During October 2013–May 2014, there were 102 cases of pneumonia diagnosed in US Air Force Academy cadets. A total of 73% of tested nasal washes contained *Chlamydia pneumoniae*. This agent can be considered to be present on campus settings during outbreaks with numerous, seemingly disconnected cases of relatively mild pneumonia.

*Chlamydia pneumoniae* is the most common *Chlamydia* species that causes human infection (1). It responsible for up to 20% of community-acquired pneumonia cases in elderly adults (1). In recent years, *C. pneumoniae* has also been identified in outbreaks of pneumonia among younger age groups in a variety of close-quarters living environments, including military installations, prisons, universities, and single-family households (2–6).

We report the findings of our investigation into an outbreak of 102 cases of pneumonia at the US Air Force Academy, Colorado Springs, CO, USA. Laboratory testing identified *C. pneumoniae* as the likely causative pathogen.

The Study

The US Air Force Academy houses ≈4,000 cadets. The cadet population is composed of approximately equal-sized freshman, sophomore, junior, and senior classes. Members of each class year are randomly distributed to 1 of 40 cadet squadrons (numbered 1–40). Each squadron is composed of ≈100 cadets of both sexes. Approximately 80% of cadets are men. Ten squadrons are grouped together to form 1 of 4 cadet groups. All cadets receive their health care at the cadet clinic or other military installations.

In October 2013, a cluster of radiographic-confirmed cases of pneumonia was identified as part of routine medical surveillance by the preventive medicine staff at the US Air Force Academy, Colorado Springs, CO, USA. Laboratory testing identified *C. pneumoniae* as the likely causative pathogen. The outbreak lasted through May 2014, and a total of 102 cases of pneumonia were identified in US Air Force Academy cadets (Figure 1). Pneumonia was diagnosed in 74 male (73%) and 28 female (27%) cadets; cases were identified in members of every class year and cadet group (Table 1). Although no major differences in attack rate were noted among cadet groups, freshmen and juniors had higher attack rates than sophomores and seniors (Table 1). For freshmen, this finding is consistent with traditional military training risk factors because freshman undergo the most physically demanding training. It is unclear why the junior class had a similar incidence of pneumonia, although this finding might reflect a higher level of social contact outside the dormitory environment for this group.

Author affiliations: US Air Force Academy, Colorado Springs, Colorado, USA (K.A. Fajardo); US Air Force School of Aerospace Medicine, Wright-Patterson Air Force Base, Ohio, USA (S.C. Zorich, J.D. Voss, J.W. Thervil); Oak Ridge Institute of Science and Education, Oak Ridge, Tennessee, USA (J.W. Thervil)

DOI: http://dx.doi.org/10.3201/eid2106.141394
Clinically, all cadets with pneumonia reported general-ized, mild upper respiratory tract infection (URI) symptoms, such as cough, sore throat, and headache at the time of ini-tial presentation. Chest radiographs showed acute, unilateral lobar consolidation for all patients. Only 4 cadets (5%) had documented evidence of fever at the time of presentation. Most cadets with pneumonia (101/102) required only a stan-dard course of oral azithromycin therapy. One cadet, who had a pulmonary abscess, required hospitalization. He was given intravenous antimicrobial drugs and discharged from the hospital after 4 days.

Sixty-eight nasal wash samples from cadets were tested at US Air Force School of Aerospace Medicine Epidemiology Laboratory. Each specimen was tested by viral culture and real-time reverse transcription PCR for influenza virus. Influenza virus–negative specimens was then tested by using multiplex PCR testing; this PCR can identify many common respiratory pathogens, including C. pneumoniae (Table 2). Of the 68 samples, 15 were from cadets with pneumonia (Table 2). Of these 15 samples, 11 (73%) were positive for C. pneumoniae, 1 (7%) was positive for influenza A (H1N1) virus, and 3 (20%) were negative for both pathogens (Table 2).

Fifty-three nasal wash specimens were collected from cadets who had URI symptoms but were not given a diagnosis of pneumonia. Of these 53 specimens, 19 (36%) were positive for C. pneumoniae (Table 2). None of the 53 cadets from whom these samples were obtained received antimicrobial drug therapy, and all recovered without complications.

When charted on the basis of cadet squadron assigned, incident pneumonia cases were generally scattered through-out the cadet population (Figure 2). Only brief, self-limited clustering of cases was noted. For example, in February 2014, three squadrons had multiple cases diagnosed within a few weeks of each other (squadrons 24, 26, and 35). However, incident cases abruptly ended in these squadrons, which made it difficult to justify a large-scale antimicrobial drug prophylaxis campaign. Antimicrobial drug prophylaxis of close contacts of cadets with pneumonia was also of unclear benefit because we observed no evidence of roommate-to-roommate transmission.

The last case was diagnosed on May 15, 2014, although the surveillance period extended through July 31, 2014. Although aggressive reinforcement of infection control measures continued throughout the outbreak, the abrupt cessation of incident cases was more likely caused by the efflux of cadets off base after senior graduation and the start of underclassman summer activities.

Conclusions
Recent evidence supports C. pneumoniae as an increas-ingly common cause of outbreaks of community-acquired pneumonia, particularly in close-quarters living environ-ments (2–6). The outbreak described supports this finding, and laboratory studies confirmed the presence of C. pneu-moniae in 11 (73%) of 15 nasal wash samples from cadets given a diagnosis of pneumonia. Furthermore, 19 (36%) of 53 cadets with acute URI symptoms, but who were not given a diagnosis of pneumonia, were also positive for C.
This finding might indicate that mild URI symptoms, rather than frank pneumonia, predominate in *C. pneumoniae* outbreaks. The long incubation period for infection with *C. pneumoniae*, estimated to be ≤4 weeks (7), also probably contributed to the difficulty in containing the outbreak because case diagnoses were generally made in a random pattern. Thus, the preventive intervention relied primarily on reinforcement of basic personal hygiene practices.

We suspect that routine testing for *C. pneumoniae* in outbreak situations is rare. Therefore, it is possible that *C. pneumoniae* commonly emerges on college campuses, in prisons, and other military training environments without any reporting. There are several reasons to be concerned about emergence of *C. pneumoniae* in these settings. First, unique transmission characteristics (incubation period, asymptomatic carriage) can lead to diagnostic uncertainty, which enables outbreaks to be sustained for long durations without a clear method for control. Second, if *C. pneumoniae* is not considered within the differential diagnosis, unnecessary testing for other pathogens might be conducted. Third, even if the acute illness is mild, *C. pneumoniae* has been linked with numerous chronic diseases (e.g., atherosclerosis [8] and asthma [9]).

Dr. Fajardo is Chief of Preventive Medicine at the United States Air Force Academy, Colorado Springs, Colorado. His primary research interest is tropical infectious diseases.

**References**

1. Myhra W, Mordhorst CH, Wang SP, Grayston JT. *Chlamydia pneumoniae*, strain TWAR, infection in Denmark 1975–1987. In: Bowie WR, Caldwell HD, Jones RP, Mardh P, Ridgway GL, Schachter J, et al., editors. Chlamydial infections. Proceedings of the 7th International Symposium on Human Chlamydial Infections; 1990 Jun 19–24; Harrison Hot Springs, British Columbia, Canada. Cambridge (UK): Cambridge University Press; 1990. p. 422.
2. Dawood FS, Ambrose JF, Russell BP, Hawksworth AW, Winchell JM, Glass N, et al. Outbreak of pneumonia in the setting of fatal pneumococcal meningitis among US Army trainees: potential role of *Chlamydia pneumoniae* infection. BMC Infect Dis. 2011;11:157. PubMed http://dx.doi.org/10.1186/1471-2334-11-157.
3. Coon RG, Balansay MS, Faix DJ, Hawksworth AW, Patterson MB, Blair PJ. *Chlamydia pneumoniae* infection among Basic Underwater Demolition/SEAL (BUD/S) candidates, Coronado, California, July 2008. Mil Med. 2011;176:320–3. http://dx.doi.org/10.7205/MILMED-D-10-00370.
4. Oktem IM, Ellidokuz H, Sevinc C, Kiline O, Aksakoglou G, Sayiner A, et al. PCR and serology were effective for identifying *Chlamydia pneumoniae* in a lower respiratory infection outbreak among military recruits. Jpn J Infect Dis. 2007;60:97–101.
5. Miyashita N, Osuchi K, Shoji H, Obase Y, Fukuda M, Yoshida K, et al. Outbreak of *Chlamydia pneumoniae* infection in long-term care facilities and an affiliated hospital. J Med Microbiol. 2005;54:1243–7. http://dx.doi.org/10.1099/jmm.0.46191-0.
6. Blasi F, Cosentini R, Denti F, Allegra L. Two family outbreaks of *Chlamydia pneumoniae* infection. Eur Respir J. 1994;7: 102–4. http://dx.doi.org/10.1183/09031936.94.07010102.
7. Heymann DL, editor. Control of communicable diseases manual. 19th ed. Washington (DC): American Public Health Association; 2008.
8. Campbell LA, Rosenfield ME. Persistent *C. pneumoniae* infection in atherosclerotic lesions: rethinking the clinical trials. Front Cell Infect Microbiol. 2014;4:34. PubMed http://dx.doi.org/10.3389/fcimb.2014.00034.
9. Atkinson TP. Is asthma an infectious disease? New evidence. Curr Allergy Asthma Rep. 2013;13:702–9. http://dx.doi.org/10.1007/s11882-013-0390-8.

**Address for correspondence:** Kevin A. Fajardo, Preventive Medicine, US Air Force Academy, Colorado Springs, CO 80840, USA; email: kevin.fajardo@us.af.mil.