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ULCER SYMPTOMS DUE TO SCHISTOSOMIASIS MANSONI

CLARIBEL WESTERMEYER, M.D.*

Schistosomiasis is rare in this part of the world but must be included in the differential when a patient from an endemic area presents ulcer symptoms. The parasites were found on liver and rectal biopsy as well as in stool examination.

The patient S. M. is a 31 year old Arabian who has been in the United States for the past one and one-half years. He was first seen on January 24, 1955 in the emergency room of the Henry Ford Hospital suffering from intense epigastric pain. He had first had mild epigastric discomfort four years ago. Three episodes occurred in that year but he had no further difficulty until the past two weeks. There was increasing generalized epigastric pain which radiated to the center of the back with vomiting and inability to eat for three days.

The physical examination was negative except for epigastric tenderness. Laboratory studies were as follows: Hemoglobin 17.7 gms; white blood count 8500; blood smear, myelocytes 1%, segmented neutrophils 53% eosinophils 24% lymphocytes 21% and monocytes 1%. Amylase 50%. Total protein was 7.4 gm. with albumin 5.0 gm., and globulin 2.4 gm. Cephalin cholesterol negative, thymol turbidity 2 units, thymol flocculation one plus. Bromsulphthalein 45 minutes 5% retention, with 3% retention in 60 minutes. Prothrombin 100%.

Sigmoidoscopic examination showed small internal hemorrhoids and several areas of friability and bleeding. X-ray examination of the esophagus was normal. Coarsening of folds was noted in the stomach. The duodenal cap filled well and showed no abnormality. Gastric acidity was normal and there was no evidence of parasites in the biliary drainage.

Microscopic examination of the rectal biopsy (figure 1) shows the rectal mucosa slightly thickened with scattered chronic inflammatory reaction. The mucosal glands are well differentiated throughout. Scattered parasite eggs are encountered in the mucosa and also in the submucosa. There is no additional inflammatory reaction localized around the eggs.

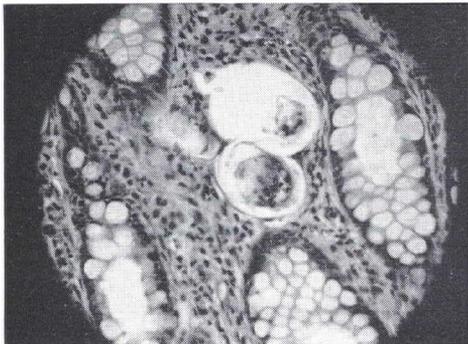


Figure 1
Schistosoma mansoni in rectal mucosa

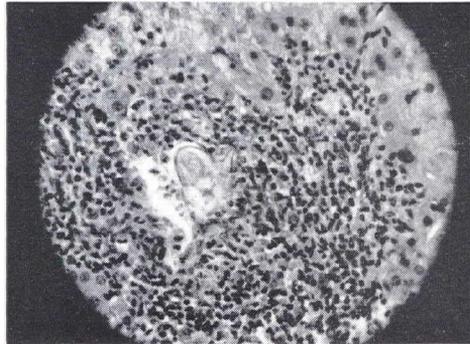


Figure 2
Schistosoma mansoni in liver

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The liver biopsy on microscopic examination shows a large, chronic inflammatory response (figure 2). Within the central portion of this collection of cells there is a schistosome egg.

DISCUSSION:

The initial contact must have occurred at least one and one-half years previously since the disease is not endemic in North America due to the absence of the appropriate snail as the intermediate host. The pain has been previously noted to be similar to peptic ulcer.¹ Epigastric pain without localization, radiation to the back, aggravation by food, nausea and vomiting, occurred in this patient. Melena was not present but is frequently associated with this disease. There was an eosinophilia of 24% and yet the degree of inflammatory response is not remarkable. Examination of unpurged stool is important since it is more likely to contain ova scrapped from the intestinal wall. However, it must be kept in mind that the ova maybe intermittently present.² The comparative merits of examination of urine, stool and of rectal biopsy material for diagnosis of schistosomiasis has been done in endemic areas. Rectal biopsy and stool examination appear equally effective for *S. Mansoni*. Although it more frequently involves the intestinal tract, it may occur in the urinary tract as well. However, the *S. Mansoni* found on urine examination is insignificant.³ The female lays her eggs in the tributaries of the portal vein and thus it is not surprising that chronic liver disease with cirrhosis and portal hypertension is a late sequelae of schistosomiasis. However, we have no evidence of cirrhosis in this patient by physical examination, liver biopsy, liver function tests or x-ray.

SUMMARY

A case of schistosoma mansoni with a history suggestive of penetrating ulcer is presented. The parasites were found in the stool examination and on biopsy of the rectal mucosae and liver.

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