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Unveiling Strongyloidiasis: A Mimicker of Inflammatory Bowel Disease with Unique Clinical Presentation

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Abstract: ***This case report presents the clinical trajectory of a patient initially diagnosed with Inflammatory Bowel Disease IBD, but subsequently revealed to be suffering from Strongyloidiasis, showcasing the challenges in accurate diagnosis and management. The patient exhibited symptoms such as fever, abdominal pain, bilious vomiting, and black, tarry stools, along with diffuse sensory motor demyelination polyradiculopathy. The article discusses the diagnostic journey, highlighting the importance of differentiating between these conditions to avoid dangerous therapeutic consequences. The unique manifestations of Strongyloidiasis, its potential to mimic IBD, and the significance of definitive histological assessment are thoroughly explored.***

Keywords: Strongyloidiasis, Inflammatory Bowel Disease, Clinical Mimicry, Diagnostic Challenges, Histopathology

1. Case Presentation

A 34 year male with diffuse motor and sensory demyelinating poly radiculoneuropathy steroids, presented with fever, abdominal pain, bilious vomiting and black, tarry stools since 15 days. Examination showed severe pallor, severe epigastric tenderness. His haemoglobin was 7gm%. CECT abdomen revealed circumferential wall thickening of the pylorus and D1, D2 segments with active bleed in duodenum. Upper GI Endoscopy showed multiple large deep ulcerations with nodular and oedematous mucosa with active bleeding in Stomach, D1, D2 duodenum and proximal jejunum. With Strong suspicion of Crohns disease Steroids were continued but patient condition did not improve.

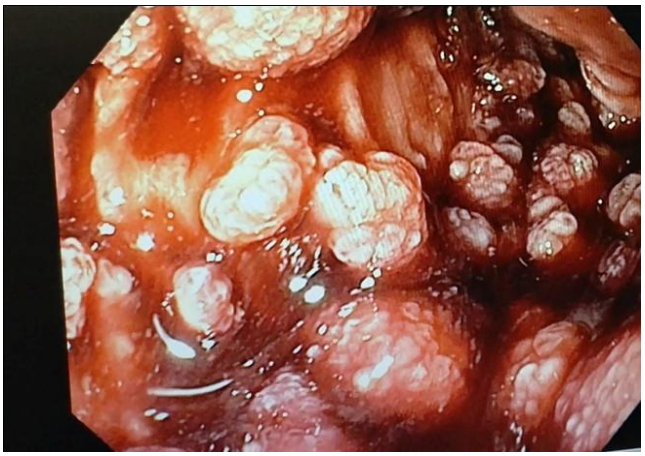

Figure 1: Luminal surface of duodenum showing multiple erosions and pseudopolyps

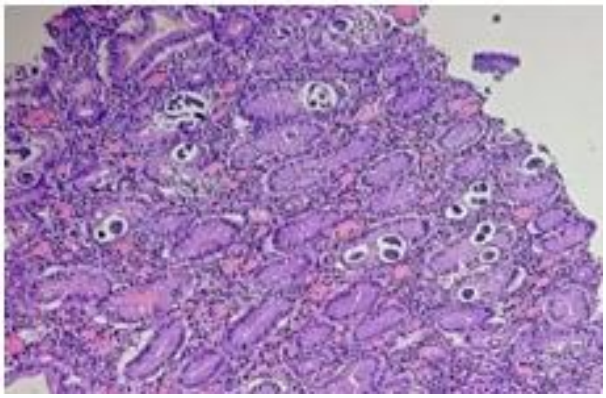

Figure 2: Numerous strongyloides eggs and larvae (H&E, 10x)

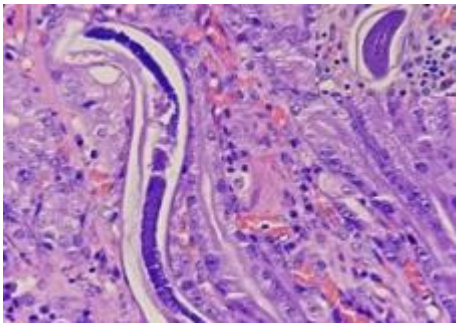

Figure 3: Adult worm with inset showing Rhabditiform larvae (H&E, 40x)

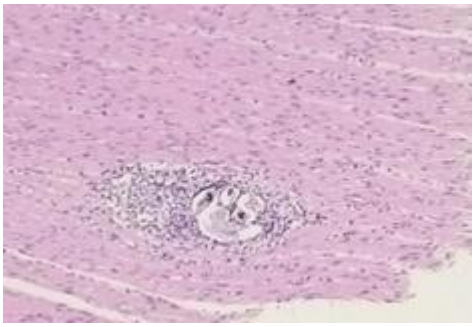

Figure 4: Strongyloides within the muscularis propria (H&E, 10x)

Endoscopic Biopsies revealed active gastritis and chronic active duodenitis, with associated strongyloides infection. . Histopathology showed eggs, rhabditiform larvae and adult worms strongyloides in the glands, crypts and muscularis propria from gastric and duodenal sections. There was no morphological evidence of IBD. Steroids were stopped and the patient was started on oral ivermectin and albendazole after which patient condition got improved

2. Discussion

Strongyloidiasis can involve many organs and, therefore, can have unspecific and unusual clinical manifestations, making the infection difficult to diagnose. Due to its unique life cycle, Strongyloides is capable of infecting a host until death of the host. Strongyloidiasis can be a severe disease, causing both hyper - infection syndrome and disseminated disease, particularly in transplantation patients. Thus, any patient who came from or traveled to an endemic area of the world may potentially be infected with this parasite, particularly if symptoms and blood and/or tissue eosinophilia are present. Clinicians should search for strongyloidiasis in any patient awaiting transplantation who has epidemiological risk factors or clinical or laboratory signs of the condition.

3. Conclusion

This case emphasizes the significance of precise diagnosis in distinguishing Strongyloidiasis from Inflammatory Bowel Disease, as misdiagnosis could lead to inappropriate immunosuppressive treatments with severe implications. Clinicians should maintain a high level of suspicion for Strongyloidiasis in patients with epidemiological risk factors or clinical signs, especially those awaiting transplantation. Awareness of the distinctive histological features of Strongyloidiasis is essential for accurate management and better patient outcomes.

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