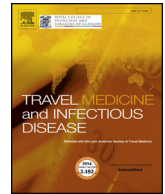




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Chronic urticaria revealing amebiasis

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A 49-year-old Ethiopian woman was admitted to our Dermatology Unit in March 2014 with a diagnosis of chronic urticaria. The patient lived in Milan, Italy, but she visited Ethiopia in July 2013. The patient stated that she was in therapy with levothyroxine for hypothyroidism and that urticaria appeared in November 2013. Furthermore, the patient declared occasional abdominal pain and diarrhoea, and weight loss (approximately 6 kg) in the last six months. Laboratory examinations, carried out at other centers, revealed blood eosinophilia [November 2013: 730 eosinophils/mm³ (=10.5%); January 2014: 1.100 eosinophils/mm³ (=15.9%)]. Dermatological examination showed numerous erythematous wheals located mainly on the forearms, abdomen and thighs. They were of different morphology and size. The patient complained of severe pruritus. At the time of admission at our Dermatology Unit, laboratory examinations showed only blood eosinophilia [800 eosinophils/mm³ (=12.3%)]. Coproparasitological examinations were positive (2 out of 3 specimens) for cysts of *Entamoeba histolytica*. Anti-*E. histolytica* IgG (Elisa) were positive (3.5 S/CO); IgM were 0.9 S/CO. Stool cultural examinations excluded infections caused by *Campylobacter* spp., *Escherichia coli*, *Salmonella* spp., *Shigella* spp. and *Giardia intestinalis*. All instrumental examinations, including ultrasonography, abdominal computed tomography and magnetic resonance, were negative. A diagnosis of chronic urticaria and amebiasis was made. The patient was successfully treated with three courses of metronidazole (1.5 g/day for 10 days each). No antihistamines were used. Follow up (three years) was negative for both urticaria and amebiasis. Amebiasis is an infection caused by *E. histolytica*. It is usually transmitted by the ingestion of food or water contaminated by faeces and containing cysts of *E. histolytica*. However, amebiasis can also be transmitted through contacts with hands or objects or by anal-oral contacts. Clinical manifestations of amebiasis include abdominal pain, watery or bloody diarrhoea, weight loss, colitis, peritonitis and liver abscesses. Anal, perianal and perineal ulcers with fistulae formation are also possible. Laboratory examinations show anemia and increase in white blood cells, sometimes with eosinophilia. According to literature

data, few cases of urticaria associated with (or caused by) amebiasis have been reported. In an Indian study published in 1972, 48 out of 78 patients (61.5%) with urticaria showed the presence of one or more parasites in three consecutive specimens of stool. Forty out of 48 of these patients had pathogenic parasites. All 48 patients were treated with metronidazole or piperazine citrate or bephenium hydroxynaphthoate. However, a follow up was possible only in 25 patients. Thirteen of these patients did not show improvement of urticaria or a worsening, while in 12 patients an improvement was observed. The authors concluded that intestinal infestations do not constitute a common cause of urticaria. In an Italian study on 218 patients with diseases of the skin such as chronic urticaria, atopic dermatitis or pruritus of unknown origin, only one patient was positive for *E. histolytica* in the stool. In another Indian study published in 2010, the presence of *Giardia lamblia* and *E. histolytica* was detected in 5 out of 150 patients (3.3%) with chronic urticaria. However, the prevalence of intestinal parasites in India is high: in a recent survey, *E. histolytica* was found in 21.8% of dwellers in South Chennai, a low socioeconomic area. Finally, *E. histolytica* was not cited as a factor associated with chronic urticaria in four extensive reviews. The case we have described demonstrates that sometimes chronic spontaneous urticaria can be caused by amebiasis. In our patient, this was demonstrated by the complete remission of urticaria by means of metronidazole, an antiamebic drug that lacks antiallergic or anti-inflammatory action, without having used antihistamines. We suggest to perform examinations for amebiasis in patients with chronic spontaneous urticaria returning from Tropical and Subtropical countries or living in countries that are endemic for amebiasis. These examinations are probably unnecessary in patients with chronic spontaneous urticaria acquired in Western European countries.

Conflicts of interest

None to be declared.

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