21 Worms You Should Know

Speaker: Edward Mitre, MD

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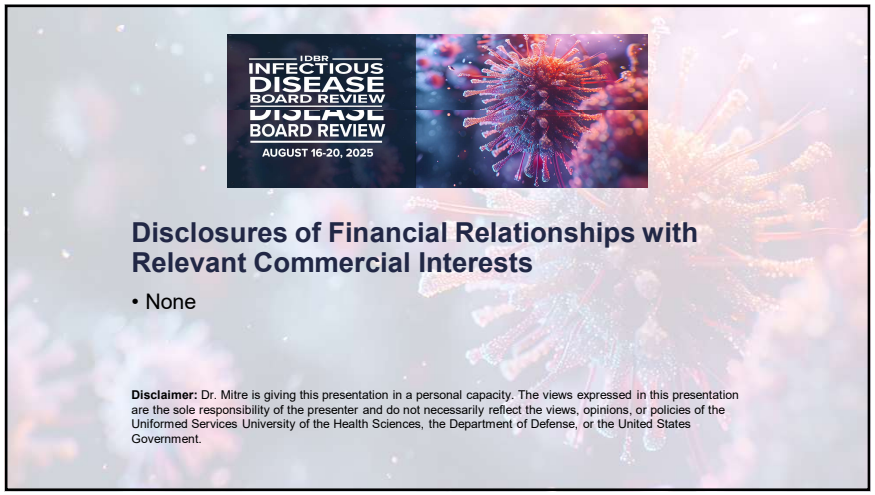

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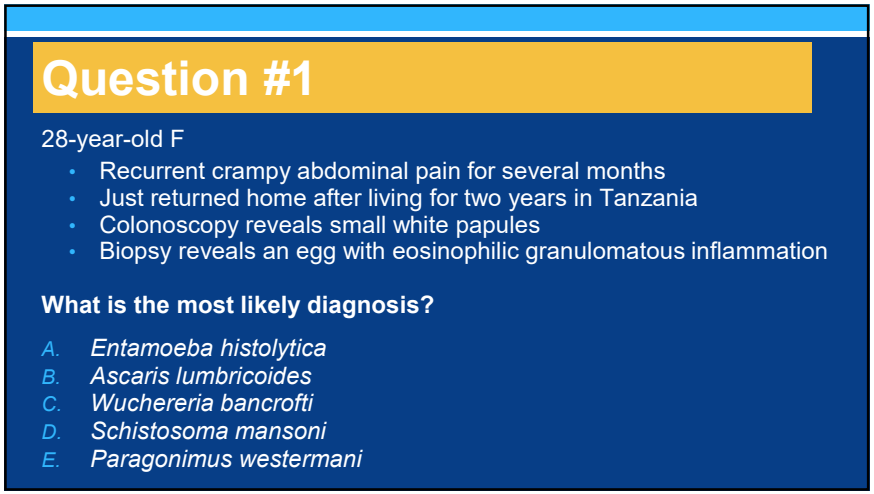

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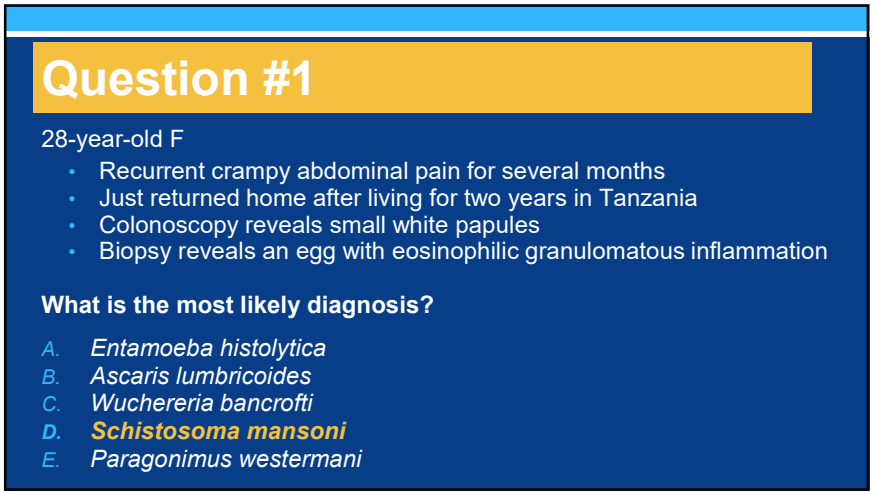

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Major Helminth Pathogens

TREMATODES

Blood flukes
- *Schistosoma mansoni*
- *Schistosoma japonicum*
- *Schistosoma haematobium*

Liver flukes
- *Fasciola hepatica*
- *Clonorchis sinensis*
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Lung flukes
- *Paragonimus westermani*

Intestinal flukes
- *Fasciolopsis buski*
- *Metagonimus yokagawai*

CESTODES

Intestinal tapeworms
- *Taenia solium*
- *Taenia saginata*
- *Diphyllobothrium latum*
- *Hymenolepis nana*

Larval cysts
- *Taenia solium*
- *Echinococcus granulosus*
- *Echinococcus multilocularis*

NEMATODES

Intestinal
- *Ascaris lumbricoides*
- *Ancylostoma duodenale*
- *Necator americanus*
- *Trichuris trichiura*
- *Strongyloides stercoralis*
- *Paracapillaria philippinensis*
- *Enterobius vermicularis*

Tissue Invasive
- *Wuchereria bancrofti*
- *Brugia malayi*
- *Onchocerca volvulus*
- *Loa loa*
- *Trichinella spiralis*
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- *Anisakis simplex*
- *Toxocara canis/cati*
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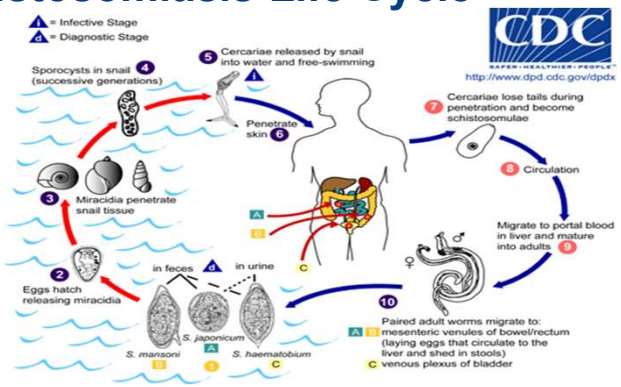
Schistosomiasis Life Cycle



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Acute Schistosomiasis

Cercarial dermatitis (Swimmer's itch)
- Urticarial plaques and pruritic papules
- Occurs upon re-exposure to cercariae penetrating skin in a sensitized individual
- Symptoms develop minutes to days after water exposure
- Can occur with human or avian schistosomes

Katayama fever
- Fever, myalgias, abdominal pain, headache, diarrhea, urticaria
- Occurs in previously unexposed hosts
- Symptoms typically start 3 - 8 weeks after water exposure
- Eosinophilia, elevated AST and alkaline phosphatase
- No reliable way to confirm diagnosis acutely as serology and stool O/P frequently negative

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Chronic Schistosomiasis

Schistosoma species
- *S. mansoni (Sm)*
- *S. japonicum (Sj)*
- *S. intercalatum (Si)*
- *S. mekongi (Smk)*
- *S. haematobium (Sh)*
- *S. haematobium/S. bovis hybrid (Sh/b)*

From Senegal, outbreak 2013 in Corsica, France

Intestinal and hepatosplenic disease (**S. mansoni +** Sj, Si, Smk, Sh/b)
- Granulomatous colitis
- Portal hypertension

Genitourinary disease (S. haematobium + Sh/b)
- Granulomatous cystitis
- Bladder fibrosis and cancer
- Obstructive uropathy

Pulmonary Disease (Sm, Sh, Sj)

CNS disease
- CNS disease (eggs to brain/spinal cord, esp *S. japonicum*)

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Schistosomiasis

Chronic genital disease
- Increasingly recognized
- Primarily due to *S. haematobium*

Women (vaginal and cervical lesions)
- Pelvic pain
- Dysmenorrhea
- Dyspareunia
- Post-coital bleeding
- Endometritis/salpingitis

Men
- Epididymitis
- Prostatitis


Sand Grains


Sandy Yellow Patches


Abnormal Vessels


Rubbery Papules

WHO Female Genital Schistosomiasis Pocket Atlas

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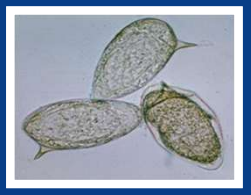
Schistosome Eggs

S. mansoni
(Lateral spine)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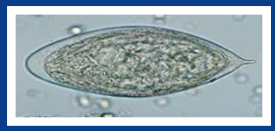
S. haematobium
(Terminal spine)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Question #2

PREVIEW QUESTION

IDBR INFECTIOUS DISEASE BOARD REVIEW 2025

A 25-year-old Peace Corps worker in Madagascar reports passing thin, white, flat tissue fragments in her stool. The microbiology lab reports the tissue fragments are proglottid segments of *Taenia solium*.

What is a long-term complication that can occur as a result of infection with the larval form of this parasite?

A. HTLV-1 infection
B. Bladder cancer
C. Appendicitis
D. Liver abscess
E. Seizures

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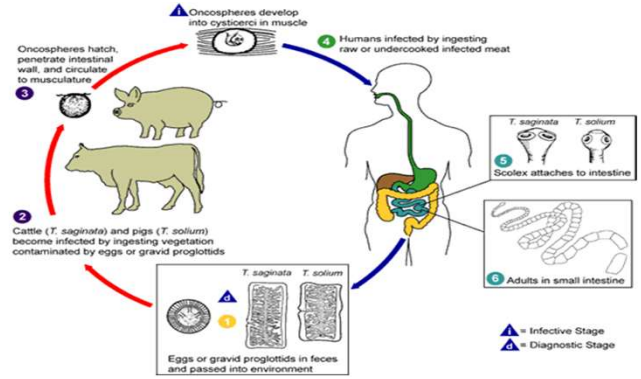
Taenia Life Cycle



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Taenia Life Cycle

Taenia solium
- Tapeworm is acquired by eating larvae in pork
- Adult tapeworm causes few symptoms

Taenia saginatum
- Acquired by eating larvae in undercooked beef
- Causes few symptoms
- Can grow to 10 m

Diphyllobothrium latum *(can grow > 10 m)*
- Acquired by ingesting fish with larvae
- ***B12 deficiency in up to 40% of patients**

Dx: Eggs/proglottids in stool **Rx**: Praziquantel (not FDA-approved)

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For some cestodes, humans can be infected by the larval stages, and this can cause severe pathology.

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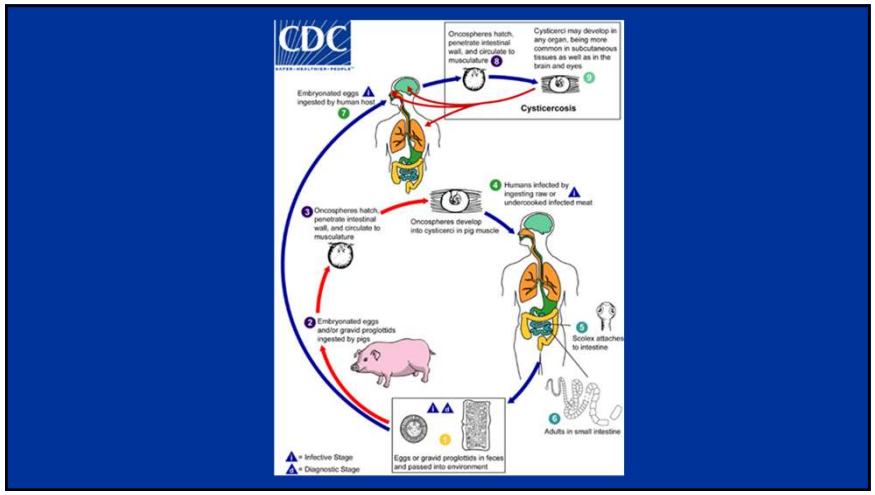

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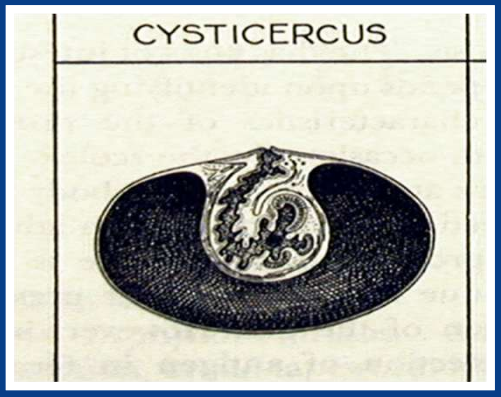
Cysticercus: a fluid filled bladder containing the invaginated head (scolex) of the larval form of a tapeworm.



Neva and Brown, Basic Clinical Parasitology 6th Edition

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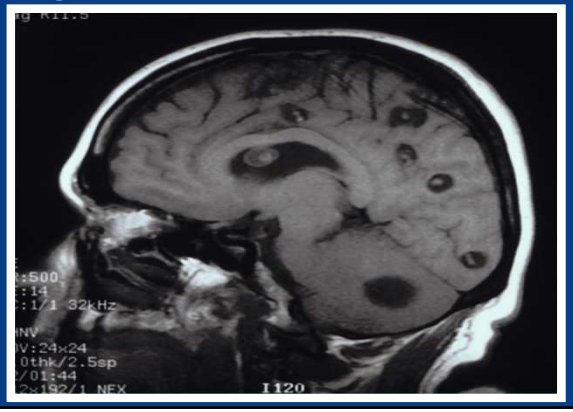
Neurocysticercosis



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Neurocysticercosis

Can cause:

- Seizures
- Hydrocephalus
- Headaches
- Focal neurologic deficits

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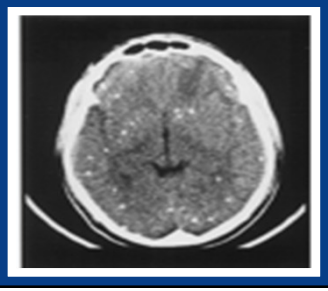
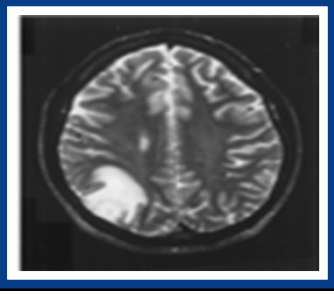
Neurocysticercosis

Multiple old calcifications



Perilesional edema – typically occurs around dying cysts and is a frequent finding on initial presentation of seizure or terrible headache.



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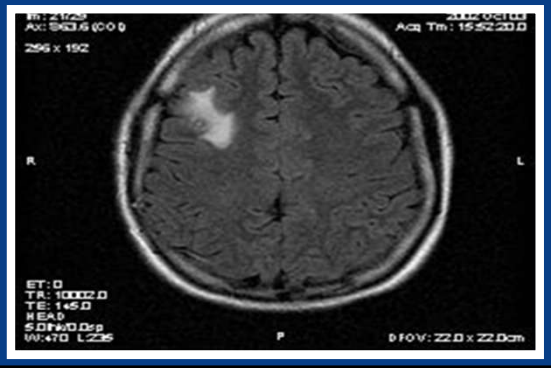
Cysticercosis:

Single lesion disease is diagnostic challenge



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Neurocysticercosis

Diagnosis:

Definitive = tissue biopsy, multiple cystic lesions each with scolex on imaging, retinal cysticercus on fundoscopy

Presumptive = suggestive lesions on imaging

Cysticercosis serology → supportive (sensitive if high burden of disease)

qPCR and antigen testing of CSF → sensitive for subarachnoid and intraventricular neurocysticercosis, and can be used to help gauge duration of treatment *(available at NIH, contact Dr. Elise O'Connell oconnellem@mail.nih.gov)*

Treatment: *Medical therapy decreases risk of future seizures, but has immediate risk of increasing seizures/brain inflammation*

If hydrocephalus or diffuse cerebral edema: initial treatment with steroids and/or surgery (not anti-parasitic Rx)

If no increased ICP: 1-2 viable cysts → albendazole for 1-2 viable cysts

> 2 viable cysts → albendazole + praziquantel

AND corticosteroids started before anti-parasitic therapy

****2017 IDSA Guidelines for Diagnosis and Treatment of Cysticercosis****

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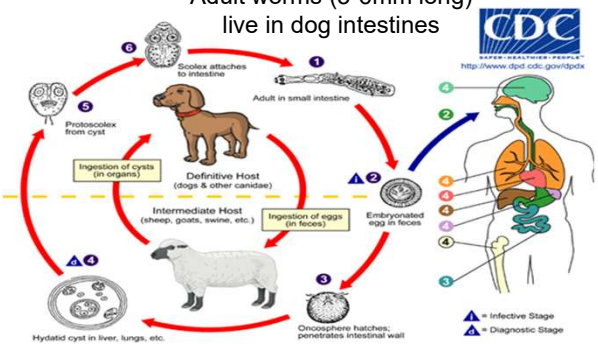
Echinococcus granulosus

Adult worms (3-6mm long) live in dog intestines



Humans = Accidental hosts

Infected by ingestion of eggs in dog feces

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Echinococcus granulosus

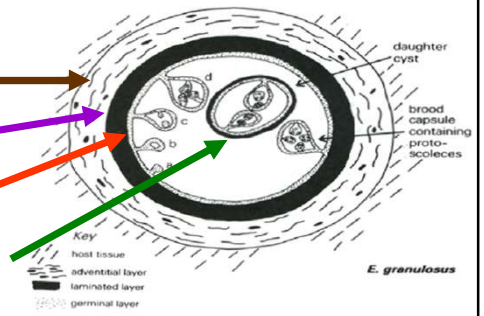
Hydatic cyst = "watery vessel"

Surrounding inflammatory response of fibrosis and chronic inflammation

Outer acellular laminated layer

Inner, nucleated germinal layer (PLURIPOTENTIAL TISSUE!)

Internal cystic fluid and daughter cysts



Echinococcus and Hydatid Disease 1995.

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Echinococcus granulosus - Presentation

Most cysts (65%) in the liver
25% in the lung, usually in the right lower lobe
Rest occur practically everywhere else in the body

Common presentations
- Allergic symptoms/anaphylaxis due to cyst rupture after trauma
- Cholangitis and biliary obstruction due to rupture into biliary tree
- Peritonitis b/c intraperitoneal rupture
- Pneumonia symptoms due to rupture into the bronchial tree

Uncommon presentations
- Bone fracture due to bone cysts
- Mechanical rupture of heart with pericardial tampanode
- Hematuria or flank pain due to renal cysts

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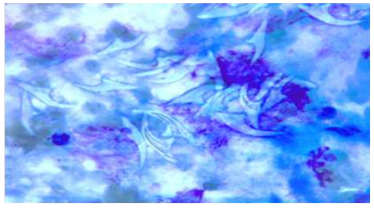
Echinococcus granulosus - Diagnosis

Radiology

Clinical Radiology (2006) 61, 737–748

Microscopy



Serology

IgG ELISA about 85% sensitive for liver cysts of E. granulosus

Only 50% sensitive in cases of single pulmonary cyst

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Echinococcus granulosus - Treatment

Reasons for not spilling cyst contents

1. Anaphylaxis may occur
2. Spilled protoscoleces can reestablish infection

Typically treat with albendazole for several days before surgery or PAIR (usually 3d-1wk before, and 1-3 months after)

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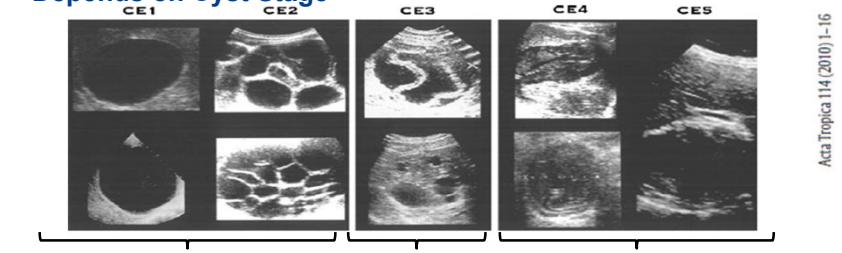
Cystic Echinococcus Treatment:

Depends on Cyst Stage



ACTIVE		TRANSITIONAL	INACTIVE
Unilocular Simply cyst Cyst wall visible	Multivesicular Multiseptated cysts	Anechoic content Detached membrane Solid matrix	Heterogenous, hypoechoic or hyperechoic No daughter cysts CE5 with thick calfied wall
---ALB +/- PAIR or Surgery---	---SURGERY---	---SURGERY--- ---PAIR if no solid matrix---	---NO TREATMENT---

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Intestinal Helminths - Lifecycles

Strongyloides and Hookworms

SKIN → LUNGS → GUT

Ascaris

INTESTINE → LIVER → LUNGS → INTESTINE

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Ascaris lumbricoides

- Large numbers of worms can cause abdominal distention and pain or intestinal obstruction
- Can cause “Loeffler’s syndrome” - an eosinophilic pneumonitis with transient pulmonary infiltrates
- Cholangitis and/or pancreatitis b/c aberrant migration

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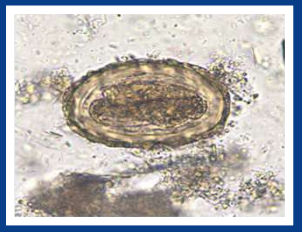
Ascaris lumbricoides - Diagnosis

Will not find eggs until 2-3 months after pulmonary symptoms occur
After 2-3 months, easy to find eggs since females make 200,000/day

Unfertilized



Fertilized

Rx: albendazole or mebendazole

CDC DPDx

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Hookworms

Ancylostoma duodenale and Necator americanus

also Ancylostoma ceylanicum (zoonotic from dogs/cats in Asia)

- MAJOR cause of ANEMIA and protein loss (b/c plasma loss)
- Pneumonitis associated with wheezing, dsypnea, dry cough
  (usually, a few days to weeks after infection)
- Urticarial rash
- Mild abdominal pain

If sensitized → papulovesicular dermatitis at entry site "ground itch"

If worms migrate laterally → **cutaneous larvae migrans**
(especially dog and cat hookworms, as late as 2-8 wks after exposure to *A. braziliense*)

Hookworms are still endemic in the U.S. → 35% of individuals from a rural community in Alabama had *N. americanus* in their stool samples

Am. J. Trop. Med. Hyg., 97(5), 2017, pp. 1623–1628

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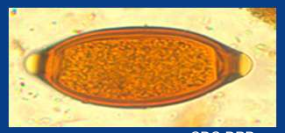
Trichuris trichiura (Whipworm)

4cm long nematode

Life cycle: Fecal-oral

In heavy infections:
- Loose and frequent stools
- Tenesmus
- Occ blood to frank blood
- In heavily infected children:
  rectal prolapse

Dx: eggs are football shaped with two polar plugs



CDC DPDx

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Question #3

A 25-year-old F from rural Peru presents with shortness of breath, bilateral interstitial infiltrates, fever, loose stools, hypotension, and *E. coli* bacteremia. She has received > 4weeks of high dose corticosteroids and cyclophosphamide for a recent diagnosis of lupus nephritis.

Which of the following anthelmintic agents should be included in her treatment regimen?

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B. *Ivermectin*
C. *Praziquantel*
D. *Pyrantel pamoate*
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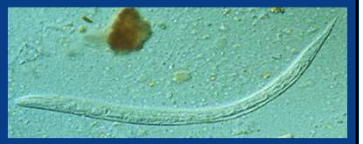
Strongyloides stercoralis

(Can complete lifecycle in host!)



Usual manifestations
GI: Mild abdominal/epigrastric pain
Pulm: Wheezing, transient infiltrates
Skin: Urticarial rashes, larva currens

Hyperinfection syndrome
→ Immunocompromised state
steroids, TNF-inhibitors, HTLV-1, malignancy, malnutrition….NOT HIV
→ Large burden of parasites

GI: Nausea, vomiting, abdominal pain, diarrhea, intestinal erosions
b/c millions of larvae in intestinal mucosa

Pulmonary: Diffuse infiltrates, wheezing, dyspnea, cough

Systemic: Fever and hypotension due to gram negative sepsis

-- Often do not see eosinophilia in hyperinfection --

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Strongyloides stercoralis

Diagnosis:
- Stool o/p (sensitivity is low - 30-60%)
- Serology

Treatment of choice: Ivermectin

Prevention in patients from endemic countries who are about to be immunosuppressed
- Empirically treat or check serology and treat if positive

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Ivermectin

Activates nematode glutamate-gated chloride channels causing muscle paralysis

Drug of choice
- Strongyloides
- Onchocerca volvulus (microfilaricidal only)
- Also has activity against Ascaris, whipworm, cutaneous larva migrans, gnathostomiasis AND ectoparasites such as scabies and lice

Image created with Google Imagen3

ADVERSE EFFECTS
→ Altered mental status in 13-year-old boy given standard dose for scabies due to a mutation in ABCB1 (aka P glycoprotein 1 and MDR1) *NEJM 2020; 383:787-789*

→ Reports of seizures, ataxia, and confusion after ingestion of large veterinary doses *NEJM 2021; 385:2197-2198*

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Question #4

A 32-year-old M from Cameroon reports intermittently experiencing a worm crawling across his eye.

Which of the following tests can be used to confirm the most likely diagnosis?

A. *Brain MRI scan*
B. *Midnight blood draw*
C. *Noon blood draw*
D. *Skin snip*
E. *Scrotal ultrasound*

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Filariae:

Tissue-invasive, thread-like nematodes, transmitted by arthropod vectors

	Adults	Microfilariae
Wuchereria bancrofti *Brugia malayi* (lymphatic filariasis) --mosquitoes--	lymphatics	blood (night)
Loa loa (eyeworm) --Chrysops flies--	SQ tissues (moving)	blood (day)
Onchocerciasis (river blindness) --blackflies--	SQ tissues (nodules)	skin

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Treatment of Filariasis

	Treatment	Avoid
Lymphatic filariasis	**DEC**	**---**
Loa Loa	**DEC**	**DEC and Ivermectin if high microfilaria level**
Onchocerciasis	**Ivermectin**	**DEC**

ADVERSE EFFECTS
Loa with high microfilaremia → encephalopathy and death
Onchocerciasis → severe skin inflammation and blindness

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W. bancrofti and B. malayi



- Asymptomatic microfilaremia
- Lymphangitis
  - Retrograde (filarial lymphangitis)
  - Bacterial skin/soft tissue infections (dermatolymphangioadenitis)
- Lymphatic dysfunction
  - Lymphedema, elephantiasis, hydrocele, chyluria

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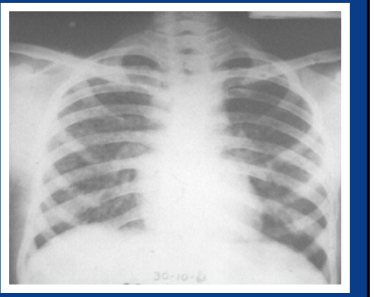
Tropical Pulmonary Eosinophilia

- Paroxysmal nocturnal asthma
- Pulmonary infiltrates
- Peripheral blood eosinophilia (>3,000/mm^3)
- Elevated serum IgE
- Rapid response to anti-filarial therapy

Likely due to excessive immune response to microfilariae in lung vasculature



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Lymphatic filariasis: Diagnosis

Definitive diagnosis
- Identification of microfilariae in nighttime blood
- Detection of circulating antigen in blood (only Wb)
- Identification of adult worm (by tissue biopsy or ultrasound "filaria dance sign")

Presumptive diagnosis
- Compatible clinical picture + positive antifilarial antibodies

Treatment
- DEC, doxycycline
- NOTE: Triple drug single dose therapy (DEC/albendazole/ivermectin) is now recommended by W.H.O. for mass drug administration eradication campaigns in areas that are NOT co-endemic for Loa loa or Onchocerca

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Manifestations of Onchocerciasis

Skin: Nodules, pruritus, rash, depigmentation, lichenification

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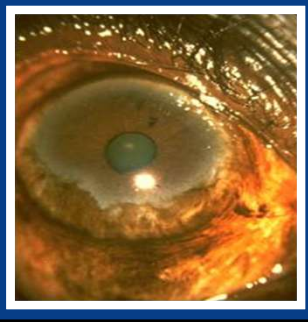
Manifestations of Onchocerciasis

Eye: Punctate keratitis, sclerosing keratitis, chorioretinitis



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Onchocerciasis

Diagnosis
- Serology
  - Anti-filarial
  - Onchocerca-specific
- Parasitologic: skin snips, nodulectomy

Treatment
Ivermectin
Moxidectin (FDA approved in 2018…has much longer half-life)
→ Both are primarily microfilaricidal
→ Therefore, need repeated treatments for many years

(Alternative: **doxycycline** for 6 weeks, which kills endosymbiotic *Wolbachia* bacteria, kills adult worms)

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Loiasis: Clinical Manifestations

- Asymptomatic microfilaremia
- Non-specific symptoms
  - Fatigue, urticaria, arthralgias, myalgias
- Calabar swellings
- Eyeworm
- End organ complications (rare)
  - Endomyocardial fibrosis, encephalopathy, renal failure

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Calabar Swelling

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Loiasis: Diagnosis

Definitive diagnosis
- Identification of adult worm in subconjunctiva
- Detection of Loa microfilaria in **noon blood**

CDC DpDx

Presumptive diagnosis
- Compatible clinical picture + positive antifilarial antibodies

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Possible Question Hints

Freshwater exposure + eosinophilia → Schistosomiasis
Crab/crayfish + pulmonary sxs + eosinophilia → Paragonimus
Cysticercosis → ANY food contaminated with tapeworm eggs
Allergic symptoms after trauma → Echinococcus
Itchy feet return to tropics → ground itch due to hookworms
Gram- sepsis after corticosteroids or TNF inhibitor → Strongyloides hyperinfection
Subcutaneous nodules → Onchocerca volvulus
Blood microfilaria night → lymphatic filariasis (day = Loa loa, skin = Ov)
Muscle pain + eosinophilia → Trichinella
Eosinophilic meningitis → Angiostrongylus
Abdominal pain after sushi → Anisakis
Eosinophilia + F + ↑ AST/ALT in child → visceral larva migrans

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Good Luck!

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