1130-0108/2010/102/9/564-565
Revista Española de Enfermedades Digestivas

Rev Esp Enferm Dig (Madrid)
Vol. 102, N.° 9, pp. 564-565, 2010

Letters to the Editor

Abdominal pain and diarrhea in patients from Ecuador

Key words: Strongyloides stercolaris. Malabsorption.

Dear Editor:

Strongyloidiasis is bowel parasite which is endemic from tropical and subtropical countries (1), with alone endemic focus on Spanish east (2). *Strongyloides stercolaris* infects mammals, men included, and it is used to complete its free life cycle in ground and faeces, and by autoinfection mechanism, perpetuates in the organism during ages, even decades.

Case report

We study the case of a 46-year-old female patient came in repeatedly, complaining of abdominal pain, diarrhea and weight loss. Originally from Ecuador, she has been living in Spain for 9 years and currently she resides in Murcia. Important medical history included intestinal resection surgery performed in Ecuador and gallstones awaiting treatment. She claimed to have been suffering for 4 months from a clinical condition of epigastric and periumbilical pain that irradiated to the right hypochondrium. She also experienced vomiting after eating and abundant green stool without any pathological findings that caused her to get up during the night, as well as significant, non-quantified weight loss.

Examination showed pale skin and mucus, cachexia, abdominal distension and diffuse pain when pressure was applied. Laboratory tests revealed microcytic anemia (hemoglobin 7 g/dL, VCM 67 nm), a normal overall white cell count but with a slightly elevated presence of eosinophils and higher levels of acute phase reactants. The abdominal X-ray was compatible with intestinal subocclusion due to the high presence of hidroaereal levels. High digestive endoscopy revealed bulboduodenitis as well as erosive gastritis. Biopsies were taken, and the laboratory reported nonspecific inflammation without any signs of villous atrophy. The endoscopy of the small intestine showed loss of valvulae conniventes in the duodenum and the jejunum and other radiological signs that suggested malabsorption. The D-xylose tests in blood and urine were negative. First-stage (rhabditiform) larvae of *Strongyloides stercolaris* were observed in one of the stool specimens sent to our Microbiology Department.

The infection was treated with ivermectin (6 g/day) for two consecutive days, after which the patient became asymptomatic. The parasite could not be detected in stool specimens collected after the treatment had been concluded.

Discussion

Strongyloides stercolaris has a complex life cycle that can cause disseminated infection in the human organism several years after exposure (3). Although in most cases the infection is asymptomatic or the clinical manifestations are mild or moderate, the parasite may take advantage of certain circumstances, like immunodepression (4) of any kind (hematological dyscrasias, immunodepressant treatment, steroids, HIV of HTLV-1 infection), to grow and disseminate large amounts of infective larvae throughout the bloodstream, which are able to affect vital organs and trigger hyperinfection syndrome, which can lead to septic shock and death (5). Therefore, given the increase of immigrants in our country from endemic areas, we should screen this demographic sector at the onset of even mild symptoms suggesting strongyloidiasis (6).

M. C. Alcántara-Zafra and T. Martínez-Jiménez

Service of Internal Medicine. Section of Digestive Diseases. Hospital Rafael Méndez. Lorca, Murcia. Spain

References

1. Posey DL, Blackburn BG, Weinberg M. High prevalence and presumptive treatment of schistosomiasis and strongyloidiasis among African refugees. Clin Infect Dis 2007; 45: 1310.
2. Alcaraz CO, Adell RI, Sánchez PS, Blasco MJ, Sánchez OA, Auñón AS, et al. Characteristics and geographical profile of strongyloidiasis in healthcare area 11 of the Valencian community (Spain). J Infect 2004; 49(2): 152-8.
3. Segarra-Newnham M. Manifestations, diagnosis and treatment of Strongyloides stercolaris infection. Ann Pharmacother 2007; 41(12): 1992-2001.
4. Keiser PB, Nutman TB. Strongyloides Stercolaris in the immunocompromised population. Clin Microbiol Rev 2004; 17: 208.
5. Newberry AM, Williams DN, Stauffer WM, Boulware DR, Hendel-Paterson BR, Walker PF. Strongyloides hyperinfection presenting as acute respiratory failure and gram-negative sepsis. Chest 2005; 128: 3681-4.
6. Nuesch R, Zimmerli L, Stockli R, Gyr N, Christoph Hatz FR. Imported strongiloidosis: a longitudinal analysis of 31 cases. J Travel Med 2005; 12: 80-4.