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Inflammatory bowel disease vs strongyloidiasis

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ABSTRACT

We report the case of a 38-year-old woman with a 10-year history of ulcerative proctosigmoiditis. Two months after traveling to Morocco, she developed gastrointestinal symptoms accompanied by eosinophilia in blood tests. Four months later, she progressed to systemic illness with pulmonary involvement. A colonoscopy

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revealed aphthous ileitis with nonspecific histology suggestive of Crohn's Disease (CD). Ultimately, serology confirmed Strongyloides stercoralis infection. Strongyloidiasis is underdiagnosed in Spain, and its differentiation from CD presents a diagnostic challenge.

Keywords: Strongyloidiasis. Crohn's disease. Ulcerative proctosigmoiditis. Hyperinfection syndrome.

Dear editor,

We present the case of a 38-year-old woman with a 10-year history of ulcerative proctosigmoiditis under treatment with topical and oral mesalazine.

Two months after traveling to Morocco, was admitted to the emergency department with intense epigastric pain and diarrhea without blood. Physical examination was notable for epigastric tenderness.

Laboratory examination was normal except for eosinophilia (10%). Stool parasitology was negative. Abdominal ultrasound was normal. Metronidazole was prescribed without improvement. Subsequently, gastroscopy was performed with no pathological findings.

After four months, the patient developed a systemic illness (fatigue, generalized arthralgias, epigastric pain, diarrhea, weight loss, and dyspnea). Thoracic CT scan revealed bilateral apical pleuropulmonary fibrosis (figure 1).

Colonoscopy revealed aphthous ileitis with nonspecific histology, findings suggestive of Crohn's Disease (CD). Budesonide 9 mg was prescribed, and initiation of adalimumab was considered due to corticosteroid dependency.

Finally, serology for *Strongyloides stercoralis* returned positive, prompting the withdrawal of corticosteroid therapy due to the risk of hyperinfection syndrome. Ivermectin was administered with clinical improvement. Antibodies against

Strongyloides became negative.

The ulcerative proctosigmoiditis remained stable with oral mesalazine.

DISCUSSION

Strongyloides stercoralis is a nematode endemic to tropical and subtropical countries. Infection occurs through the cutaneous penetration of filariform larvae from soil or water sources. It has the ability to auto-infect. The larvae, after passing through the intestines, invade the mucosa and re-enter the systemic circulation, leading to a chronic disease (1, 2).

Four clinical syndromes are described: asymptomatic carrier state, acute infection with Löffler syndrome, chronic infection with digestive, pulmonary, and/or cutaneous involvement, and hyperinfection syndrome with disseminated disease (3).

Gastrointestinal involvement includes epigastric pain and chronic malabsorptive diarrhea (2). Differential diagnosis with CD and other chronic colitis (intestinal tuberculosis, parasitic and viral infections, sarcoidosis, etc.) should be made.

A recent systematic review concluded that strongyloidiasis is underdiagnosed in Spain (4). Its differential diagnosis with CD poses a challenge, and clinical suspicion is crucial. Strongyloidiasis should be suspected in patients with a history of travel to endemic areas and/or chronic gastrointestinal and pulmonary symptoms accompanied by eosinophilia.

A specialist pathologist is required as larvae are sometimes not evident in biopsies. The Baermann technique increases the sensitivity of biopsy studies (3).

In cases of suspected inflammatory bowel disease flare-ups, other etiologies must be ruled out (1, 5). This is especially relevant in this case, as the initiation of systemic corticosteroid therapy can lead to progression from chronic colitis to a fulminant systemic disease (5).

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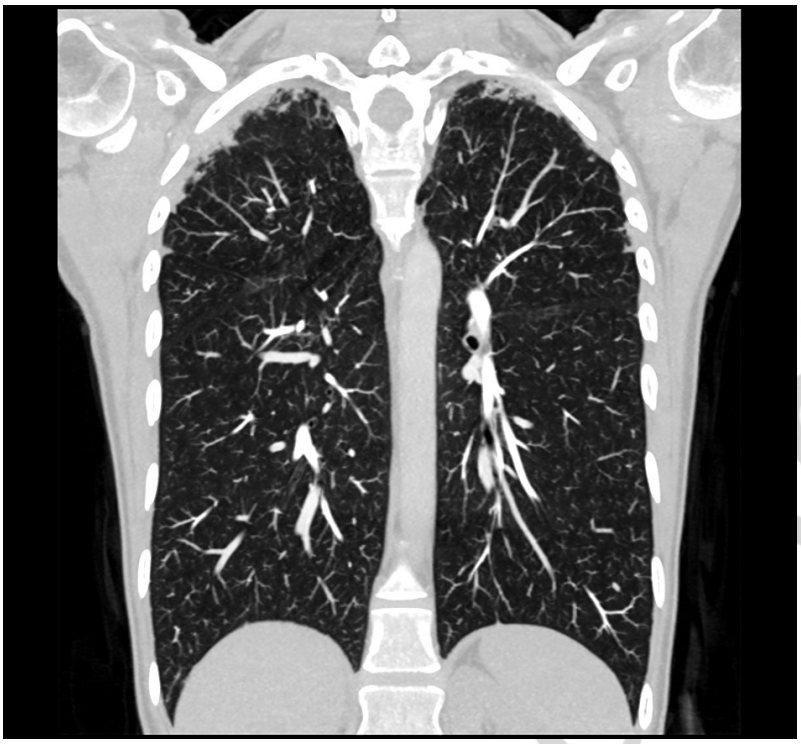

FIGURE: chest CT image that reveals bilateral apical pleuropulmonary fibrosis.