

BILHARZIASIS: A GRANULOMATOUS PARASITIC DISORDER WITH GRAVE IMPLICATIONS

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1. Introduction

Bilharziasis or schistosomiasis is one of the most common parasitic infection of Egyptians and also occurs in several other parts of Africa, Asia and South America. It affects more than 200 million people in at least 75 countries; mostly tropical. Schistosomal lesions – according to parasite species- primarily affect the genitourinary system or the intestinal tract. However, due to emboli of ova and/or dead worms, many other sites can be affected, as the liver, lung, and other sites. Lesions of schistosomiasis are numerous including dermatitis at the site of cercarial penetration and significant granulomatous lesions ending in fibrosis; mainly caused by ova trapped within the tissues. Dead worms cause further serious necrotizing vascular lesions. The endemicity of *the* Bilharzial disease depends on the urban disposal of urine or stools, the presence of suitable snail hosts, and the human exposure to cercariae (WHO, 1993). In Egypt, the disease was known by ancient Egyptians, thousands of years ago and was called "aaa", expressing the patient's suffering from dysuria and hematuria. Theodor Bilharz, was the first to discover the causing worms and the disease was named after this German scientist "Bilharziasis". There are five major species of *schistosoma* affecting man; *S. mansoni*, *S. hematobium*, *S. japonicum*, *S. intercalatum*, and *S. mekongi*. The first two species are the main causes of Egyptian schistosomiasis.

A.: *Schistosoma haematobium* (*S. haematobium*), that mainly infects the genitourinary system.

B.: *Schistosoma mansoni* (*S. mansoni*), that affects mainly the digestive system and liver.

1.2 Discovery of schistosomes (Bilharzia worms) by Theodor Bilharz

In 1850, Professor Wilhelm Griesinger from Kiel was hired by the then viceroy of Egypt, Abbas I, as director of the Kasr El Aini medical school in Cairo along with Theodor Bilharz as his assistant. Theodor Maximilian Bilharz was a young German Pathologist from the University of Tübingen. There, he excelled at anatomy, and in addition gained an interest in helminthology from his professor, Karl Theodor von Siebold. Bilharz was at the age of 25 when he went to Egypt and whilst working in Cairo; he made his momentous discovery of *Distomum haematobium*, later renamed *Schistosoma haematobium*, as described in the main history document. By year 1852, when Bilharz discovered his parasite, he sent letters to his professor (Theodor von Siebold) in Germany, describing the new parasite during a post-mortem examination as follows; “*After my attention had been drawn to the liver, I soon found a white long helminth in the blood of the portal vein in quantity, which I assumed to be a nematode, but which I immediately recognized as something new. The microscope revealed a splendid distomum with a flat body and a curving tail which exceeded the body about ten times in length. Yet the tail was not loosely inserted like those of the cercariae but was the continued flat substance of the body of the worm itself which was rolled at the side against the abdominal surface to a half-channel*”.

He soon realized that these helminths were trematodes, with uniquely two sexes, the

flattened worms he had first seen being the males which held a single thread-like female in a fold of its body (the gynaecophoric canal), as described in a letter a few months later; “*I have not told you yet about the new phases into which my worm of the portal vein has entered. This has not developed into a fairy tail, as I had assumed, but something more miraculous- a trematode, with separate sexes. The worm which I had described to you in my last letter was the male. When I examined the intestinal veins more carefully.....,I soon found samples of the worm which harboured a grey thread in the canal of their tails. You can picture my surprise when I saw that a trematode projected out of the anterior opening of the canal*”.

He then went on describing the morphological features of this second threadlike worm, which on the basis of internal structures such as the vitellaria and ovaries, he correctly identified as the female parasite, which he named *Distomum haematobium*. The next year he described some further findings, based on more post-mortem examination:

“Opening the urinary bladder we detected many excrescences which are unfamiliar in Europe....I cut into the largest of these excrescences and found a white thread remaining on the knife. I looked at it more closely and discovered our Distomum haematobium”.

He then went on describing the females , which he noted in the urinary bladder, looking different from those he had previously see:;

“They differ from those found in intestinal veins by the greater clarity of their inner organs..... and even more so by the immense abundance of ova, which were present in all stages of development”

However, even with these differences he still thought he was dealing with a single species. He also described the eggs associated with these parasites as having; “..a thin, delicate eggshell with a pointed process”

These findings were presented, along with remarks by Prof. Theodor von Siebold, in the Journal *Zeitschrift fur Wissenschaftliche Zoologies* in 1852, as the first scientific description of this new parasitic helminth.

Bilharz also discovered the tapeworm *Hymenolepis nana*. He died at the age of 37 of typhoid fever, contracted on an expedition to the upper Nile.



Figure 1. Bilharzia worm (Male) as appeared enlarged Thousands times by the scanning Electron Microscope, showing its two suckers and the ventral groove.

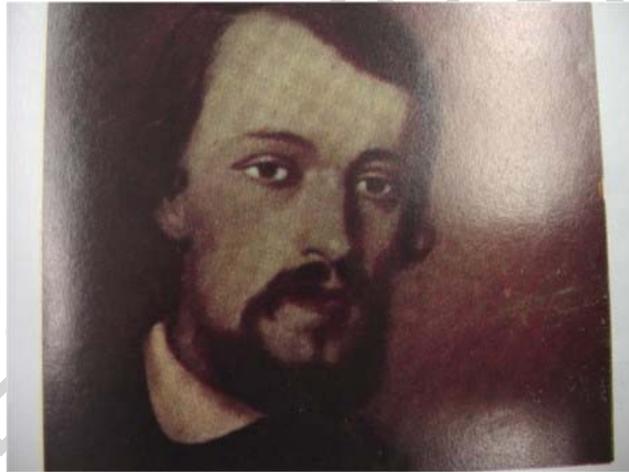


Figure 2. The German Scientist; Theodore Bilharz, who discovered Bilharzia worm in Egypt.

2. Life cycle of the Bilharzial parasite

2.1 Schistosomiasis species and their stages

The three species of schistosomiasis (*S. mansoni*, *S. haematobium* and *S. japonicum*) have similar life cycle and develop over successive stages, namely, eggs miracidium, first stage sporocyst, second stage sporocyst, cercaria, schistosomule and adult worm. Life cycle alternates between asexual (invertebrate host) and sexual (vertebrate host) generations.

2.2. Asexual part of life cycle (intermediate host phase)

The eggs from an adult female in the definitive mammalian host are passed into fresh water

via the urine or stools according to the species of *Schistosoma*. Fortunate miracidia penetrate the snails, lose their cilia and metamorphose into two generations of sporocysts, which migrate to the digestive gland of the snail and mature into hundreds of fork-tailed cercariae. The intermediate host phase takes 3-5 weeks. At full maturity, cercariae emerge from the snails.

2.3. Sexual part of the cycle

Without successful vertebrate host contact, the cercariae will die within 48-72 hours. Following cercarial contact with the skin of vertebrate host (usually man), penetration takes place. The fork-tailed cercariae lose their tails and become known as schistosomule. They enter the lymphatics of dermis and pass to the regional lymph nodes, apparently reaching the circulation through the thoracic duct. They then pass through pulmonary circuit, from the right to the left side of the heart. The lung stage occurs 3-6 weeks after infection. Finally the schistosomule enter the systemic circulation where some reach the mesenteric vessels, while others may pass directly through the diaphragm to reach the liver. Schistosomula can only mature in intrahepatic portal veins where each schistosomule develops into an adult male or female worm. Apparently, only those worms able to pass from arterial to venous side would survive. This takes place inside the abdominal organs drained by the portal system. *Bilharzia* worms; being living in blood vessels are fed upon blood and blood constituents and that is why they excrete brown bilharzial pigment (rich in hemosiderin from red blood cells). Each worm has two suckers; one ventral and one anterior, by which it can be attached to the wall of blood vessels (see photos in section 10). Adult worms mate in the small vasculature of the liver and make a paired migration against the flow of venous blood to the predestined venous plexus. When venous caliber impedes further paired migration, the female progresses alone to mesenteric veins (*S. mansoni* and *S. japonicum*) or the veins of the vesical plexus (*S. haematobium*) where they lay their eggs. The oviposition starts 4-6 weeks after initial cercarial infection. Average number of eggs/day differs according to the species. *S. haematobium* 500-1000, *S. mansoni* 350-400 and *S. japonicum* 1500-3000 eggs/day. About 50% of the deposited eggs pass through the venules wall into the tissue, those of *S. haematobium* mainly into trapped into the bladder wall, those of *S. japonicum* and *S. mansoni* mainly into the wall of the small intestine, Large intestine respectively. They then pass through the mucosa to be excreted in urine or faeces. The remaining 50% of eggs remain trapped in the tissues of the bladder or intestine or they are swept back into the portal circulation and are trapped in the liver. Some eggs may be found also in the genital tract, lungs, central nervous system and other organs.

2.4. Eggs

Eggs trapped within the tissues secrete histolytic enzymes which help their passage through the tissues and they also secrete antigenic proteins which are responsible for much of the pathology of schistosomiasis.

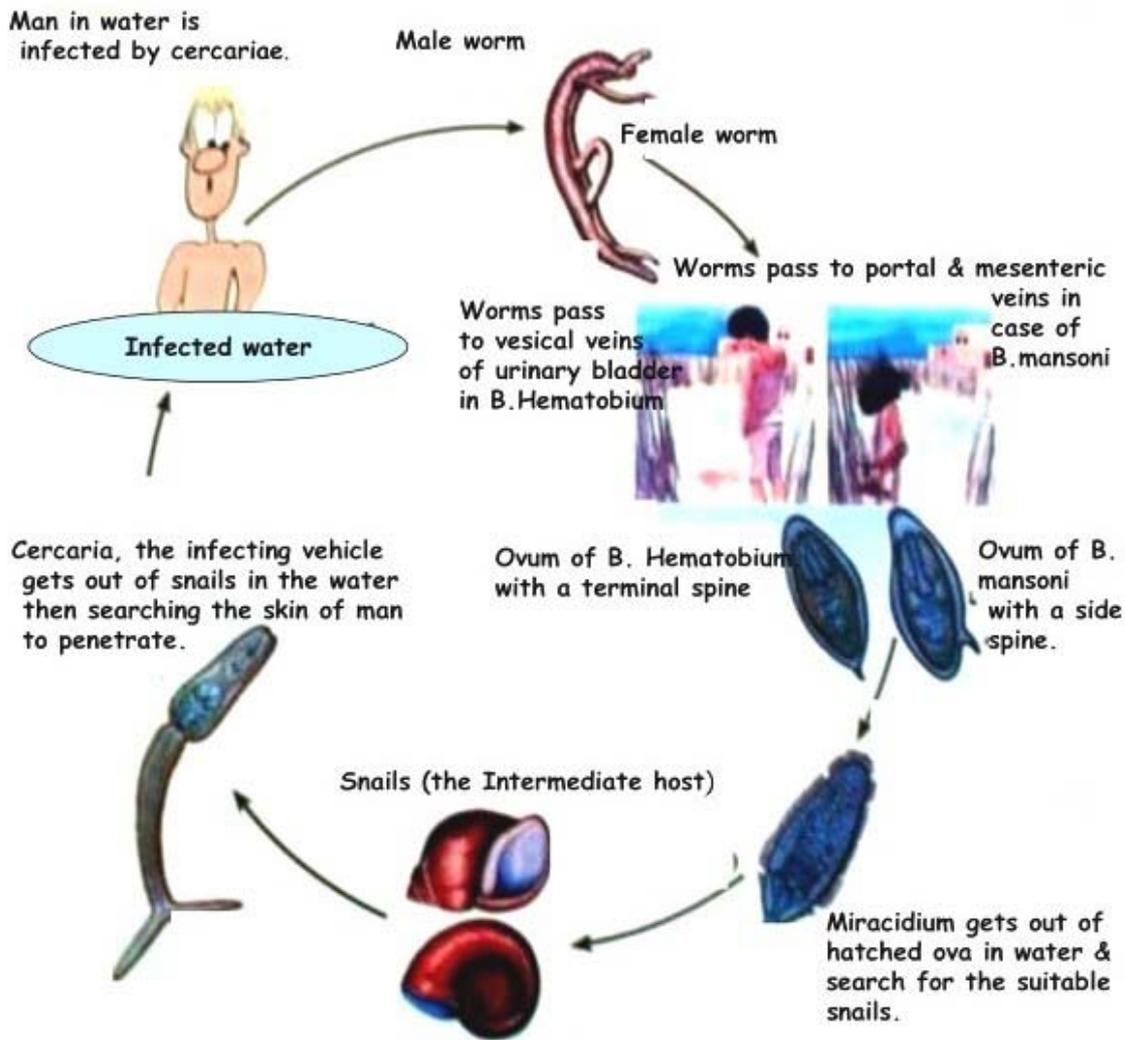


Figure 3 Life cycle of Bilharzia worm.

3. Pathogenesis of schistosomiasis

3.1. Eggs

The schistosoma eggs in the mammalian host don't multiply and the short-lived embryos are protected from phagocytosis by the egg shells. Soon, after egg laying, the embryos mature and begin to secrete antigenic material through ultramicroscopic pores in the egg shell. These pores are also the route for nutrients and metabolites to and from the eggs and the route for the release of proteolytic enzymes responsible for eruption of eggs from the veins to the tissues. The organisms live for further 2 weeks and after their death, emission of antigen rapidly wanes.

3.2. Egg granulomas

Most of the pathology of schistosomiasis results from granuloma formation around Schistosoma eggs (ova), known as periovarial granulomas whereas it has been attributed to the antigenic secretions of schistosoma eggs. Cell types in the S.mansoni granuloma vary

with prior sensitization, length of infection and the time passed after setting of eggs in the tissues.

3.3. Mechanisms underlying granuloma formation

Periovular granuloma is mainly built up by a cellular mediated immune reaction. Antibody deposits are also found, probably functioning as a local humoral antibody barrier which allows a slow and progressive neutralization of antigens.

3.4. Pathological stages of schistosomiasis

There are two distinct stages of schistosomiasis. The early acute stage which appears 8-12 weeks post- infection (P.I.) and is characterized by vigorous T-cell mediated granulomatous response and inflammatory lymphokine production. The chronic stage develops 16-20 weeks P.I. and is characterized by spontaneous modulation of granulomatous response with reduced lymphokine production and elevated humoral response. The acute granuloma is large and diffuse, and is usually composed of eosinophils, neutrophils and lymphocytes while chronic granuloma is small and better circumscribed and is composed of lymphocytes, macrophages, epithelioid cells, fibroblasts and multinucleated giant cells. In an experimental study in our Pathology Department in Theodor Bilharz Research Institute. We studied the different stages of schistosoma mansoni granulomas in mice and followed the different types of the deposited collagens within and around these granulomas. Groups of albino white lab-bred mice were infected by 60 cercariae each of the S.mansoni type, via tail immersion as to mimic exactly the natural infection. Sacrification of mice was performed at different weeks intervals in order to study the granulomas stages in the liver. At 5th week post infection, ova starts to appear inside the lumens of the hepatic veins as well as also the bilharzia worms. At 6th week interval, moderate sized, purely cellular granulomas starts to appear in the portal areas around the bilharzia ova. At 8th week, large mainly cellular granulomas are formed around the eggs with a loose network made of thin collagenous fibrils in the background, proved by the immunofluorescent techniques to be procollagen III and collagen III. With the progress of the Bilharzial infection, more collagen is deposited that form thick dense fibrosis, the granulomas decrease slightly in size or may become adherent or confluent together due to their crowdedness in the portal areas and their cellular contents gradually decrease in number. The immunofluorescent techniques proved that this later fibrosis is formed of collagen I. further studies proved that both procollagen III and collagen III, are reversible by anti-schistosomal treatment, while collagen I, being thick and more intense is irreversible by treatment.

4. Clinical features of Bilharziasis due to Schistosoma mansoni infection

The stages schistosomiasis include invasion, maturation, acute infection and chronic infection. These stages result in three well-defined syndromes, cercarial dermatitis or swimmer's itch, acute schistosomiasis (acute bilharziasis) or Katayama fever and chronic schistosomiasis (chronic Bilharziasis).

4.1. Skin Lesions

During the stage of invasion, the cercariae penetrate the skin or mucous membranes in less

than 15 minutes acting by combination of cercarial muscular action and glandular secretion. In insensitive persons, the reaction to invasion is mild and transient erythema usually appears within 12 hours and soon disappears but after repeated exposures, the skin shows itchy papules and local edema. In endemic areas, the local people often show no local skin reaction which may be a reflection of passive immunity derived from the mother, followed by active immunity in childhood. Cercarial dermatitis is likely a result of host sensitization. It's diagnosis at this stage is quite difficult and treatment is usually not advised.

4.2. Acute schistosomiasis

May develop 3-9 weeks after exposure to infection. This period coincide with the onset of egg production although the earliest phase of the syndrome can be initiated by the parasite (worm) antigens present before oviposition. The clinical severity of acute schistosomiasis is closely correlated with the intensity of *S.mansoni* infection. Elevation of serum IgG, IgE and IgM in patients indicated that the illness is associated with intense immune-activity.

4.2.1. Katayama fever

Is a form of serum sickness resulting from cross reaction between worm and egg antigens with antibody levels rising rapidly resulting in the formation of antigen-antibody immune complexes.

4.2.2. Symptoms of the acute stage

In immune persons, this stage is usually asymptomatic but in primary infection of non immune individuals, it is manifested by fever, headache, nausea, vomiting, diarrhea, dry cough, lymphadenopathy, hepatosplenomegally and peripheral eosinophilia. Symptoms last from few weeks to two or three month end gradually abate without therapeutic intervention although heavy primary infection can be fatal.

4.2.3. Treatment of Acute Phase

The best therapeutic approach to acute schistosomiasis is by the use of schistosomicides alone or in combination with steroids.

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bilharzial infection].

Biographical Sketch

Dr. Maha Mahmoud Akl, born in Cairo, Egypt 19/07/1952, is a medical graduate, from Cairo University. She pursued her postgraduate studies and training in Kasr El Ainy Teaching Hospital, which is the main teaching hospital for Cairo University. She was appointed in the Pathology Department, Theodor Bilharz Research Institute affiliated to the Ministry of High Education & Scientific Research as a Pathology instructor 1977 –1982, Assistant lecturer .in 1983 and in 1987 became an Ass.Prof. Of Pathology: She was appointed as Professor of Pathology in 1997.

From 1994-2006 she became the HEAD OF PATHOLOGY Department of Theodor Bilharz Research Institute, In 1988, she was appointed as a Scientific Supervisor on the Unit of Scientific & Cultural Relationship of the Institute. In 2001 she was appointed as the head of Lagnet Al Efad of the Institute. In 2002, became a member in the Council for judging Promotion of the Staff Members into Ass.Professors & Professors.

Prof. AKI is a member of the Egyptian Association of Laboratory Medicine, and a member of the Egyptian Society of Pathologists as well as a member of both the Arab division of the International Academy of Pathology and a member of the European Society of Pathology. At present (2006), she is the Head of Pathology Department in Theodor Bilharz Research Institute since 1994-present.