Intestinal amoebiasis for 36 years

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Summary

A case is reported of amoebic dysentery in a former soldier who had symptoms of *Entamoeba histolytica* infection for 36 years. It emphasizes the need for careful search for parasites in the stools of any patient with bowel symptoms because the consequences of wrong diagnosis are potentially catastrophic.

Introduction

Entamoeba histolytica has a world-wide distribution. When amoebiasis is encountered in this country it is nearly always in patients who have visited the tropics. The diagnosis is often missed, sometimes with fatal results (Stamm, 1976). The literature alludes to amoebiasis of long duration before diagnosis (Maynard and Vickery, 1977; Wright, 1966). Symptoms have been described for 45 years in a soldier who probably acquired infection while serving with Kitchener in Egypt (Paine, 1977). The authors report a case of amoebic dysentery in another former soldier who had symptoms of *E. histolytica* infection for 36 years.

Case report

A 54-year-old man was admitted to Queen Elizabeth Military Hospital (QEMH) in April 1979. While in the Army during World War II he was invalided home from India in 1943 with amoebic dysentery. He received several courses of emetine in Queen Alexandra Military Hospital, Millbank. Attacks of abdominal pain and diarrhoea continued over the years and he was told he had a 'spastic colon'. Antispasmodic preparations were prescribed without benefit. He never again travelled abroad. For 6 months before admission to QEMH his diarrhoea increased to 8 or 9 mucoid stools a day. Defaecation was preceded by crampy lower abdominal pain. He lost 5 kg weight. Two weeks before admission he began to pass fresh blood per rectum. On admission he was tender in both iliac fossae but physical examination was otherwise negative. A stool passed soon after admission was streaked with

blood and mucus. Microscopical examination showed numerous motile amoebic trophozoites containing red blood cells. Many Charcot-Leyden crystals were also present but other parasites were not seen. Sigmoidoscopic examination to 15 cm exposed oedematous and friable mucosa coated with yellow liquid faeces. Only one patch of ulceration was seen with 3 tiny discrete openings close together. Mucoid material curetted from this region contained numerous erythrophagocytic trophozoites. A biopsy specimen missed the ulcers and showed only non-specific mucosal inflammation with heavy eosinophil infiltration of the lamina propria. However, the loose exudate attached to this specimen contained myriads of amoebic trophozoites. The serum indirect fluorescent antibody test for amoebiasis was positive at a titre of 1 : 64. A full blood count was normal except for mild eosinophilia. Other tests, including liver function tests and a barium-enema examination were normal. The patient was treated with metronidazole 400 mg thrice daily for 5 days followed by diloxanide furoate 500 mg thrice daily for 10 days. His symptoms subsided in a few days and repeat sigmoidoscopic examination one month later was normal. Three months after discharge from hospital he remained symptom-free. Microscopy of 3 stools was negative for amoebae and other parasites.

Discussion

The patient's war-time medical documents were not obtained but it can be assumed the diagnosis of amoebic dysentery made in 1943 was correct. Emetine, one of the few amoebicidal drugs then available, was useful in acute amoebic dysentery but often failed to eradicate the parasite and achieve cure (Elsdon-Dew, 1972). The authors believe that the patient's symptoms during the 36 years before he presented to them were due to chronic intestinal amoebiasis that relapsed acutely in the few months before admission without any obvious aggravating cause. The mucosal appearances

at sigmoidoscopic examination were non-specific and a diagnosis of idiopathic ulcerative colitis might have been made had a search for amoebae been unsuccessful. The consequences of steroid therapy could then have been catastrophic (Leading Article, 1978). This case emphasizes that amoebiasis must always be considered and a careful search for parasites made of the stools of any patient with bowel symptoms, particularly if there is a history of travel to the tropics, however long ago.

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