New aspects of human trichinellosis: the impact of new Trichinella species

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Trichinellosis is a re-emerging zoonosis and more clinical awareness is needed. In particular, the description of new Trichinella species such as T papuae and T murrelli and the occurrence of human cases caused by T pseudospiralis, until very recently thought to occur only in animals, requires changes in our handling of clinical trichinellosis, because existing knowledge is based mostly on cases due to classical T spiralis infection. The aim of the present review is to integrate the experiences derived from different outbreaks around the world, caused by different Trichinella species, in order to provide a more comprehensive approach to diagnosis and treatment.

Trichinellosis is a parasitic infection caused by a nematode belonging to the genus Trichinella. Virtually all mammals are susceptible to infection by one or more species of the genus; however, humans appear to be especially prone to developing clinical disease. Over the past decade, the number of outbreaks around the world appear to have increased markedly, reflecting a changing epidemiological paradigm. The severity of the clinical course depends on parasitic factors such as the species involved, the number of living larvae ingested, and host factors such as sex, age, ethnic group, and immune status. It is the purpose of this review to highlight the changes in our understanding of this zoonosis and to suggest some new approaches to the diagnosis and treatment of the infection.

The clinical course of the acute period of infection is characterised by two phases, an enteral phase, in which the parasite alters intestinal function, and a parenteral phase, which is associated with an inflammatory and allergic response to muscle invasion by the larval parasites. Gastrointestinal signs appear first, then fever, myalgia, periocular oedema, characterise the clinical picture. Death is now rare, owing to improved treatment, but may result from congestive heart failure due to myocarditis, encephalitis, pneumonitis, hypokalaemia, or adrenal gland insufficiency.

A definitive diagnosis may be made when L1 larvae are found in a muscle biopsy; however, anamnestic criteria and laboratory findings such as hypereosinophilia, total IgE, and muscle enzyme level increase may help in diagnosis. The use of newer specific serological tests (enzyme linked immunosorbent assay (ELISA) and immunoblot) can improve diagnosis. Treatment is based on anti-inflammatory drugs and anthelmintics such as mebendazole and albendazole; the use of these drugs is now aided by greater clinical experience with trichinellosis associated with the increased number of outbreaks.

The description of new Trichinella species, such as T murrelli and T papuae, as well as the occurrence of outbreaks caused by species not previously recognised as infective for humans, such as T pseudospiralis, now render the clinical picture of trichinellosis potentially more complicated. Clinicians and particularly infectious disease specialists should consider the issues discussed in this review when making a diagnosis and choosing treatment.

SYSTEMATICS

Trichinellosis results from infection by a parasitic nematode belonging to the genus Trichinella. Trichinellosis has been an important, though often unrecognised, disease for thousands of years. Species of trichinella responsible for the infection are widely distributed, including the Arctic, temperate lands, and the tropics. Virtually all mammals are susceptible to infection by one or more species; however, humans appear to be especially prone to developing clinical disease. Infection with wild animal species of trichinella is far more common than is generally recognised. Human trichinellosis is an important food borne zoonosis because of its epizootic nature and the economic burden associated with preventing its incursion into the human food chain. Its importance in even developed countries is exemplified by the fact that over 20 000 cases have occurred in Europe from 1991–2000. From the time of the discovery of trichinella in 1835 until the middle of the next century, it was commonly assumed that all trichinellosis was caused by a single species, Trichinella spiralis (Owen, 1835). More than a century later, T spiralis had been reported from more than 100 different naturally or experimentally infected mammalian hosts and was believed to be a single species with low host specificity and spread around the world with the movement of domestic swine. Over the last decade, the application of molecular and biochemical methods in conjunction with experimental studies on biology have resulted in the identification of seven Trichinella species, which

Abbreviations: ADCC, antibody dependent cellular cytotoxicity; CPK, creatine phosphokinase; ELSA, enzyme linked immunosorbent assay; IL-5, interleukin-5; LDH, lactate dehydrogenase
have distinct epidemiological and geographical distributions (table 1). Although the species are difficult to differentiate morphologically, they can be typed with molecular and certain biological characters.  

LIFE CYCLE

All stages in the life cycle of trichinella occur in individual mammalian hosts. When skeletal muscle containing the infective larvae is ingested by another mammal, the larvae are released by the action of gastric fluids and pass into the small intestine. There, the parasites invade the small intestine epithelial wall, and molt four times before becoming sexually mature. After copulation, the females begin to expel newborn larvae about six or seven days after infection. This process continues for the life of the female. Although it is generally believed that the adult worms may persist in the intestine for only several weeks, there is evidence that they may survive for much longer periods, especially if the host’s immune system is compromised. Most of the newborn larvae penetrate into the submucosa and are carried in the circulatory system to various organs, including the myocardium, brain, lungs, retina, lymph nodes, pancreas, and cerebrospinal fluid. However, only the larvae that invade the skeletal muscle survive. In most species they gradually encyst and develop into the infective stage about 21 to 30 days after infection (fig 1A). However, in two species, T pseudospiralis and T papuae, the muscle larvae do not induce the formation of a cyst or capsule (fig 1B). Larval infectivity can be retained for many years, depending on the species of host. The larvae appear to be non-pathogenic for the natural hosts (excluding humans) unless very large numbers are involved.

EPIDEMIOLOGY

The most salient feature of this parasite’s epidemiology is its obligate transmission by ingestion of meat. A second cardinal feature is its existence in two normally separate ecological systems, the sylvatic and the domestic. In certain circumstances, the two biotopes are linked through man’s activities, resulting in the exposure of humans to Trichinella species normally confined to sylvatic animals. The species most frequently associated with human infection is T spiralis, the species that is normally found in domestic pigs. The domestic cycle of T spiralis involves a complex set of potential routes. Transmission on a farm may result from predation on or scavenging other animals (for example, rodents), hog cannibalism, and the feeding of uncooked meat scraps. Until recently, outbreaks predominantly resulted from consumption of T spiralis infected pork in local, single source outbreaks; however, increasingly, the mass marketing of meat can disseminate the parasite throughout a large population. Also of importance is the growing proportion of outbreaks caused by sylvatic Trichinella species, either directly through game meat or through spillover to domestic animals. Recent reports also indicate that infected herbivores (horses, sheep, goats, and cattle) have been the source of outbreaks, a new variation on the traditional model of trichinellosis epidemiology. Examples are recent human infections attributed to T pseudospiralis in New Zealand in 1994, recently in Thailand where 59 people were infected by pig meat, and in France where an outbreak from wild boar meat occurred in 1999.  

In countries where meat inspection for trichinella is not mandatory, other strategies for reducing consumer risk are followed. In the United States, for example, consumers are advised on proper meat handling procedures (for example, cooking, freezing, curing) for killing any trichinella present. Cooking to an internal temperature of 60°C for at least one minute is advised. Consumers are also urged to freeze pork at either −15°C for 20 days, −23°C for 10 days, or −30°C for six days if the meat is less than 19 cm thick. These temperatures may not be adequate, however, for wild game meat infected with species such as T nativa, which is freeze resistant. The curing of pork sufficient to kill trichinella is difficult to standardise. Commercial production of ready-to-eat pork products is carried out under scrutiny of regulatory agencies to ensure food safety.

Table 1 Characteristics of the seven identified Trichinella species

<table>
<thead>
<tr>
<th>Trichinella species*</th>
<th>Muscle capsule</th>
<th>Infectivity for pigs</th>
<th>Freeze resistance</th>
<th>Molecular markers (PCR)</th>
<th>Reported sources</th>
<th>General geographic distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>T spiralis</td>
<td>+</td>
<td>++++</td>
<td>±</td>
<td>173 bp</td>
<td>Pork; game; horse meat</td>
<td>Cosmopolitan</td>
</tr>
<tr>
<td>T britovi</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>127, 252 bp</td>
<td>Pork; game; horse meat</td>
<td>Temperate Europe/Asia</td>
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<tr>
<td>T pseudospiralis</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>300, 360 bp</td>
<td>Pork; game</td>
<td>Cosmopolitan</td>
</tr>
<tr>
<td>T papuae</td>
<td>−</td>
<td>+</td>
<td>−</td>
<td>240 bp</td>
<td>Pork; game</td>
<td>Papua New Guinea</td>
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<tr>
<td>T nativa</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>127 bp</td>
<td>Game</td>
<td>Arctic/subarctic</td>
</tr>
<tr>
<td>T neeloni</td>
<td>+</td>
<td>−</td>
<td>+++</td>
<td>155, 404 bp</td>
<td>Game</td>
<td>Africa (south of Sahara)</td>
</tr>
<tr>
<td>T murrelli</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>127, 361 bp</td>
<td>Game; horse meat</td>
<td>North America</td>
</tr>
</tbody>
</table>

*See reference 2 for details. PCR, polymerase chain reaction; bp, base pairs.

Figure 1 Histological appearance of Trichinella species L, larvae located in diaphragms of mice experimentally infected. (A) Sample from a mouse infected with T britovi. Note around the nurse cell numerous inflammatory cells (trichrome stain; original magnification × 200). (B) Sample from a mouse infected with T pseudospiralis. Only few inflammatory cells are present around the L, larva (haematoxylin and eosin; original magnification × 200).
**PATHOGENESIS**

**Enteral phase**

At intestinal level, the mechanisms regulating the immune response to a primary infection in humans, are not clear. The prolonged diarrhoea observed in outbreaks in the Canadian Arctic suggests adult worms persist in the intestine of people with frequent exposure to infection. This could be due to a possible downregulation of the intestinal immune response or of gut physiology, or to a preeminent state.

Experimental studies in rodents infected with *T. spiralis* have shown that the early phase of helminthic infection, when the parasite is present in the gastrointestinal tract, induces a type 1 hypersensitivity reaction, leading to increased levels of mast cells, eosinophils, and parasite specific IgE production. This isotype has a protective role in intestinal immunity in rodents. Very recently, it was shown that the mucosal mast cell protease-1 plays a crucial part in determining the expulsion of *Trichinella* adult worms, in fact knock-out mice for the corresponding gene significantly delayed expulsion and increased the number of encysted larvae, compared with wild type animals.

In the jejunum of patients infected with *T. spiralis* an increased number of mucosal mast cells occurs.

Diarrhoea during infection is a consequence of a physiological process induced by the parasite, resulting in active secretion of ions and water, as occurs with *Vibrio cholerae*.10

**Parenteral phase**

This is associated with inflammatory and allergic responses caused by the invasion of the muscles by the migrating larvae. This invasion can damage the muscle cells directly, or indirectly stimulating the infiltration of inflammatory cells, primarily eosinophils. A correlation between the eosinophil levels and serum muscle enzymes has been observed in *Trichinella* patients, suggesting that muscle damage may be mediated by these granulocytes.11

The involvement of the central nervous system during infection, the so-called neurotrichinosis, arises mainly from vascular perturbations, for example, vasculitis and granulomatous inflammatory reactions surrounding invading larvae. The newborn larvae tend to wander, causing damage before maturing inflammatory reactions surrounding invading larvae. This is associated with inflammatory and allergic responses caused by the invasion of the muscles by the migrating larvae. This is associated with inflammatory and allergic responses to the parasite alters intestinal function, and a type I hypersensitivity reaction, leading to increased levels of mast cells, eosinophils, and parasite specific IgE production. This isotype has a protective role in intestinal immunity in rodents.

Electrical fibrillations and muscle hypercontractility.

**Immunological aspects**

The mechanisms responsible for the pronounced eosinophilia, frequently observed in trichinosis, are not well understood. Differentiating factors specific for eosinophils such as interferon-γ (IL-5), 12 produced by the Th2 subset of CD4+ T cells, may be involved. Recently, in experimental infections, it has been shown that this cytokine could act by protecting cells from the apoptotic death which normally affects eosinophils. The role of IgE in inducing the eosinophilia is controversial. Eosinophils are cytotoxic for newborn larvae in both animal (fig 2) and human antibody dependent cellular cytotoxicity (ADCC) “in vitro” reactions, 13 14 by releasing the major basic protein,15 peroxidase, 16 or reactive oxygen species. However, their actual role “in vivo” is not clear. Suppression of eosinophilia by an IL-5 specific monoclonal antibody “in vivo” does not modify either primary or secondary parasitic infections in mice. Knock-out and transgenic mice for IL-5 have the same parasitic burden as controls, however in the former case the cytokine seems to promote expulsion and muscle hypercontractility.

Nevertheless, a very recent study has shown that IL-5 deficient mice show an impaired defence against a secondary *T. spiralis* infection, at intestinal level, suggesting a relevant role of this cytokine in challenge infections.17

The few data on the non-encapsulated species are from experimental infections with *T. pseudospiralis*. This species appears to be less virulent and pathogenic than *T. spiralis*, generating less inflammation at intestinal and muscle level. This is probably due to the ability of this species to induce elevations in host plasma corticosterone.18

**CLINICAL MANIFESTATIONS**

The severity of the clinical course depends on the species involved. For example, in the recent outbreak in Thailand caused by *T. pseudospiralis*, the clinical course in patients was unusually prolonged. Other factors affecting the clinical course are the number of living larvae ingested, and sex, age, and ethnic group of the host. Immune status also plays an important part as shown in humans, and in experimental infections in which steroids and immunosuppressive treatments prolong the survival of adult intestinal worms. Furthermore, the prolonged diarrhoea in the absence of myalgia, reported in elderly Inuit people, may be due to previously acquired immunity against the enteral and parenteral stages of the parasite.19

The disease incubation period ranges from seven to 30 days, depending on the severity of infection. When the course of infection is more severe, the incubation period is brief, although death may also occur in association with a longer incubation period.20

The clinical course of the acute period of infection is characterised by two phases, an enteral phase, in which the parasite alters intestinal function, and a parenteral phase, which is associated with an inflammatory and allergic response to muscle invasion by the larval parasites. The first gastrointestinal signs result from mucosal invasion by the L1 (stage 1 (ingested) larvae. These signs typically last two to seven days, but may persist for weeks. Subsequently, the so called trichinellotic syndrome or general trichinelliosis syndrome, begins (see below). However, the acute phase, lasting one to eight weeks, is commonly asymptomatic, especially when the number of larvae ingested is low.

The clinical course of enteral infection may be abortive (symptomatology not complete), mild (complete even if mild), moderate, and severe (frequently associated with...
Antibodies oriented toward muscle fibers also appear in the blood, generally peaking four to eight weeks after infection. They may persist up to the third or fourth week. The principal graphic alterations may be present from the second week and then may persist up to the third or fourth week.

Muscles are mainly affected during the parental phase, including the myocardium. The central nervous system, lungs, kidney, and skin may be affected. The trichinellosis syndrome is characterised by facial oedema, muscle pain and swelling, weakness, and frequently fever; anorexia, headache, conjunctivitis, and urticaria occur less frequently. Fever, usually remittent, usually begins at two weeks, and peaks after four weeks, with values up to 40–41°C in severe cases. Despite fever, patients may appear in good condition. Ocular signs (oedema of the eyelids, chemosis, conjunctivitis, conjunctival haemorrhages, disturbed vision, and ocular pain) at this time may help in diagnosis. Periorbital oedema is peculiar to trichinellosis, ranging from 17% to 100% of patients in over 2000 trichinellosis cases reviewed. This oedema is probably the result of an allergic response.

The entire face may also be involved, giving patients a characteristic look, often rendering them unrecognisable. The frequency of facial oedema during infections caused by *T. murrelli* was lower than that observed in *T. spiralis* human infections that occurred in France in the same year. At this time the muscles of the rest of the body usually become painful. Extraocular muscles, masseters, tongue and larynx muscles, diaphragm, neck muscles, and intercostal muscles are most frequently infected.

The pain may be so severe as to limit function of the arms and legs, inhibiting walking, speaking, moving the tongue, breathing, and swallowing. Weakness is also a consequence of the muscle involvement. The muscles become stiff, hard, and oedematus; the oedema may be so intense as to simulate hypothyreosis. Oedema lasts one or two weeks and disappears with increased diuresis. Myalgia and asthenia lasted more than four months in the Thailand outbreak caused by *T. pseudospiralis*.

Gastrointestinal symptoms such as diarrhoea may also extend into this parental phase. Dyspnoea (even ventilatory failure), coughing, and hoarseness may also be present. Dyspnoea is caused primarily by parasite invasion and consequent inflammations of respiratory muscles such as the diaphragm. Bronchopneumonia and infarction may also be involved. In the first days of treatment with albendazole in a *T. pseudospiralis* outbreak difficulty of respiration was observed, probably due to the release of toxic products from damaged parasites. The cough begins in correspondence with the passage of the larvae through the capillary bed of the lungs, about one week after infection.

Neurological manifestations, more common in severe infections, occur in 10% to 24% of cases. In 55 patients affected by neurotrichinosis, meningoencephalitis signs were the most frequently observed clinical signs (96%), followed by focal paralysis or paresis (73%), and delirium (71%); psychosis was also reported.

Headache is very common in trichinellosis, and is exacerbated by movements of the head. Mortality due to central nervous system involvement is now less frequent because of the improved treatment.

Myocarditis is the most frequent cardiovascular complication, leading sometimes to heart failure or bronchopneumonia; in some cases death occurs between the fourth and the eighth week of infection, although sudden death may occur even earlier. Arrhythmias, secondary to myocarditis, may also occur. In one case it was necessary to use a pacemaker for one year to maintain normal cardiac rhythm. Electrocardiographic alterations may be present from the second week and may persist up to the third or fourth week. The principal alterations are premature contractions, prolongation of the P-R interval, small QRS complexes with intraventricular block, and flattening or inversion of the T waves, especially lead II and precordial leads. Blood pressure may be low during the early phase of infection and may also remain low during convalescence. Oedema due to heart failure has been observed, generally later when oedema due to myositis has almost disappeared. Less frequent vascular signs are epistaxis, haemoptysis, haemorrhages from the bowel, thrombosis of the femoral or pulmonary artery, and embolism. In one fatal case, the arterioles of different organs were affected by disseminated intravascular coagulation with platelet fibrin thrombi. Less frequent are petechial haemorrhages, mainly subungual, and roseola and maculopapular exanthems, resembling measles.

After the acute period, convalescence follows (lasting from months to years), usually with a complete recovery. Over the ensuing years, muscle larvae are slowly destroyed, followed by calcification. This may occur earlier in infections with sylvatic species.

The existence of chronic trichinellosis or as some investigators prefer, “persisting sequelae” (the persistence of myalgia, early fatigability, ocular signs, and headache for decades), is somewhat controversial and requires investigations. Some recent studies have confirmed the occurrence of these sequelae for periods up to 10 years after clinical recovery.

Although death is now rare in trichinellosis, owing to improved treatment, it may result from congestive heart failure due to myocarditis, encephalitis, pneumonitis, hypokalaemia, or adrenal gland insufficiency. In the United States, during the period 1991–96, in 230 cases reported to the Centers for Disease Control in Atlanta, only three deaths occurred. During the outbreak caused by *T. pseudospiralis* in Thailand there was one fatality in 59 patients, due probably to the very large amount of parasite-infected meat ingested. During a horsemeat outbreak in France, caused by the newly described *T. murrelli*, a 0.46% mortality rate was observed. No deaths were reported in outbreaks caused by *T. britovi*.

**DIAGNOSIS**

Is trichinellosis a low prevalence disease or is it frequently misdiagnosed? The answer is not obvious.

When the infection occurs in epizootic or outbreak form its diagnosis is easier. It is difficult in low level or sporadic infections, because the clinical picture is often common to many other diseases, infectious or not, such as typhoid fever, influenza, chronic fatigue syndrome, myositis during HIV infection, polyarteritis nodosa, and eosinophilic leukaemia. This makes it is necessary to carry out a differential diagnosis.

Special care must be taken when developing clinical histories; particular attention should be paid to eating habits during the weeks before the onset of symptoms. Exposure to infected meat (raw or incompletely cooked), the presence of gastroenteritis, myalgia, facial oedema, subungal or conjunctival haemorrhages, and an increase in eosinophil levels should suggest trichinellosis. Electromyography may help in the diagnosis of moderate and severe infections during the acute period, even if the muscle changes are not pathognomonic. With clinical improvement, electromyography changes generally disappear within two to three months, although these alterations may persist for one to eight years.

**Muscle biopsy**

A definitive diagnosis may be made when L1 larvae are found in a muscle biopsy, generally performed in the deltoid muscle; although in humans other muscles are more infected, the deltoid is preferred because it is more accessible. Muscle biopsy is recommended only in rare and difficult cases, particularly when serology is not clear. A negative result, however, does not
examine the presence of a low level infection. **Artificial digestion** (1% pepsin-hydrochloric acid) of a muscle sample is more sensitive than direct microscopic observation of the tissue specimen. Importantly, the isolation from muscle cannot be carried out before 17 to 21 days of infection because larvae are not yet resistant to digestion. **When T. pseudospiralis or T. papuae** (non-encapsulating species) are suspected as aetiological agents, digestion methods must be performed with care. A muscle biopsy is useful, however, not only for making a diagnosis but also to collect important information on the level of infection. Histological examinations may reveal modifications of skeletal muscles, including basophilic degeneration of the fibres, fatty metamorphosis, hyaline or hydropic degeneration, or both, and interstitial inflammation; sometimes it is possible to observe dead non-encapsulated parasites. Increased vascularity, small haemorrhages, accumulation of inflammatory cells, mainly eosinophils, among the muscle cells (myositis) are also visible.

Encapsulation of the parasite, with the exception of *T. pseudospiralis and T. papuae*, begins at about two weeks and is usually completed at five weeks of infection, depending on the *Trichinella* species involved. In humans, calcification begins about five months after infection and is usually completed after 18 months. As already mentioned, the diagnosis of trichinellosis is difficult in sporadic cases, but is even more difficult when central nervous system involvement is present. Neurotrichinosis is sometimes accompanied by multifocal central nervous system lesions, nodular or ring-like, and showing frequently contrast enhancement. However, computed tomography images of the brain have been normal also in the presence of neurological manifestations.

**LABORATORY FINDINGS**

**Non-specific findings**

The main laboratory findings useful for diagnosis are shown in the table 2.

Muscle enzymes such as creatine phosphokinase (CPK) and lactate dehydrogenase (LDH) may remain raised for more than four months, as occurred in >90% of patients affected by *T. pseudospiralis* in Thailand.

CPK isoenzyme profiles are not very helpful. An increased CPK isoenzyme-MB level, generally ascribed to myocardial damage, has been observed in 35% of *Trichinella* patients examined, with no cardiological symptoms, suggesting a release of this isoenzyme from other damaged striated muscle cells. LDH should be evaluated together with CPK, even if the former is less specific. When high levels of CPK and LDH are present, a differential diagnosis with myocarditis is necessary. Before antibody levels increase, the level of total serum LDH and the isoenzymatic forms LD1 and LD2 may increase in about 50% of patients.

Immunoglobulin level changes may also occur, the most characteristic being an increase in total IgE. However, this increase is not a consistent phenomenon and it is better to not exclude trichinellosis by its absence. A poor correlation with specific IgE has been observed in *T. spiralis* and *T. britovi* infections.

**Specific findings (immunodiagnosis)**

Many serological tests are available for diagnosis. According to Ljungström there are three objectives in immunodiagnosis: (1) recognising the acute infection to allow early anthelmintic treatment, (2) making a retrospective diagnosis, and (3) adding information to the epidemiology of the infection. Seroconversion usually occurs between the third and fifth week of infection and serum may remain positive up to one year or more after cessation of clinical symptoms. Antibodies have been detected, however, up to 19 years after the end of the acute phase of infection. Antibody levels do not correlate with the severity of the clinical course nor with a particular clinical course.

Indirect haemagglutination, bentonite flocculation, indirect immunofluorescence, latex agglutination, and enzyme linked immunosorbent assay (ELISA) are the more commonly used tests, the last being the most sensitive. Factors such as sensitivity, specificity, convenience, simplicity, cost, and commercial availability must be considered when choosing a test. However, a diagnostic laboratory should have at least two or more tests available to ensure a correct diagnosis: one to detect the response against a soluble antigen and another for antibodies that react with parasite surface antigens. For the latter, the indirect immunofluorescence test is performed with whole *L.* larvae killed with formalin, or with unfixed frozen sections of infected muscles; the latter is more sensitive. With this test all specific immunoglobulins can be evaluated. In the ELISA method, excretory-secretory (E/S) antigens are preferable to crude extracts of *T. spiralis* muscle larvae, since they give a higher specificity. This is particularly important in tropical regions where cross reactions with other helminth parasites could give false positive results. Cross reactions with *Trichinella* antigens were observed in patients with autoimmune diseases. It is necessary to standardise as much as possible the antigens used for diagnostic purposes. Recombinant or synthetic antigens have been developed. The ELISA can also be used for the evaluation of the different immunoglobulin classes or IgG subclasses of antibodies, but with a lower sensitivity compared with ELISA IgG. Specific IgM has been detected after 11 years of infection. The data on specific IgE are contradictory. Circulating antigens are also not completely reliable. They were found in 47% of

<table>
<thead>
<tr>
<th>Table 2 Laboratory findings in human trichinellosis</th>
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<tbody>
<tr>
<td><strong>Constant</strong></td>
</tr>
<tr>
<td><em>Hyperesinophilia</em> <em>(up to 19,000/µl)</em></td>
</tr>
<tr>
<td>Leucocytosis, up to 24,000/µl</td>
</tr>
<tr>
<td>CPK (up to 17,000 units/l)</td>
</tr>
<tr>
<td>LDH, aldolase level increase</td>
</tr>
<tr>
<td>Total IgE level increase</td>
</tr>
</tbody>
</table>

Parameters useful in diagnosis when modified are shown in bold. *Based on the absolute number rather than the percentage.*
Table 3  Treatment for intestinal and muscle stages of trichinellosis

<table>
<thead>
<tr>
<th>Symptomatic treatment</th>
<th>Specific treatment</th>
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<tbody>
<tr>
<td>Analgesic drugs</td>
<td>Mebendazole 200-400 mg three times/day, followed by 400 to 500 mg three times a day for 10 days</td>
</tr>
<tr>
<td>Antiparetic drugs</td>
<td>Albendazole 400 mg/day for three days, followed by 800 mg/day for 15 days (is particularly efficient in T pseudospiralis infections)</td>
</tr>
<tr>
<td>Bed rest</td>
<td>Thiabendazole 50 mg/kg for five days</td>
</tr>
<tr>
<td>Corticosteroids (prednisolone at 50 mg/day)</td>
<td></td>
</tr>
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</table>

From references 98–100.

Key references


TREATMENT

It is difficult to differentiate the efficacy of drug treatment from natural recovery of infection in mild to moderate cases. Factors such as the Trichinella species involved, intensity and length of infection, and host response can aid in deciding on the treatment course.

Light infections do not require treatment. The treatment goal for the very early infection phase is to limit muscle invasion by larvae; when this has already occurred the goal is to reduce muscle damage, which is responsible for the major clinical manifestations. Therapeutic plasma levels of the drug should be maintained for an extended period, rather than high levels for short periods. The success of treatment is evident from clinical improvement of the patient’s symptomatology. In a blinded, placebo controlled trial of antiparasitic drugs for the treatment of myositis during a trichinellosis outbreak (Thailand), mebendazole and thiabendazole were more efficient than placebo or flunazolone; however 30% of volunteers did not tolerate the side effects of thiabendazole.

The authors did not mention the Trichinella species responsible for infection. When muscle larvae are already encapsulated drugs such as mebendazole are not able to control infections very well. In infections caused by T pseudospiralis albendazole (800 mg/day in four doses) is particularly efficient, without apparent side effects (see table 3).

The recent occurrence of new Trichinella species, such as T murrelli and T pseudospiralis, in outbreaks in humans, could render the clinical picture of trichinellosis more complicated than when all infections were believed to be caused by T spiralis. Clinicians and infectious diseases specialists should consider this when making diagnosis, since the clinical signs and symptoms may differ, and the therapeutic choices be less clear.

REFERENCES

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