Ross River virus

Background
Ross River virus is Australia’s most common and widespread arbovirus. It causes epidemic polyarthritis and is associated with significant morbidity and cost to society.

Objective
This article aims to increase clinicians’ awareness of the epidemiological and clinical features of Ross River virus and provide information regarding prevention, diagnosis and management.

Discussion
Ross River virus occurs throughout Australia and numerous outbreaks have occurred. Most cases occur in northern Australia during the wet season, and individuals with high exposure to mosquitoes are most at risk. Arthralgia is the most common presenting symptom and is usually associated with rash, fever and lethargy. No treatment alters the course of the illness, although patients may benefit from simple analgesics or nonsteroidal anti-inflammatory drugs. Symptoms usually resolve within 6 months. Personal protective measures against mosquitoes are an important prevention strategy.

Ross River virus (RRV) is a mosquito transmitted alphavirus that causes epidemic polyarthritis and arthralgias, with about half of patients also experiencing fever and rash. It is Australia’s most common arbovirus with about 5000 cases notified every year (Figure 1).1

The first documented outbreak of RRV occurred in 1928 in Narranderra and Hay in New South Wales2,3 with subsequent outbreaks described during World War II among troops in the Northern Territory4 and Queensland.5 The virus was isolated in 1959 from an Aedes vigilax mosquito along the Ross River near Townsville in Queensland,6 although it was not until 1985 that it was isolated from an Australian patient with polyarthritis.7 Outbreaks have since occurred in all Australian states, including Tasmania, and have occurred in metropolitan areas of Sydney (New South Wales),8 Perth (Western Australia)9 and Brisbane (Queensland).10 Most notifications are from Queensland, with high case rates also reported from Northern Territory and the Kimberley region in Western Australia (Figure 1).

Risk factors for outbreaks include higher rainfalls and higher maximum tides,11 and in northern Australia most cases occur during the months January to April.

The largest ever RRV outbreak, affecting more than 60 000 people, occurred in the western Pacific in 1979–1980 and involved the islands of Fiji,12 Samoa,13 the Cook Islands,14 and New Caledonia.15 The virus apparently disappeared from the region, although was recently reported again in travellers returning from Fiji,16,17 suggesting the probable reintroduction of RRV to Fiji from the neighbouring endemic regions of Australia, Papua New Guinea or the Solomon Islands.

Over 30 mosquito species have been implicated as possible vectors of RRV, but those most strongly associated with transmission include the tidal breeding Aedes vigilax (Figure 2) and Aedes camptorhynchus, found along the northern and southern Australian coastlines respectively, and the freshwater Culex annulirostris, found throughout all of Australia, except Tasmania (Table 1). Aedes notoscriptus has also been implicated as a likely vector. Kangaroos and wallabies are the main reservoir hosts of RRV, although in urban areas possums and horses, and possibly birds and flying foxes, may play a role.18 During epidemics, human-
mosquito-human transmission has almost certainly occurred. Vertical transmission in mosquitoes can occur, and desiccation resistant Ochlerotatus eggs may allow maintenance of the virus throughout drought conditions. As yet there has been no documented case of transfusion transmitted RRV, however, the occurrence of asymptomatic viraemia suggests that this risk cannot be excluded.

**Prevention**

Ross River virus occurs more commonly in people who have participated in outdoor activities, and camping is a particular risk factor. Personal protective measures against mosquitoes including wearing light coloured clothing, using insect repellents, and burning citronella candles and mosquito coils all significantly reduce the risk of RRV and are particularly important at dawn and dusk when mosquitoes are most active. Screens should be fitted to windows and doors in high risk areas and mosquito breeding should be minimised by removing open water containers and water holding plants (Figure 3) from around homes.

**Clinical manifestations**

Ross River virus most commonly occurs in adults aged 25–44 years, with males and females equally affected. The incubation period is generally 7–9 days, with a reported range of 3–21 days. Subclinical infection probably occurs in up to 30% of those infected.

**Acute symptoms and signs**

Joint pain is the most common presenting symptom and is present in more than 95% of patients (Table 2). Joint manifestations are usually symmetrical and acute, and most commonly involve the fingers, toes, wrists, ankles, knees and elbows. About 50% of patients have associated joint swelling, while a minority have effusions, disorders of ligamentous or muscular attachments (enthesopathy) or other abnormal findings. Tiredness is experienced by more than 90% of patients, and fever, myalgias or headache each occur in 50–60% of patients. Rash occurs in about 50% of patients and may be the presenting symptom. The rash is generally maculopapular, and appears predominantly on the limbs and trunk, although it may also involve the face, hands and feet. Anorexia, nausea and decreased libido have been reported in about a third of patients, and there are case reports of splenomegaly, haematuria, glomerulonephritis, meningitis and encephalitis. In the acute setting, functional ability can be significantly impaired, with about half of patients requiring time off work.

**Chronic manifestations of RRV**

Studies from the 1980s and 1990s suggested that the clinical manifestations of RRV disease could be prolonged, with reports of arthralgias, tiredness and depression persisting years after diagnosis. These retrospective studies however, were limited by respondent bias and in some cases relied on patients recalling symptoms months to years after diagnosis. Some studies used inconsistent criteria to diagnose RRV disease and did not account for comorbid conditions.
to 15% at 3 months. Arthralgias resolved for the majority of patients by 5–7 months, with the median number of painful joint groups decreasing from four to one over 4 months, and then to zero by 5–7 months. Psychological and physical functioning returned to normal by 2–5 months and 4–6 months respectively.

Premorbid and concurrent conditions may influence the course of RRV disease. One study found that at 6 months after diagnosis nearly half of patients had a comorbid condition, with rheumatologic conditions and depression being the most common. While the prevalence of these conditions was not greater than expected in the RRV disease cohort, the impact on clinical outcome was significant. Among patients with RRV disease alone, the majority had almost completely recovered their physical and mental health by 6 months, whereas those with a comorbid condition had significant illness up to 12 months after diagnosis. Only one of 60 patients had persisting symptoms at 12 months in the absence of any diagnosis other than RRV disease. Another study evaluated the association between RRV and chronic fatigue syndrome and followed 250 patients for 12 months following a diagnosis of RRV, Ebstein-Barr virus or Q fever. The incidence of chronic fatigue was 12% at 6 months and 9% at 12 months, and did not differ between infective agents. Its onset was predicted only by the severity of the acute illness and not by premorbid psychiatric or medical disorders.

**Diagnosis**

Ross River virus should be suspected in patients presenting with acute polyarthritis and/or rash and with a history of travel to, or residence in, an endemic area. Differential diagnoses may include infectious mononucleosis, rubella, Q fever, other rheumatic conditions such as rheumatoid arthritis and systemic lupus erythematosis, and other arboviruses such as Barmah Forest virus (Table 2).

Diagnosis is confirmed by serology. Immunoglobulin M (IgM) is produced early in the course of infection and hence its detection in an acute phase sample, collected within 7 days of symptom onset, provides a presumptive diagnosis of recent infection. However, IgM can persist for months to years after infection, and false positives may be caused by Barmah Forest virus, rubella, Q fever or rheumatoid factor. Confirmation of the diagnosis therefore requires demonstration of immunoglobulin G (IgG) seroconversion. A convalescent sample should be collected 10–14 days later and tested in parallel by the same laboratory. Diagnosis is confirmed by a four-fold increase in IgG antibody titre. Ross River virus can be detected by polymerase chain

**Table 1. Arboviruses of importance to Australia**

<table>
<thead>
<tr>
<th>Genus</th>
<th>Species</th>
<th>Number of cases reported in Australia in 2008</th>
<th>Geographical distribution</th>
<th>Clinical manifestations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alphaviruses</td>
<td>Ross River virus</td>
<td>5650</td>
<td>Occurs throughout all of Australia, particularly in northern Australia</td>
<td>Acute onset of joint pains +/- rash, fever, lethargy and myalgia</td>
</tr>
<tr>
<td></td>
<td>Barmah Forest virus</td>
<td>2103</td>
<td>Occurs throughout all of Australia, particularly in northern Australia</td>
<td>Similar to RRV, although joint pains less prominent and rash more prominent</td>
</tr>
<tr>
<td></td>
<td>Chikungunya virus</td>
<td>9</td>
<td>Occurs throughout Africa and many areas of Asia. Imported cases occur in Australia</td>
<td>Acute onset of fever, headache, myalgia, nausea and vomiting, and severe arthralgia</td>
</tr>
<tr>
<td>Flaviviruses</td>
<td>Dengue virus</td>
<td>558</td>
<td>Endemic throughout tropical and subtropical parts of the world</td>
<td>Acute onset of fever, lethargy, headache, rash and severe myalgias</td>
</tr>
<tr>
<td></td>
<td>Japanese encephalitis virus</td>
<td>1</td>
<td>Endemic throughout Asia and the Pacific</td>
<td>&gt;95% of cases are subclinical. Can cause encephalitis with a high mortality</td>
</tr>
<tr>
<td></td>
<td>Murray Valley encephalitis virus</td>
<td>2</td>
<td>Endemic in northern Australia, although cases occasionally occur in southeastern Australia</td>
<td>Usually subclinical or mild disease consisting of fever, headache, nausea and vomiting. A small percentage progress to meningitis or encephalitis</td>
</tr>
<tr>
<td></td>
<td>Kunjin virus</td>
<td>1</td>
<td>Endemic in northern Australia, although cases occasionally occur in southeastern Australia</td>
<td>Usually subclinical or mild disease consisting of fever, lymphadenopathy, lethargy and rash. May progress to encephalitis</td>
</tr>
</tbody>
</table>
Symptoms/sign | Frequency (%)
--- | ---
Joint pains | 95
Tiredness | 90
Fever | 50–60
Myalgia | 60
Rash | 40–60
Headache | 50
Joint swelling | 50
Depression | 45

reaction (PCR), however, the usefulness of this test is limited by the short duration of viraemia that follows infection.

**Management**

No treatment has been shown to shorten the duration or alter the course of RRV. In one study, 36% of patients reported that NSAIDs provided the most effective relief, while 16% found over-the-counter analgesics (aspirin or paracetamol) to be most effective. Swimming, hydrotherapy, physiotherapy or massage was the most effective treatment for 10% of patients, while one-quarter found that rest provided the only relief. Eighteen percent found no relief from any form of treatment. Another study found that 58% of patients took NSAIDs at some stage of their illness and were largely satisfied with their effectiveness. Corticosteroids have been used in some patients, however, there is no evidence to support their effectiveness and they are not recommended.

**Public health implications**

Ross River virus requires notification to the appropriate state or territory health department, and notification rates are monitored to detect the occurrence of outbreaks. The outbreak potential of RRV has been clearly demonstrated by the 1979 Pacific epidemic and by smaller epidemics throughout Australia. Outbreaks tend to occur after rainy periods or flooding, and health practitioners should be particularly alert to the possibility of RRV at these times. Outbreaks may also follow urban development that occurs in or around wetlands or salt marshes and increases population exposure to mosquito breeding sites. It is also possible that increasing climate variability may affect mosquito breeding habitats and patterns and may increase the incidence of RRV. Outbreak control measures include identification of the important mosquito species involved and elimination of their breeding sites.

**Summary of important points**

- Joint pain is the most common presenting symptom of RRV and most commonly affects the fingers, toes, hands, feet, elbows and knees.
- Acute symptoms can be severe and debilitating and frequently last up to 3 months.
- Symptoms resolve over 4–6 months in the majority of patients.
- Symptoms are often more severe and prolonged in the presence of comorbid conditions.
- There is no specific treatment, although NSAIDs may provide relief.
- Personal protective measures against mosquitoes significantly reduce the risk of disease and should be recommended.

**Conflict of interest:** none declared.

**References**