The yellow fever virus belongs to the genus Flavivirus and is related to other viruses of the same genus such as dengue, Zika, Japanese encephalitis and West Nile viruses. The virus is transmitted to humans mainly by sylvatic mosquito vectors of the genera *Haemagogus* and *Sabethes* as well as by the *Aedes aegypti* mosquito. The clinical spectrum of yellow fever ranges from asymptomatic or mild infection to potentially fatal severe conditions with hemorrhage and jaundice. Suspicion of yellow fever is based on the patient’s clinical features, places and dates of travel (if the patient is from a non-endemic country or area), activities, and epidemiologic history of the location where the presumed infection occurred. Thus, confirmation by laboratory techniques should be addressed for characterization of cases and of the outbreak.

The most important measure of prevention of yellow fever is vaccination which provides protective immunity against the disease to 80-100% of those vaccinated after 10 days and 99% immunity after 30 days. Although the yellow fever vaccine is safe and adverse events are uncommon, contraindications and safe immunization practices must be respected.

**Sample types and laboratory procedures**

The diagnosis of yellow fever is made by virological methods (detection of the virus or of its genetic material in serum or tissue) using virus isolation or Reverse transcription polymerase chain reaction (RT-PCR), or by means of serological testing for the detection of antibodies.

**Biosafety considerations**

All biological samples (whole blood, serum or fresh tissue) should be considered as potentially infectious. All laboratory personnel handling these samples must be vaccinated against yellow fever and use appropriate personal protective equipment. Likewise, it is recommended to carry out all procedures in certified class II biosafety cabinets and to take all necessary precautions to avoid percutaneous exposure. Procedures for handling of non-human samples should be carefully assessed according to the biosafety manual of the laboratory, and use of Class III biosafety cabinets should be considered.

**Virological diagnosis**

- **Molecular diagnostics**: Viral RNA can be detected during the first 5 days from symptom onset (viremic phase) and using molecular techniques such as end-point of real-time RT-PCR. Occasionally, viral RNA can be detected up to 7 days from symptom onset. Thus, it is recommended to perform both RT-PCR and IgM ELISA for samples collected between days 5 and 7 from the onset of symptom (figure 1). A positive result (when using the appropriate controls) confirms the diagnosis.
- **Viral isolation:** Viral isolation can be performed through intracerebral inoculation in mice or in cell culture (using Vero or C6/36 cells; may be performed under BSL2 containment). However, because of its complexity, this methodology is rarely used as a diagnostic tool and is recommended mainly for research studies complementary to public health surveillance.

- **Postmortem diagnosis:** Histopathological analysis with immunohistochemistry performed on liver sections is considered the "gold standard" for the diagnosis of yellow fever in fatal cases. Additionally, molecular detection can also be performed in fresh or paraffin-embedded tissue samples to confirm the cases. The procedure may be carried out under BSL2 containment (See above the section *Biosafety considerations* for non-human samples).

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**Figure 1. Indications for yellow fever diagnosis according to the number of days since the onset of symptoms**

![Figure 1](image-url)

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**Serological diagnosis**

Serology (the detection of specific antibodies) is useful for diagnosing yellow fever during the post-viremic phase of the disease (i.e., from the 5th day since the onset of symptoms).

A positive IgM reaction by enzyme-linked immunosorbent assay (ELISA) (mainly IgM antibody-capture, MAC-ELISA) or any other immunoassay (indirect immunofluorescence) in a sample collected from the 5th day of symptom onset is presumptive of recent yellow fever virus infection. Currently, there are not commercially available, validated IgM ELISA kits. Therefore, in-house protocols using whole purified antigen may be standardized.

**The confirmation of a case of yellow fever by IgM ELISA will depend on the epidemiological situation and the results of the laboratory differential diagnosis. In areas where other flaviviruses co-circulate (especially dengue and Zika), the probability of cross-reactivity is higher** (figure 2).

Other serological techniques include the detection of IgG antibodies by ELISA and of neutralizing antibodies by plaque reduction neutralization test (PRNT). IgG ELISA is useful with paired samples (collected at least 1 week apart), while PRNT90 may be useful with paired samples, or with a single post-viremic sample if the assay includes multiple flaviviruses.

A seroconversion (negative results in the first sample and positive result in the second sample), a more than 4-fold increase in antibody titers in paired samples, or a detectable antibody titer against yellow fever in a post-viremic sample by PRNT90 is presumptive of yellow fever virus infection. Confirmation
of a yellow fever case using these techniques will depend on the epidemiological situation and the results of the laboratory differential diagnosis. In areas with co-circulation of other flaviviruses the probability of cross reactivity is higher (see figure 2). Additionally, in those areas where active vaccination campaigns are ongoing, detection of vaccine induced antibodies may occur and then diagnosis should be carefully interpreted (see below the section Post-vaccination immune response).

**Figure 2**

![Algorithm for confirmation of Yellow Fever cases](image)

**Interpretation of serology results and differential diagnosis**

Serological techniques are often cross-reactive among flavivirus infections (in particular, in secondary flavivirus infections). This should be considered in areas where the co-circulation of yellow fever virus with other flaviviruses (dengue, St. Louis encephalitis, Zika, and others of the Japanese encephalitis complex) is documented and the population is likely to have been previously infected with these viruses. Also, it should be noted that in individuals vaccinated against yellow fever, vaccine-induced IgM can be detected for several months or even years.
Therefore, it is recommended to carry out the parallel detection of antibodies to other flaviviruses and to carefully interpret the results taking into consideration the individual vaccination history as well as the available epidemiological information.

In general, the PRNT offers greater specificity than the detection of IgM and IgG. However, cross-reactivity has also been documented for the neutralization assays. Thus, it is also recommended that this technique be performed using antigens for several flaviviruses.

Moreover, the differential diagnosis of yellow fever should include other febrile and febrile icteric syndromes – such as dengue, leptospirosis, malaria, viral hepatitis, among others – depending on the epidemiological profile of the affected country or area.

A case of yellow fever will be confirmed by serological techniques only if the differential laboratory diagnosis, taking into consideration the epidemiological situation of the country, is negative for another flavivirus (Figure 2).

Post-vaccination immune response

Vaccination induces a relatively low viremia that decreases after 4 to 7 days. Concurrently, an IgM response develops. This response cannot be differentiated from the IgM response induced by a natural infection. Approximately 10 days after vaccination, the vaccinee is considered to be protected against a natural infection. The IgM response may be detected from around day 5 onwards with a peak occurring generally 2 weeks after vaccination. Subsequently, antibody levels tend to decrease. However, in a significant proportion of individuals, the IgM response can be detected one month and in some cases (mainly travelers) up to 3-4 years. In addition, neutralizing antibodies induced by vaccination can be detected for several decades. Therefore, the interpretation of serological results in vaccinated individuals is complex, particularly in those who have recently been vaccinated and results should be carefully assessed.

Sample conservation

- Whole blood (in EDTA tube) or serum (red-top tube) should be kept refrigerated (2 - 8 °C) if processed (or sent to a reference laboratory) within 48 hours.

- Serum should be kept frozen (-10 to -20 °C) if processed after 48 hours but in a period of no more than 7 days.

- Serum should be kept frozen (-70 °C) if processed more than a week after. Serum samples can be stored at -70 °C for extended periods of time.

- Multiple freeze-thaw cycles should be avoided.

- Fresh tissue samples (approximately 1 cm³) can be used for molecular diagnosis. Freeze at -70 °C and send to a reference laboratory on dry ice. If not possible, store fresh tissue in sterile saline or refrigerated PBS (2-8 °C) and ship with refrigerant gels.
For histopathological and immunohistochemistry analyses, tissue samples (approximately 1 cm³) must be fixed in buffered formalin and sent to a pathology laboratory at room temperature. Liver is the tissue of choice for histopathological and immunohistochemistry analyses. Spleen and kidney samples may also be useful.

Shipping of samples to the reference laboratory by air

The following are some aspects to consider for shipping samples by air:

- The cold chain should be maintained with dry ice (if possible) or with refrigerant gel. Triple packaging should always be used.
- Samples should be shipped, if possible, within the first 48 hours.
- The original samples must be packaged, marked, labeled (if dry ice is used) and registered as category B.
- The shipment must be accompanied by the complete clinical and epidemiological record.

References


- Centers for Disease Control and Prevention (CDC). Yellow Fever: Symptoms and Treatment. 13 August 2015. Available online at: https://www.cdc.gov/yellowfever/symptoms/index.html


