

An unexpected infection during the pandemic

GUILLERMO ANDRÉS HERRERA-RUEDA, MARÍA FERNANDA VARGAS-DÍAZ • MEDELLÍN (COLOMBIA)

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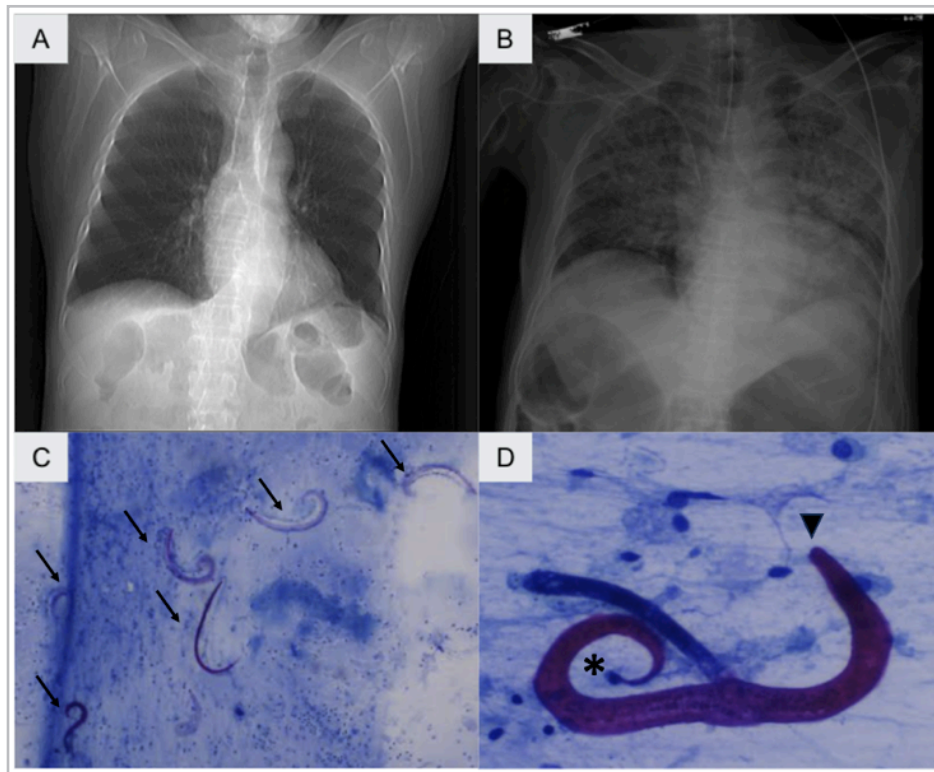


Figure A. A chest x-ray taken on the patient's admission, with discrete and nonspecific findings in the lung parenchyma. **Figure B.** A follow up x-ray with clear evidence of bilateral alveolar opacities due to multilobar involvement. **Figure C.** Modified Romanowsky staining of the bronchoalveolar lavage sample showing multiple purple-hued parasitic figures on a blue background, compatible with filariform larvae (black arrows). **Figure D.** Filariform larvae with greater enlargement. The tail (asterisk) and distal region of the pharynx (triangle) are shown.

A 75-year-old man with Hodgkin lymphoma had lived in a rural area until two decades ago. Five days after a long-term steroid dose he presented to the emergency room with a complaint of fever, cough and abdominal pain. A chest x-ray showed discrete signs of nonspecific atypical pneumonia (**Figure A**), with a negative SARS-CoV-2 RT-PCR. He worsened, requiring antibiotics and ventilatory support. The comparative image revealed bilateral alveolar opacities (**Figure B**), with fiberoptic evidence of structures compatible with *Strongyloides filariform* larvae (**Figures C and D**). Consequently, ivermectin and albendazole were added to the antibiotic treatment.

Strongyloides stercoralis can maintain endogenous reinfestation cycles even for years. Immunosuppression can facilitate parasitic proliferation and thus the occurrence of hyperinfestation syndrome (1). Patients who reside in or visit endemic areas and are coinfecting with human T-cell lymphotropic virus (HTLV-1), receive immuno-

modulators or cytotoxic therapy or have hematological malignancies, are at risk for this condition (3). Since these risk factors are common in our setting, we recommend universal deworming with ivermectin or albendazole for patients in these circumstances (4, 5).

Keywords: *Strongyloides*, glucocorticoids, opportunistic infections, Hodgkin disease, COVID-19

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Dr. Guillermo Andrés Herrera-Rueda: Especialista en Hematología. Universidad de Antioquia; Dra. María Fernanda Vargas-Díaz: Especialista en Hematología. Clínica Las Américas. Medellín (Colombia). Correspondencia: Guillermo Andrés Herrera-Rueda. E-Mail: guillermo.herrera@udea.edu.co Received: 12/IX/2023 Accepted: 26/I/2023