin embedded. Slides are first treated with ~~a primer~~ rabbit or mouse anti-tularemia serum, washed and thereafter treated with a ~~seconder~~ fluorescein-isothiocyanate-conjugated or a horseradish peroxidase-labelled anti-rabbit or anti-mouse serum. The samples are examined under a fluorescence or light microscope. Large numbers of bacteria can be seen in necrotic lesions and in the blood.

1.3. ~~Culture~~ Bacterial isolation

*~~Francisella tularensis~~* ~~will not grow on ordinary media, although an occasional strain can sometimes, on initial isolation, grow on blood agar. Incubation is at 37°C in ambient air or in 5% CO~~~~2~~~~. Heart~~ The bacteria can be isolated from heart blood, liver, spleen, bone marrow or tularemic granulomas (from lungs, pericardium, kidney, liver, spleen, etc.) from moribund animals ~~should be used for culture. It is necessary to use special culture media, such as the media given below.~~, however it is highly fastidious; it will not grow on ordinary media, although an occasional strain can sometimes grow on blood agar on initial isolation. Culture preparations are incubated at 37°C, in ambient air or in 5% CO2.

1.3.1. The culture media listed below are all appropriate for isolating *F. tularensis*

i) Francis medium

Peptone agar containing 0.1% cystine (or cysteine) and 1% glucose, to which is added, before solidification, 8–10% defribrinated rabbit, horse or human blood.

ii) McCoy and Chapin medium

This consists of 60 g egg yolk and 40 ml normal saline solution, carefully mixed and coagulated by heating to 75°C.

iii) Modified Thayer–Martin agar

Glucose cysteine agar (GCA)-medium base supplemented with haemoglobin and ~~IsoVitaleX~~ a commercially available enrichment additive containing nicotinamide adenine dinucleotide with other factors.

~~Media can be stored for up to 8–10 days at 4°C.~~ Colonies that form on McCoy and Chapin medium are small, prominent, round and transparent. A more abundant growth is obtained on Francis medium and modified Thayer–Martin agar, with confluent colonies that have a milky appearance and a mucoid consistency. On either medium, colonies do not appear until after 48 hours’ incubation at 37°C.

~~The following selective medium can be used in addition to the non-selective~~

1.3.2. Selective media

Cystine heart agar broth (CHAB) supplemented with 7.5 mg colistin, 2.5 mg amphotericin, 0.5 mg lincomycin, 4 mg trimethoprim and 10 mg ampicillin per litre (WHO, 2007) is commonly used for complex clinical spcimens. Growth in CHAB medium enables the presumptive identification of *F. tularensis* by characteristic growth at 24–48 hours of round and smooth green opalescent shiny colonies, 2–4 mm in diameter.

~~Differential criteria for the identification of~~ *~~F. tularensis~~* ~~include absence of growth on ordinary media, distinctive cellular morphology, and specific fluorescent antibody and slide agglutination reactions.~~

1.3.3. Identification of isolates

The bacteria are nonmotile, nonsporulating, bipolar staining, and of uniform appearance in 24-hour cultures, but pleomorphic in older cultures. Biochemical tests can provide a presumptive identification of isolates, but confirmation using immunological or molecular methods is typical. Type A subspecies may be biochemically distinguished from Type B subspecies by the fact that most Type A ferment glycerol.

*~~Francisella tularensis~~* ~~can be identified in stained smears, by agglutination with tularemia hyperimmune antiserum, or by animal inoculation. In areas of North America where both types of~~ *~~F. tularensis~~* ~~may occur, Type A may be distinguished from Type B by the fact that most Type A ferment glycerol.~~

~~The bacteria can also be identified by PCR.~~

1.4. Molecular techniques

PCR-based assays are useful for the detection of *F. tularensis* DNA directly from human, animal and environment samples. They can also determine the *F. tularensis* subspecies or genotypes, either from isolated strains or directly from clinical samples.

Methods for detection of *F. tularensis* DNA ~~that have been used~~ include classical PCR (Barns *et al.*, 2005; Sjostedt *et al.*, 1997) and real-time PCR systems (Versage *et al.*, 2003). It is to be noted that PCR testing of ticks must use specific gene targets or PCR fragment sequencing to differentiate *F. tularensis* from *Francisella*-like endosymbionts (Kreizinger *et al.*, 2013; Kugeler *et al.*, 2005; Michelet *et al.*, 2013).

A conventional PCR system targeting the 16S rRNA gene followed by PCR product sequencing was designed to detect *F. tularensis* and *F. philomiragia,* as well as the *Francisella*-like tick endosymbionts by Barns *et al.* (2005) with the following primer pair:

Fr153F0.1: 5’-GCC-CAT-TTG-AGG-GGG-ATA-CC-3’ ~~and~~   
Fr1281R0.1: 5’-GGA-CTA-AGA-GTA-CCT-TTT-TGA-GT-3’.

Cycling conditions consist of initial denaturation for 10 minutes at 95°C followed by 30 amplification cycles of denaturation for 30 seconds at 94°C, primer annealing at 60°C for 1 minute and extension at 72°C for 1 minute.

A real-time PCR system targeting the *tul4* gene was designed by Versage *et al.* (2003) to detect specifically ~~detect~~ only *F. tularensis* with the following primers and probe:

Tul4F: 5’-ATT-ACA-ATG-GCA-GGC-TCC-AGA-3’,   
Tul4R: 5’-TGC-CCA-AGT-TTT-ATC-GTT-CTT-CT-3’ ~~and~~   
Tul4P: FAM-5’-TTC-TAA-GTG-CCA-TGA-TAC-AAG-CTT-CCC-AAT-TAC-TAA-G-3’-BHQ.

The probe is synthesised with a 6-carboxy-fluorescein reporter molecule attached to the 5’end and a black hole quencher attached to the 3’ end. The PCR consists of initial denaturation for 10 minutes at 95°C followed by 45 amplification cycles of denaturation for 15 seconds at 95°C, primer annealing at 60°C for 30 seconds.

~~Certain~~ Appropriate methods for differentiation of *F. tularensis* subspecies and genotypes include certain PCR ~~systems (Birdshell~~ assays (Birdsell *et al.*, 2014; Johansson *et al*., 2000; Kugeler *et al.*, 2006), ~~canSNP (~~canonical single nucleotide polymorphism~~)~~ analysis (canSNP; Vogler *et al.*, 2009a), ~~canINDELs~~ typing ~~(~~of canonical insertions and deletions~~)~~ (canINDELs; Svensson *et al.*, 2009) and ~~MLVA (~~multi-locus variable-number tandem repeat analysis~~)~~ (MLVA; Johansson *et al.*, 2004; Vogler *et al.*, 2009b~~), are appropriate methods for differentiation of~~ *~~F. tularensis~~* ~~subspecies and genotypes.~~).

1.5. Animal inoculation

Animal inoculation is not recommended because of welfare and biosafety concerns. It should only be undertaken when ~~isolation~~ culture enhancement in a laboratory animal is considered unavoidable, and where proper animal biosafety facilities and cages are available (see chapter 1.1.4).

Tularemic granuloma or a piece of septicaemic organ (e.g. spleen, liver) is excised and about 1 g of tissue sample is homogenised and suspended in 2 ml of normal saline. A laboratory animal (preferably mouse) is injected subcutaneously with 0.5 ml of suspension. Diseased animals will die after 2–10 days of injection. Heart blood and bone-marrow samples are inoculated on culture media on the day of the laboratory animal’s death (Gyuranecz *et al.*, 2009).

2. Serological tests

Serology is carried out for diagnosis of tularemia in humans but is of limited value in sensitive animal species, which usually die before specific antibodies can develop. Serology may be ~~employed~~ conducted either on sera or on lung extracts (Morner *et al*., 1988) in epidemiological surveys of animals that are resistant or relatively resistant to infection, such as sheep, cattle, pigs, moose, dogs, foxes, wild boars, birds or the European brown hare in Central Europe (Gyuranecz *et al.*, 2011; Morner *et al*., 1988; Otto *et al.*, 2014). As there is no antigenic difference between Type A and Type B strains, the less virulent *F. tularensis* ssp. *holarctica* and its attenuated live vaccine strain (LVS, NCTC 10857) could be used as antigen in all serological tests. The most commonly used serological test for diagnosis of tularemia is the microagglutination test, but other tests (immunofluorescence and enzyme-linked immunosorbent assay [ELISA]) have comparable sensitivity and specificity (Maurin, 2020).

2.1. Agglutination tests

The ~~most commonly~~ antigen used ~~serological tests are the~~ in agglutination tests~~. The antigen~~ is typically a culture of *F. tularensis* on Francis medium. The culture is harvested after 5–6 days. Younger cultures yield a poorer antigen. The colonies are suspended in ~~96~~ 95% alcohol, giving a thick suspension that can be stored for 1–7 days at room temperature. The sediment is washed with normal saline and resuspended in an equal volume of normal saline. Crystal violet powder is added to a final concentration of 0.25%. The bacteria are stained by adding crystal violet and incubating at 37°C for at least 24 hours and at most 7 days.

After the supernatant fluid has been discarded, the deposit is suspended in normal saline with or without thimerosal (merthiolate) at a final concentration of 1/10,000, or formaldehyde at a final concentration of 0.5%. The suspension is calibrated with positive and negative sera and adjusted by adding normal saline to provide an antigen that when tested on a slide gives readily visible stained agglutination reactions against a clear fluid background.

Possible cross-reactions with S-type *Brucella* species and *Legionella* sp. have to be taken into consideration. Agglutination tests primarily detect IgM, although IgG contributes to the agglutination.

2.1.1. Slide agglutination

Slide agglutination is a useful field method (Gyuranecz *et al.*, 2011). In the slide agglutination test 1 drop of whole blood (approx. 0.04 ml) is mixed with 1 drop of antigen and the reaction is considered positive if flakes appear within 1–3 minutes at 20–25°C.

2.1.2. Tube agglutination

The test is performed in tubes containing a fixed amount of antigen (0.9 ml) and different dilutions of serum commencing with 1/10, 1/20, 1/40, etc. The results are read after 20 minutes of shaking, or after 1 hour in a water bath at 37°C followed by overnight storage at room temperature. The agglutinated sediment is visible to the naked eye or, preferably, by using a hand lens. The positive tubes are those that have a clear supernatant fluid.

2.1.3. Microagglutination

The test is performed in microtitre-plates. Serial two-fold dilutions of sera (25 μl) are mixed with an equal volume of formalin-inactivated whole cell suspension (Chaignat *et al.*, 2014). The plates are read ~~out~~ after incubation at 37°C for 18 hours. The agglutinated sediment is visible to the naked eye or, preferably, by using a hand lens. The positive wells are those that have a clear supernatant fluid.

2.2. Enzyme-linked immunosorbent assay

Another serological test, the ~~enzyme-linked immunosorbent assay (~~ELISA~~)~~, also allows an early diagnosis of tularemia (Carlsson *et al*., 1979; Chaignat *et al.*, 2014). Different antigens, whole bacteria as well as subcellular components (e.g. purified lipopolysaccharide), have been used as recall antigens against immunoglobulins IgA, IgM and IgG. Two weeks after the onset of tularemia, specific antibodies can be detected in the serum (Chaignat *et al.*, 2014; Fulop *et al*., 1991). Because IgM is sustained for a long period ~~and~~, it cannot be used as an indicator of recent infection (Bevanger *et al.,* 1994). For routine diagnosis, whole, heat-killed (65°C for 30 minutes) bacteria can be used as antigen. Bacteria can be coated to plastic plates, using the usual procedures (Carlsson *et al*., 1979) followed by serial dilutions of the serum to be tested. Positive reactions can be visualised by anti-antibodies labelled with enzyme. The test should also be read in a photometer with positive and negative sera as controls.

c. REQUIREMENTS FOR VACCINES

The attenuated *F. tularensis* subsp. *holarctica* live vaccine strain (LVS, NCTC 10857) ~~has been~~ was developed in the 1950s and used for decades ~~as a tularemia vaccine, especially in~~ to protect laboratory workers handling large volumes of *F. tularensis* cultures~~. This vaccine~~, however, it is no longer used because of its overall limited efficacy and concern about reversion to virulence, ~~although a derivative~~. A number of ~~LVS is still used to immunise people in endemic regions of Russia.~~ novel vaccines against tularemia are under development using different approaches, but ~~not~~ none have yet ~~licensed~~ received regulatory approval for human or animal use (Carvalho *et al.,* 2014; Conlan, 2011).

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**NB:** At the time of publication (2022) there was no OIE Reference Laboratory for tularemia  
(see Table in Part 4 of this *Terrestrial Manual* or consult the OIE Web site for the most up-to-date list: <https://www.oie.int/en/what-we-offer/expertise-network/reference-laboratories/#ui-id-3>).

**NB:** First adopted in 1991; Most recent updates adopted in 2016.

1. A combination of agent identification methods applied on the same clinical sample is recommended. [↑](#footnote-ref-2)