The presence of a competent vector, optimal climatic conditions and the possibility of returning patients who are viremic are prerequisites for autochthonous transmission of arboviruses, are currently being met in many countries in Europe. Health professionals should be trained to identify arboviral diseases symptoms and to introduce them into the differential diagnosis, not only among patients returning from the tropics, but also in local patients from countries and areas with the presence of suitable vectors, so that possible outbreaks can be identified before they can have major consequences. Epidemiological and entomological surveillance is necessary to detect and control further outbreaks and to minimize the risk of local transmission in vector-colonized areas.

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Competing interests

None.

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Tularemia: diagnosis of an unexpected oculoglandular case in a non-endemic area by universal PCR

Tularemia: diagnóstico de un caso oculoglandular inesperado en un área no endémica mediante PCR universal

Dear Editor,

Tularemia is a zoonotic disease caused by *Francisella tularensis*, a Gram-negative facultative intracellular coccobacillus[1] with four recognized subspecies[2]: *tularensis* (type A), *holarctica* (type B), *mediasiatica* and *novicida*. Type A is found in North America, while type B is located, but not exclusively, in the northern hemisphere.[3] In Spain, it was an uncommon disease until 1997, when the first tularemia outbreak occurred in Castilla y León.[4] Until now, all cases reported in Spain were caused by *F. tularensis* subsp. *holarctica.* Clinical manifestations of tularemia fall into two main forms: ulceroglandular (>90% of cases in Europe)[2] and typhoidal. However, there are three more clinical forms: oculoglandular, oropharyngeal/gastrointestinal and pneumonic.

We have previously published the first case of ulceroglandular tularemia in a non-endemic area (Asturias, Spain).[5] Here, we present the first reported case of oculoglandular tularemia occurred in the same region which worried us.

An 88-year-old male presented to the emergency department of our hospital in April 2017 for diagnosis and management of pain in his right eye and the presence of conjunctival discharge. He did not have other symptoms, history of trauma, drug intake, or any recently local or systemic infection. His laboratory workup only showed a high value of C-reactive protein (5.5 mg/dL) and his medical and surgical histories were noncontributory. A diagnostic of viral conjunctivitis was done and he was treated with lubricant and anti-inflammatory drops.

Two months later, he was brought to the Department of Oral and Maxillofacial Surgery with a painful cervical mass (Fig. 1), weight loss and discomfort. He did not declared a recent travel, contact to ill people or animals although he lives in a rural area. Clinical examination revealed the presence of a right neck mass measur-

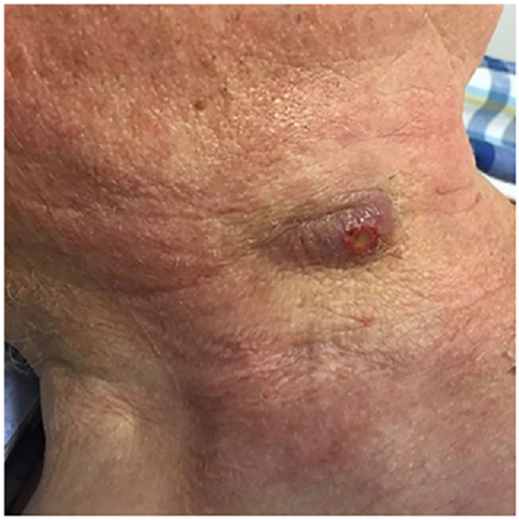

Fig. 1. Cervical mass observed in physical examination one month after conjunctivitis.