Case report

Fatal pancytopenia due to albendazole treatment for strongyloidiasis

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ABSTRACT
We report 7 cases of strongyloidiasis that had occurred from 2016 through 2017 in a tertiary hospital of southern China. Three of the 7 patients (age 66–77) with farming exposure many years ago developed symptomatic infection while receiving immunosuppressant for underlying medical conditions. The majority of them were treated with albendazole due to unavailability of ivermectin in mainland China. One of the 7 patients, with underlying IgG4 sclerosing cholangitis and secondary biliary cirrhosis was on immunosuppressives and developed severe pancytopenia 15 days after albendazole treatment. He ultimately died of polymicrobial sepsis. This was the second fatal case being reported in the literature as a consequence of albendazole-induced myelosuppression. We have undertaken a review of the literature regarding the use of albendazole for strongyloidiasis and its adverse effect with a focus on myelosuppression as a rare but potentially serious event.

Introduction

Strongyloides stercoralis infection remains endemic in developing countries in tropics and subtropics. The ability to complete lifecycle inside human body enables the helminth to persist for years after acquisition. Immunosuppression later in life suppresses the T-cell response in controlling the worm burden, and can result in hyperinfection and even dissemination. Patient may develop severe pneumonia and even menigitis at the most severe end of spectrum. Although prompt treatment with antihelminthics like albendazole and ivermectin can be life-saving, the side effects of them could be fatal in turn. We report a case series involving 7 patients with strongyloidiasis, in which one of them died due to myelosuppression from albendazole.

Case series

We prospectively followed up and collected data on all laboratory confirmed cases of Strongyloides stercoralis infections at The University of Hong Kong-Shenzhen Hospital in mainland China between July 2016 and November 2017.

Seven cases of strongyloidiasis were encountered over the period of time. Details of the patients has been summarized in Table 1. Four of the seven patients were male. The age ranged from 49 to 83 years-old. Six of them had worked as farmers in paddy fields in the past. The two patients that presented with intestinal strongyloidiasis were not on any immunosuppressants, and both improved after 7 days of albendazole. The remaining five patients suffered from either hyperinfection or disseminated disease. Four of the five patients (80%) were taking corticosteroids for underlying autoimmune diseases. Three of those four patients with either hyperinfection or disseminated strongyloidiasis, were treated with albendazole alone achieving pathastological cure. Patient 5 with underlying IgG4 sclerosing cholangitis and secondary biliary cirrhosis on prednisolone 40 mg daily presented as hyperinfection. His sputum showed S. stercoralis that produced crawling tracks on agar. This patient developed severe pancytopenia after 15 days of albendazole, complicated by polymicrobial neutropenic sepsis. He developed bacteremia due to ESBL producing Klebsiella pneumoniae, as well as methicillin-resistant Staphylococcus aureus (MRSA) pneumonia and Cunninghamella pulmonary mucormycosis, finally succumbed with multiple cavitating lung lesions (Fig. 1). Although there was no evidence of strongyloidiasis from the respiratory specimen at the time of demise, parasitological clearance could not be declared as treatment...
Table 1
Summary of the Clinical Features of the 7 Patients with Strongyloidiasis.

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex/Age</th>
<th>Farming History</th>
<th>Underlying condition</th>
<th>Immunosuppressant</th>
<th>Presentation</th>
<th>Syndrome</th>
<th>Detection of Strongyloides</th>
<th>Treatment</th>
<th>Parasitological Care</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F/83y</td>
<td>Yes</td>
<td>Diabetes mellitus</td>
<td>Nil</td>
<td>Abdominal discomfort</td>
<td>Chronic intestinal infection</td>
<td>Stool</td>
<td>Albendazole 400 mg BD x 7 days</td>
<td>Yes</td>
<td>Clinical resolution</td>
</tr>
<tr>
<td>2</td>
<td>M/64y</td>
<td>Yes</td>
<td>Hypertension</td>
<td>Nil</td>
<td>Abdominal discomfort</td>
<td>Chronic intestinal infection</td>
<td>Stool</td>
<td>Albendazole 400 mg BD x 7 days</td>
<td>Not documented</td>
<td>Clinical resolution</td>
</tr>
<tr>
<td>3</td>
<td>F/67y</td>
<td>Yes</td>
<td>Henoch-Schönlein purpura</td>
<td>Methylprednisolone</td>
<td>Abdominal pain</td>
<td>Disseminated</td>
<td>Endoscopic biopsy</td>
<td>Albendazole 400 mg BD x 10 days; Ivermectin 200 μg/kg/day x 14 days after symptomatic relapse</td>
<td>Yes</td>
<td>Relapse after cessation of albendazole</td>
</tr>
<tr>
<td>4</td>
<td>M/49y</td>
<td>No</td>
<td>Pemphigus vulgaris</td>
<td>Methylprednisolone</td>
<td>Vomiting</td>
<td>Disseminated</td>
<td>Endoscopic biopsy</td>
<td>Albendazole 400 mg BD x 21 days</td>
<td>Yes</td>
<td>Clinical resolution</td>
</tr>
<tr>
<td>5</td>
<td>M/77y</td>
<td>Yes</td>
<td>IgG4 sclerosing cholangitis</td>
<td>Methylprednisolone 50 mg daily Azathioprine 40 mg daily Prednisone</td>
<td>Diarrhea</td>
<td>Community-acquired pneumonia</td>
<td>Sputum</td>
<td>Albendazole 400 mg x 15 days</td>
<td>Not documented</td>
<td>Death due to polymicrobial infections complicating albendazole-induced pancytopenia</td>
</tr>
<tr>
<td>6</td>
<td>F/72y</td>
<td>Yes</td>
<td>Rheumatoid arthritis</td>
<td>Methylprednisolone 8 mg daily Methotrexate 10 mg once a week</td>
<td>Abdominal pain</td>
<td>Disseminated</td>
<td>Stool</td>
<td>Albendazole 400 mg mg x 2 days Ivermectin 200 μg/kg/day x 14 days after it is acquired</td>
<td>Yes</td>
<td>Clinical resolution</td>
</tr>
<tr>
<td>7</td>
<td>M/75y</td>
<td>Yes</td>
<td>HBV cirrhosis</td>
<td>Nil</td>
<td>Diarrhea</td>
<td>Disseminated</td>
<td>Stool</td>
<td>Albendazole 200 μg/kg/day x 10 days</td>
<td>Yes</td>
<td>Clinical resolution</td>
</tr>
</tbody>
</table>

HBV: Hepatitis B Virus; HCC: hepatocellular carcinoma.
Chronic intestinal infection: detection of *Strongyloides stercoralis* and symptoms confined to intestinal tract; Hyperinfection: the total parasitic load increases while the detection of *Strongyloides stercoralis* and the clinical manifestations are confined to the usual migration route; Disseminated: detection of *Strongyloides stercoralis* with symptomatic organ involvement outside the usual migration route.
was not completed and there were no documented negative specimen 2–4 weeks after albendazole. Bone marrow examination showed extreme hypocellularity and trilineage hypoplasia (Fig. 2). This is the second fatal case reported in the literature as a result of albendazole-induced myelosuppression.

Discussion

About 55–100 million people are infected by *S. stercoralis* worldwide each year [1]. The prevalence of *S. stercoralis* infection in China had been reported as 0.12% [2]. There was a regional variation with a higher prevalence noted in the southern and southwestern provinces such as Yunnan (11.7%) [3] and a lower prevalence in eastern part of China such as Shandong (1.29%) [4]; and in the more arid Western China (0.04%) [5]. Six of our 7 patients had past history of farming and had come from Guangdong province of South China. It was most likely that they had acquired the *S. stercoralis* infection from the paddy field by exposing the bare skin of their legs and feet to the soil. The two of patients that developed intestinal symptoms only were not on any immunosuppressants whereas 4 of the remaining 5 patients with hyperinfection or disseminated disease were.

Both ivermectin and albendazole have been used for intestinal strongyloidiasis without hyperinfection or dissemination. However, ivermectin has not been available in China for a number of years as the sole manufacturer for ivermectin in China has discontinued its production. A review article was published in 2016 comparing the efficacy of albendazole and ivermectin in the treatment of uncomplicated strongyloidiasis (i.e. no evidence of hyperinfection or dissemination) [6]. It was found that a single dose or two doses of ivermectin (each dose 200 μg/kg) was more efficacious in achieving a parasitological cure in each of the 4 published trials compared with 3–7 days of albendazole (daily dose of 400–800 mg). The pooled risk ratio is 1.79 (95% confidence interval 1.55-2.08). The rate of parasitological cure for ivermectin was 82.7%–95%; whereas it was 37.5–63.3% for albendazole [6]. Historically, thiabendazole had been another drug of choice for treating uncomplicated strongyloidiasis. Even though it had been shown to demonstrate similar efficacy in parasitological cure compared with ivermectin (risk ratio 1.07, 95% confidence interval 0.96–1.20), it was not favored due to more adverse events [6]. As expected, our two patients with uncomplicated strongyloidiasis were successfully treated with 7 days of oral albendazole.

To date, no trials have been reported that compared the efficacy
between ivermectin and albendazole in the treatment of complicated strongyloidiasis (i.e. hyperinfection or disseminated diseases due to S. stercoralis). The existing experience and recommendations have been based on case reports. Buonfrate et al. summarized the clinical features, treatment and outcome of 133 cases of complicated strongyloidiasis receiving single agent for treatment between 1991 and 2011 [7]. The mortality of patients receiving ivermectin only was 47% (18 out of 38 patients), whereas mortality of patients receiving albendazole only was 73% (25 out of 34 patients). No further statistical analysis was performed in this systematic review. In our series, 4 out of the 5 patients with hyperinfection or disseminated strongyloidiasis were treated with albendazole (patients 3–6), with or without ivermectin. Patient 4 achieved parasitological cure after 21 days of albendazole given at 400 mg twice daily. Patient 3 had symptomatic recurrence despite parasitological cure, required additional of ivermectin. Patient 6 also achieved parasitological cure after 2 days of albendazole. Patient 5 was treated with a course of albendazole but died without any documentation of parasitological clearance, as it requires negative sputum and stool exams performing 2–4 weeks after treatment. Therefore, albendazole achieved parasitological cure in 3 out of 4 patients while the remaining patient without documented clearance eventually succumbed.

Albendazole belongs to the benzimidazole class of drugs and is used to treat a wide range of parasitic diseases. It is generally well tolerated with low incidences of gastrointestinal discomfort. Rarely, albendazole is associated with more severe side effects such as leukopenia (0.044%), anemia (0.004%), and raised liver enzymes (0.035%) [8]. One of our patients (patient 5) was noted to have pancytopenia 15 days after albendazole treatment. He went on and developed Klebsiella pneumoniae bacteremia, MRSAs pneumonia, and pulmonary mucormycosis due to Cunninghamamella spp. and died of multiorgan failure soon afterwards. On review of the literature, there was one other fatal case of albendazole-induced pancytopenia, being reported by Opatrny et al. and which was similar to our patient 5 [9]. In Opatrny’s report, the patient was started on albendazole for hydatid cyst disease and developed pancytopenia 16 days after the treatment. It was complicated by Klebsiella pneumoniae bacteremia, and the patient died of esophageal variceal bleeding due to severe thrombocytopenia. In 2014, there were 2 cases of bilineage cytopenia reported separately [10,11], both following a month of albendazole use, especially in prolonged course (> 10 days), or where there is pre-existing liver dysfunction.

In view of the potential fatal outcome of complicated strongyloidiasis and treatment limitation, screening of patient at risk might provide an important step in preventing its development. Risk factors for hyperinfection and disseminated strongyloidiasis include the use of immunosuppressive drugs including corticosteroids, the presence of human T-lymphotropic virus-1 (HTLV-1) infection, recipients of solid organ or hematological stem cell transplant, patients with hematological malignancy, hypogammaglobulinemia, uremia, severe malnutrition, or diabetes mellitus [13]. It may be prudent to screen patients for intestinal carriage of Strongyloides before starting immunosuppression where there are also a past history of farming, residence or travel to endemic area. The sensitivity of single stool examination is only 75.9% for intestinal carriage of S. stercoralis, but increases to 92% with 3 stool specimens [14]. However, the negative predictive value varies with local disease prevalence. In a low prevalence setting, the use of serological testing is preferable. In the past, immunofluorescence antibody testing against Strongyloides had been used predominantly. More recently, the use of enzyme-linked immunosorbent assay (ELISA) and luciferase immunoprecipitation system (LIPS) has increased the sensitivity up to 97%, and the negative predictive value is nearly 100% in low prevalence setting [15]. Stool molecular testing is only used in a few reference laboratories and the sensitivity is unclear at this stage. Southern China has relatively high prevalence of Strongyloides stercoralis. Hence, we recommend screening with multiple stool microscopy examination and a peripheral blood examination for eosinophil count before commencement of immunosuppressive therapy.

Conclusion

In summary, we have reported 7 cases of strongyloidiasis and its course of treatment that had occurred in an endemic part of China. Immunosuppression appeared to be an important risk factor for the development of complicated strongyloidiasis. Albendazole induced myelosuppression is a rare but serious concern and may lead to death through neutropenic sepsis. Hence, the use of albendazole should be accompanied by careful and close monitoring of full blood count especially during prolonged treatment.

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Potential conflicts of interest

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References


