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A Case of a Man Living with HIV-1 Infection Co-Infected with Schistosomiasis

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Introduction

Human Schistosomiasis is a chronic tropical infection caused by the species Schistosoma Mansoni, Schistosoma Haematobium or Schistosoma Japonicum which alternatively reproduces sexually and asexually within a suitable host [1]. Schistosomiasis remains a global concern with 240 million cases reported globally and is primarily concentrated in the sub-Saharan African regions [2]. As this causes 200,000 deaths annually, it is important to consider Schistosomiasis as underlying diagnosis in migrants living with Human Immunodeficiency Virus (HIV) infection who presents with disparate symptoms and signs [3].

Case Presentation

A 47-year-old Zimbabwean man presented to our HIV Clinic in April 2025 with a 1-year history of painless, non-itchy, non-healing lesions on his arms and legs (Figures 1,2). His GP had given a course of antibiotics at the time, but this had no effect on the lesions. He recalled having some intense irritation at the beginning which then gradually subsided. He also remembered having an episode of bright red blood in his stools in December 2024. There were no other symptoms or signs on a systemic enquiry particularly having no fevers, weight or appetite loss. This gentleman was diagnosed with HIV-1 infection in 2017 and commenced combined antiretroviral therapy (ART). His current ART regimen is a 2-drug, single tablet ART regimen of Lamivudine and Dolutegravir. He also has a past medical history of erectile dysfunction and pre-diabetes. He is married to a female partner also living with stable HIV infection and attends our care. He denies other partners and has no children. He has no known allergies, does not smoke, take any recreational drugs and drinks alcohol socially only. He travels regularly to Zimbabwe and exercises regularly. Examination revealed skin lesions on his arms and legs which were non-inflammatory and painless in nature. The rest of his examination was normal, in particular having no palpable lymphadenopathy or organomegaly.

Figure 1

Figure 2

Investigations

He had a comprehensive infection screen having a HIV-1 viral load of <40 copies/ml with a CD4 count of 360 which is on the low side. He was negative for Hepatitis A, B and C as well as Syphilis, EBV, CMV, VZV, Cryptococcus and TB-Elispot tests. His haematology and biochemistry results (including haemoglobin electrophoresis for Sickle Cell and Thalassaemia) were essentially normal and in particular showed no eosinophilia. A Chest X-Ray was reported as normal. He had a negative Faecal

Immunochemistry Test (FIT) and urine culture tests, and a stool microscopy was negative for ova, cysts and parasites. A tropical screen test was negative for Strongyloidiasis and Leishmaniasis, but positive for Schistosomiasis showing a moderately positive antibody score of 5/9. On further questioning, he revealed that he regularly swam in the Kamoyo River in Zimbabwe which is endemic for Schistosomiasis. As this has a potential malignancy risk (particularly from the GI based Schistosoma Mansoni species) and with a history of a previous bright red lower gastrointestinal (GI) bleed, he was referred for imaging and a colonoscopy. A CT scan of his abdomen and pelvis was reported as normal, but the colonoscopy showed mucosal inflammation, colonic ulcers, mild sigmoid diverticulosis and no evidence of parasites. Three biopsies were taken from the ulcers which revealed inflammation only with no signs of malignancy. As part of current guidelines, he is now on GI monitoring and surveillance with 3-yearly colonoscopies planned as it may take many years for the parasite to release further eggs.

Management

He was treated with standard Praziquantel 20mg/kg over 1 day in 3 doses which worked out to be 2 grams given three times in one day and the patient did not describe and adverse events from the medication taken. His Schistosoma antibody titre score dropped to 3/9 after 6 months which suggested successful treatment, and he felt the skin lesions were subsiding. There are currently no markers to signify a test of cure.

Discussion

This case report demonstrates the presence of atypical, prolonged skin lesions which initially presented with intense irritation and is typical of a 'swimmer's itch' or skin penetration by the freshwater borne snail vector. The initial acute phase of Katayama Syndrome of fever, rash, myalgia and pneumonitis may have been absent due to the presence of HIV co-infection with some immunosuppression which potentially dampens any granulomatous response [4]. This further increases the risk of egg dissemination to target organs namely lungs, colon, bladder, liver and in some cases, the central nervous system [5]. It is therefore imperative to monitor potential clinical features in these areas as it was not possible to ascertain the Schistosoma species type.

With global warming and climate changes, it is important to consider tropical vector borne diseases particularly with a multitude of seemingly disparate symptoms and signs. Despite the UK having a low incidence of Schistosomiasis, 700 million individuals globally are at risk and thus it is important to take a detailed occupational and travel history particularly in returning travellers from endemic areas highlighting any local outbreaks and known risk 'pools of water' areas [6]. Low to moderate levels of antibody titres may not justify treatment in Schistosomiasis mono-infection but in the context of potential immunosuppressive HIV co-infection, it is prudent to treat.

Declarations

This patient gave full consent for this case to be presented and discussed anonymously and there are no conflicts of interest declared.

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