

# Bio Terror Bible

## EXPOSING THE COMING BIO-TERROR PANDEMIC

**BIOTERRORBIBLE.COM:** Totally inexcusable lab [“accidents”](#) have been occurring at BSL Labs (biosafety level labs) within the United States and around the world. Should a bio-terror pandemic arise, it is possible that a lab “accident” may serve as the scapegoat and source of the deadly pathogen.

**Title:** Deadly Virus Threatens Second Worker At Lab Fellow Researcher Died From Rare Herpes B Infection Last Month

**Date:** January 1, 1998

**Source:** [Spokesman](#)

**Abstract:** Three weeks after a researcher died of a herpes B virus contracted when a monkey splashed fluid in her eye, a co-worker may have been exposed in the same way, even though she was wearing goggles.

The unidentified researcher at the Yerkes Regional Primate Research Center was released Wednesday from Emory University Hospital after four days of tests.

“Her physicians have found no evidence of herpes B infection,” said Sylvia Wroble, an Emory spokeswoman. “Out of that same precaution and concern, however, we will continue to monitor her over the next months.”

Macaque monkeys, the type used for research at Yerkes, are common carriers of herpes B virus. Though it is usually harmless to monkeys, the virus is fatal to 70 percent of humans who contract it.

Although monkey-to-human herpes B infections are extremely rare, it was second time this month that a lab worker at Yerkes, a research arm of Emory, has been hospitalized after being hit in the eye by body fluids.

Elizabeth Griffin, 22, died of herpes B complications on Dec. 10, six weeks after a rhesus monkey, a type of macaque, infected her as she was moving its cage. It was unclear what the fluid was.

Yerkes employees are supposed to wear goggles when there is a chance that bodily fluids containing the virus - saliva and sometimes urine - might be swept up into the air, such as when a cage is being cleaned, but not when they move the animals.

Unlike Griffin, the second worker was wearing eye protection, Wroble said. She would not discuss other specifics of the incident.

But Robin Slater, a friend of the researcher's, said fluid seeped in from the sides of her goggles. He said she had a red eye and had been given antibiotics, but otherwise seemed fine.

Griffin appeared well initially, except for an inflamed eye that appeared almost two weeks after she was splashed. After 10 days of treatment in the hospital - during which doctors confirmed she was infected with the virus - she was well enough to go home. She was readmitted a short time later.

Herpes B has an incubation period of up to three weeks.

Only 40 cases of monkey-to-human herpes B infections have been recorded since 1933. Ms. Griffin's case was the first not caused by a bite or scratch, Yerkes said.

Yerkes, which has about 2,800 primates, performs tests on 15 primate species in researching treatments for AIDS, cardiovascular disease, Parkinson's disease and cancer ([Spokesman, 1998](#)).

**Title:** Fatal Cercopithecine Herpesvirus 1 (B Virus) Infection Following A Mucocutaneous Exposure And Interim Recommendations For Worker Protection

**Date:** December 18, 1998

**Source:** [CDC](#)

**Abstract:** On December 10, 1997, a 22-year-old female worker at a primate center died from Cercopithecine herpesvirus 1 (B virus) infection 42 days after biologic material (possibly fecal) from a rhesus macaque (*Macaca mulatta*) splashed into her right eye. This report summarizes the clinical features of her illness and the subsequent investigation by CDC in response to a technical assistance request from the Occupational Safety and Health Administration (OSHA) and presents interim recommendations to prevent ocular splash exposures. This investigation documented the hazard of ocular splashes and indicated that dendritic corneal lesions, such as herpetic skin vesicles, are not always present in B virus infection (1).

The exposure occurred on October 29, 1997, while the worker moved the animal within cages during a routine capture of free-ranging monkeys. She was not wearing protective eyewear because the activities in which she was engaged involved caged macaques, and the activities were judged by the primate center to carry a low risk for exposure to B virus. Following the exposure, the worker wiped her eye with a paper towel and, approximately 45 minutes later, irrigated the eye for 2-3 minutes with tap water but did not file an incident report. The monkey involved was not identified.

On November 8, the worker's eye was red and swollen. At the emergency department (ED) of a medical center affiliated with the same university as the primate center, she informed the physician that she worked with nonhuman primates and may have been exposed to B virus. Dendritic corneal lesions typical of ocular herpes infections were not observed by Wood's lamp examination. The ED physician consulted the B virus protocol in place in the ED and then consulted an infectious diseases specialist by telephone. On the basis of the reported circumstances of the contact and the absence of previous recognized transmission of B virus following mucocutaneous exposure, the infectious diseases specialist concluded that B virus infection was unlikely but recommended follow-up with the infectious diseases clinic within the next few days. The ED physician prescribed sulfonamide eye drops.

An appointment at the infectious diseases clinic was not available immediately. On November 11, the worker called her primary-care physician for a referral because her eye symptoms were worsening. The physician referred her to an ophthalmologist, who elicited history of a recent cat scratch and prescribed doxycycline for suspected Parinaud's oculoglandular syndrome secondary to cat-scratch fever. Routine eye cultures were obtained. Confirmatory serologic testing for *Bartonella* species, also ordered during the visit, subsequently was negative.

On November 13, the worker sought care from another ophthalmologist because of increased right retro-orbital pain and onset of photophobia, anorexia, nausea, and abdominal pain. After reconsultation with the infectious diseases specialist, the worker was immediately hospitalized for suspected B virus infection. The worker's temperature, normal on admission, reached 101.4 F (38.6 C) during the first day of

hospitalization. Physical examination identified a swollen right orbit with conjunctivitis and one small tender right preauricular lymph node. Laboratory examination of urine found trace proteinuria. Cerebrospinal fluid (CSF) analysis identified 8 white blood cells per milliliter (83% lymphocytes {normal: 0-10 cells, 100% mononuclear}). Serum for Western blot testing and CSF specimens and eye swabs for B virus culture were sent to the B Virus Research and Resource Laboratory. All previously collected eye cultures were retrieved from commercial laboratories to minimize biosafety hazards to laboratory workers.

Acyclovir therapy (15 mg/kg intravenously every 8 hours) was started within 2 hours of hospital admission. On November 14, therapy was changed to ganciclovir (5 mg/kg every 12 hours) when a vesicular eruption was noted in the distribution of the first and second branches of the right trigeminal nerve. Magnetic resonance imaging (MRI) of the head was normal. The vesicles resolved over the following week. A sharp mid-cervical/high thoracic back discomfort occurred on November 19 but subsided over an 8-hour period. All symptoms resolved, and on November 24 the worker was discharged on outpatient intravenous (IV) ganciclovir therapy.

Despite uninterrupted ganciclovir therapy, on November 25 the worker woke with right foot weakness, inability to urinate, and lower abdominal pain, followed by a rapidly progressive ascending myelitis. The hospital readmission examination found profound right leg weakness, moderate left leg weakness, decreased hand grip strength bilaterally, and urinary retention. MRI revealed abnormalities extending from the cervical spinal cord to the upper thoracic cord. The worker was intubated electively within 13 hours and developed flaccid paralysis from C2 caudad.

The diagnosis of postviral acute demyelinating encephalomyelitis was considered by neurology consultants, and a short course of plasmapheresis and steroids was administered. On November 30 seizure activity (involuntary facial and eye movements) developed, and foscarnet, usually not recommended for B virus infection because of its toxicity, was added to ongoing ganciclovir therapy. During December 1-9, the worker developed nosocomial pneumonia with bacteremia, followed by adult respiratory distress syndrome. Repeat MRI revealed abnormalities extending from midbrain through the thoracic spinal cord. On December 10, the worker died from refractory respiratory failure.

Eye and CSF cultures obtained in the hospital on November 13 and November 14 were negative for B virus when tested at the B Virus Research and Resource Laboratory. Serum collected November 13 and November 21 and tested for reactivity to B virus by Western blot showed indeterminate and positive reactivity, respectively, confirming B virus infection ([CDC, 1998](#)).