Nosocomial Parasitic Infections

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ABSTRACT
Nosocomial infections develop a minimum of 48 h after hospital admission in patients who are free from infections at the time of admission. In addition to other agents that cause infection, the etiology of nosocomial infections involves various parasites. In light of literature data, the aim of this review was to address the agents that cause nosocomial parasitic infection.

Keywords: Hospital-acquired infections, nosocomial infection, parasites

INTRODUCTION
Nosocomial infections develop a minimum of 48 h after hospital admission in patients who are free from infections at the time of admission. In addition to other agents that cause infection, the etiology of nosocomial infections involves various parasites. In light of literature data, the aim of this review was to address the agents that cause nosocomial parasitic infection.

Waterborne Nosocomial Parasitic Agents
There can be many sources of nosocomial infections in a hospital. The most prominent among the important and controllable causes of nosocomial pathogens is the water supply of the hospital. Waterborne contagion can occur in hospitals due to showering, drinking the water, and using contaminated medical equipment washed with tap water. Hospital water sources include water tanks, showers, and tap water. There are some protozoans that run the risk of causing waterborne transmission or that have actually caused outbreaks in hospitals. Major outbreaks of waterborne Toxoplasma gondii have already been reported. Therefore, T. gondii can be an agent that potentially causes waterborne nosocomial parasitic infection (2). Diarrhea cases were seen, due to Encephalitozoon intestinalis, in the ward of immunosuppressed children in Spain between 2012 and 2013, and protozoans were subsequently isolated from the hospital’s water tank (3). In another study conducted in South Africa, free-living amoebae, at a rate of 79.4%, were isolated from water and biofilm samples collected from various departments and units of a hospital. Therefore, free-living amoebae could be a potential nosocomial agent for both immunosuppressed patients and hospital employees (4). Another protozoan that can be transmitted by water is Cryptosporidium. Just how severe an infection can be is shown by an outbreak caused by chlorine-resistant Cryptosporidium oocysts in the public water supply in Milwaukee in 1993. The outbreak affected 403,000 individuals and caused 69 deaths (5). Immunosuppressed patients in hospitals are easy targets for Cryptosporidium infection. Cryptosporidium infections can become chronic in immunosuppressed patients. This can lead to severe extraintestinal complications (6). Nosocomial Cryptosporidium infections can cause outbreaks as Cryptosporidium can be transmitted by food, direct contact, and, occasionally, hospital equipment. They generally affect patients with human immunodeficiency virus (HIV), transplant patients, patients with malignancies, and children (7). In an outbreak in China that involved 6284 pediatric patients who were admitted to three different hospitals with non-gastrointestinal complaints between 2007 and 2009, Cryptosporidium species were detected in 102 cases. However, the source could not be identified (8). To prevent the risk of Cryptosporidium oocyst, drinking water can be kept at a temperature of ≥72.4°C, or water treatment systems with a 1 µm filter can be used (9).

Transfusion-Transmitted Nosocomial Parasitic Agents
Another possible cause of nosocomial contagion is transmission by transfusion. The most well-known blood parasite that can be transmitted via transfusion is the Plasmodium species. Increasing the number of journeys to endemic areas results in an increased risk of transfusion-transmitted malaria (10). In Turkey, donors are tested for certain viral diseases and syphilis, and, as per law no. 2857, it has become obligatory to test for agents that cause malaria in blood donors. However, some limitations were implemented in the circular of the General Directorate of Treatment Services (dated October 8, 1997), and it was deemed appropriate to continue testing for malaria parasites only in donors who have a risk of contracting malaria (11). There are no recent reports of transfusion-transmitted malaria in Turkey. In a study conducted

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in 2012, only 2.97% of the 202 donors who were rejected due to the risk of malaria were found to be malaria positive (12). *Plasmodium vivax, Plasmodium malariae, Plasmodium falciparum,* and *Plasmodium ovale* in investigating the agents that cause transfusion-transmitted malaria globally were, until recently, reported as the agents, whereas the presence of transfusion-transmitted *Plasmodium knowlesi* was reported in recent years in endemic areas (13). In some regions in America, *Babesia microti,* which is a blood parasite transmitted by ticks, is the most frequently seen microbial agent that is transmitted by transfusion. A total of 160 transmission cases due to transfusion were reported in the USA between 1979 and 2009 (14). *T. gondii* is another protozoan that can be transmitted by transfusion. In a meta-analysis conducted in Iran, the seroprevalence of *T. gondii* was reported to be 34.4% in a blood donor group of 4538 individuals (15). *Leishmania* spp. and *Trypanosoma* spp. are protozoans that are rarely transmitted by transfusion. There are reports of transfusion-transmitted *Trypanosoma* infections in endemic areas within Central and South America, as well as Mexico (16). In addition, there are a few reported cases of kala-azar that are thought to have been transmitted by transfusion. The majority of the kala-azar cases are pediatric patients (17). One case in the advanced age group, which comprises a few patients, was reported in Greece in 2012. A 77-year-old patient with chronic renal failure who was treated in an intensive care unit died, and the postmortem biopsy showed amastigotes in the bone marrow. Upon investigation of the etiology, it was found that the patient had undergone cholecystectomy 3 months previously and received two units of blood transfusion. One of the donors was *Leishmania* positive according to the serological test result conducted; therefore, it was concluded that the infection was transmitted by transfusion (18). The use of leukocyte reduction filters to prevent the transmission of *Toxoplasma, Trypanosoma,* and *Leishmania* by transfusion in hospitalized patients is recommended (16, 19, 20).

**Transplantation-Transmitted Nosocomial Parasitic Agents**

Transmission by transplantation is another cause of the nosocomial transmission of parasites. Cases of malaria have been reported after kidney, liver, heart, and bone marrow transplants. The malaria agents were reported to be *P. vivax, P. falciparum, P. ovale,* and *P. malariae* (21). *T. gondii* infections are parasitic infections that can also be seen in the recipient after solid organ transplantation. The highest rate of transmission from a toxoplasma seropositive donor to the recipient is seen after heart transplants (50%), followed by liver (20%) and kidney transplants (<1%) (22). The mortality of *T. gondii* infections seen in the recipient in the post-transplantation period is high. This is because the recipient usually develops a disseminated infection. The rate was reported to be 64.5% in the follow-up of patients after kidney transplantation and 50% after heart transplantation (23, 24). There are some reports of leishmaniasis cases after transplantation. Leishmaniasis cases are usually associated with kidney transplantation (77%). However, there are also several reports of cases occurring after liver, heart, lung, pancreas, and bone marrow transplantation (25). *Strongyloides stercoralis* is a rare parasitic agent that is transmitted after transplantation. There are a few reports involving donor-derived *S. stercoralis* infection in the recipient. These infections, which result in a high mortality rate, are mostly transmitted from donors that come from areas where *S. stercoralis* is endemic (26). One of the known transmission routes of *Trypanosoma cruzi* is by transplantation (27). However, successful transplantations with the administration of prophylactic treatment from a *T. cruzi* seropositive donor to a seronegative recipient have been reported in recent years. Salvador et al. (28) reported that *T. cruzi* DNA is negative 6 months after the completion of prophylaxis in a seronegative patient who received benznidazole prophylaxis following lung transplantation from a seropositive donor.

**Hospital Equipment-Acquired Parasitic Agents**

Nosocomial parasitic infections can sometimes be acquired from contaminated hospital equipment. There are reports of *Plasmodium,* a genus of protozoans, being transmitted by injectors, contaminated gloves, and contacting bedside glucometers (29-31). *S. stercoralis* has also been reported to be transmitted from contaminated endoscopes (32). Therefore, hospital staff should rigorously check to prevent transmission from hospital equipment.

**Parasitic Agents in the Etiology of Nosocomial Diarrhea**

In the etiology of nosocomial diarrhea, in addition to bacterial and viral agents, intestinal parasites have also been reported at various concentrations. In a study conducted in Saudi Arabia, protozoans have been reported at a rate of 19.8% in the etiology of nosocomial diarrhea in patients admitted in surgery wards. *Cryptosporidium parvum,* *Blastocystis hominis,* *Giardia lamblia,* and *Entamoeba histolytica* were found at the rates of 6.6%, 6.6%, 3.5%, and 3.1%, respectively (33). In another study, *C. parvum* and *E. histolytica* were isolated at the rates of 2.5% and 6.2%, respectively, from the stool samples of children aged <5 years admitted to the pediatric ward of a hospital in Iraq with nosocomial diarrhea (34). There are other studies that investigate intestinal parasites in hospitalized patients. Intestinal parasites were detected in 18.8% and 4.8%, respectively, of asymptomatic male and female patients who were admitted to a psychiatric hospital in Ghana. These parasites were reported to be *E. histolytica/dispar* cysts, *G. lamblia* trophozoites, *C. parvum* oocysts, *Hymenolepis nana* eggs, *Trichuris trichiura* eggs, *Ascaris lumbricoides* eggs, and *S. stercoralis* larvae (35). In a study conducted in Turkey by Östman et al. (36) in 2004, nosocomial parasitic agents, including *Enterobius vermicularis,* *Giardia intestinalis,* *B. hominis,* *E. histolytica,* and *Dientamoeba fragilis,* were detected in 33.3% of the patients who were admitted to some wards and the intensive care unit in Manisa Public Hospital.

**Nosocomial Transmission of Ectoparasitic Infection Agents**

There are several infestations that occur due to ectoparasites in hospitals. Scabies, which is an ectoparasitic infection caused by *Sarcoptes scabiei,* is among these infestations. Infestation occurs by close contact, sexual intercourse, and, more rarely, due to sleeping in the same bed. Scabies typically clinically manifests with skin lesions and pruritus that aggravates at night. The form of scabies seen in patients receiving immunosuppressive treatment, patients with HIV infection, and patients with mental retardation is usually Norwegian scabies or crusted scabies (37). The host has 5–15 microorganisms in typical cases of scabies, whereas the host may have millions of microorganisms.
CONCLUSION

Although parasitic infections are commonly seen worldwide, they are usually ignored in the etiology of nosocomial infection. However, various agents that cause nosocomial parasitic infections were reported in some studies. Therefore, clinicians should definitely consider parasitic infections in the etiology of nosocomial infection, and hospital infection control committees should take measures against parasitic infections. Finally, in-hospital training sessions on this issue should be planned by the training units.

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REFERENCES

1. Rezai MS, Shahmohammadi S. Nosocomial infections in Iranian pediatric patients with burn injuries: A Review. Pediatr Rev 2015; 3: e680. [CrossRef]
2. Anaissie EJ, Penzak SR, Dignani MC. The hospital water supply as a source of nosocomial infections: a plea for action. Arch Intern Med 2002; 162: 1483-92. [CrossRef]
3. Coria P, Uzirac C, Alba A, Noemi I, Pino A, Cerva JL. The water supply of a pediatric hospital as a possible source of an outbreak of diarrhea due to Microsporidium spp. in immunocompromised patients. Rev Chilena Infectol 2016; 33: 373-9. [CrossRef]
4. Muchesa P, Leifels M, Jurzic, D, Barnard TG, Bartie C. Free-living amoebae isolated from a hospital water system in South Africa: A potential source of nosocomial and occupational infection. Water Supply 2015; 16: 70-8. [CrossRef]
5. Mac Kenzie WR, Hoxie NJ, Proctor ME, Gradus MS, Blair KA, Peterson DE, et al. A massive outbreak in Milwaukee of cryptosporidiosis infection transmitted through the water supply. N Engl J Med 1994; 331: 167-71. [CrossRef]
6. Brunet J, Lemoine JP, Pesson B, Valot S, Sauvour M, Dalle F. Ruling out nosocomial transmission of Cryptosporidium in a renal transplantation unit: case report. BMC Infect Dis 2016; 16: 363. [CrossRef]
7. Vanathy K, Parija SC, Mandal J, Hamide A, Krishnamurthy S. Cryptosporidiosis: A mini review. Trop Parasitol 2017; 7: 72-80. [CrossRef]
8. Feng Y, Wang L, Duan L, Gomez-Puerta LA, Zhang L, Zhao X, et al. Extended outbreak of cryptosporidiosis in a pediatric hospital, China. Emerg Infect Dis 2012; 18: 312-4. [CrossRef]
9. Bilung LM, Tahar AS, Yunos NE, Apun K, Lim YA, Nillian E, et al. Detection of Cryptosporidium and Cyclospora oocysts from environmental water for drinking and recreational activities in Sarawak, Malaysia. Biomed Res Int 2017; 2017: 4636420. [CrossRef]
10. Buddeberg F, Schimmer BB, Spahn DR. Transfusion-transmissible infections and transfusion-related immunomodulation. Best Pract Res Clin Anaesthesiol 2008; 22: 503-17. [CrossRef]
11. Tekin A, Kan ve Kan Urünleri Nakli ile Bulaşan Enfeksiyonlar. Konu-ralp Tip Dergisi 2011; 3: 38-45. [CrossRef]
12. Değirmenci A, Döşkaya M, Caner A, Nergis Ş, Gül K, Aydinok Y, et al. Action plan to regain unnecessary deferred blood donors due to malaria risk in Turkey. Transfus Apher Sci 2012; 46: 269-75. [CrossRef]
13. Bird EM, Paramawaran U, William T, Khoo TM, Grigg MJ, Aziz A, et al. Transfusion-transmitted severe Plasmodium knowlesi malaria in a
splenectomized patient with beta-thalassemia major in Sabah, Malaysia: a case report. Malar J 2016; 15: 357. [CrossRef]

14. Hervaldt BL, Linden JV, Bosserman E, Young C, Olkowska D, Wilson M. Transfusion-associated babesiosis in the United States: a description of cases. Ann Transf Med 2011; 155: 509-19. [CrossRef]

15. Mansouri A, Adhami Mojarrad MR, Badgar G, Abasian L, Rahmati S, Kootie W, et al. Epidemiology of Toxoplasma gondii among blood donors in Iran: A systematic review and meta-analysis. Transfus Apher Sci 2017; 56: 404-9. [CrossRef]

16. Singh G, Sehgal R. Transfusion-transmitted leishmaniasis: A case report and review of literature. Indian J Med Microbiol 2006; 24: 165-70.

17. Mpaka MA, Danil Z, Kyriakou DS, Zakynthinos E. Septic shock due to visceral leishmaniasis, probably transmitted from blood transfusion. J Infect Dev Ctries 2009; 3: 479-83. [CrossRef]

18. Cardo L, Asher L. Electron micrographic study of the removal of Trypanosoma cruzi from blood products by leukodepletion filters. Transfusion 2006; 46: 1067-8. [CrossRef]

19. Cardo L, Salata J, Harman R, Mendez J, Weina PJ. Leukodepletion filters reduce Leishmania in blood products when used at collection or at the bedside. Transfusion 2006; 46: 896-902. [CrossRef]

20. Pierotti LC, Levi ME, Di Santi SM, Segurado AC, Petersen E. Malaria disease recommendations for solid organ transplant recipients and donors. Transplantation 2018;102: S16-26. [CrossRef]

21. Renoult E, Georges E, Biava MF, Hulin C, Frimat L, Hestin D, et al. Nosocomial malaria and saline flush. Emerg Infect Dis 2005; 11: 1147-50. [CrossRef]

22. Alrifai SB, Alsaaedi A, Mahmood YA, Ali AA, Al-Kaisi LA. Prevalence and etiology of nosocomial diarrhea in children < 5 years in Tikrit teaching hospital. East Mediterr Health J 2009; 15: 1111-8. [CrossRef]

23. Cardo L, Salata J, Harman R, Mendez J, Weina PJ. Leukodepletion filters reduce Leishmania in blood products when used at collection or at the bedside. Transfusion 2006; 46: 896-902. [CrossRef]

24. Schaffner A. Pretransplant evaluation for infections in donors and recipients of solid organs. Clin Infect Dis 2001; 33: 59-14. [CrossRef]

25. Antinori S, Cascio A, Parravicini C, Bianchi R, Corbellino M. Leishmaniasis among transplant recipients. Lancet Infect Dis 2008; 8: 191-9. [CrossRef]

26. Kim JH, Kim DS, Yoon YK, Sohn JW, Kim MJ. Donor-Derived Strongyloidiasis Infection in Solid Organ Transplant Recipients: A Review and Pooled Analysis. Transplant Proc 2016; 48: 354-60. [CrossRef]

27. Dey A, Singh S. Transfusion-transmitted leishmaniasis: A case report and review of literature. Indian J Med Microbiol 2006; 24: 165-70.

28. Duedu KO, Karikari YA, Attah SK, Ayeh-Kumi PF. Prevalence of intestinal parasites among patients of a Ghanaian psychiatry hospital. BMC Res Notes 2015; 8: 651. [CrossRef]

29. Alrifai SB, Alsaaedi A, Mahmood YA, Ali AA, Al-Kaisi LA. Prevalence and etiology of nosocomial diarrhea in children < 5 years in Tikrit teaching hospital. East Mediterr Health J 2009; 15: 1111-8. [CrossRef]

30. Östan I, Mumcuoğlu I, Kurt O, Yereli K. Manisa yöresinde nozokomial bağırsak parazitozlarının araştırılması. Türkiye Parazitol Derg 2004; 28: 27-30.

31. Mowlavi G, Nateghpour M, Teimoori S, Amin A, Noohi F, Kargar F. Complications associated with esophagogastroduodenoscopy and with esophageal dilatation. Gastrointest Endosc 1976; 23: 16-9. [CrossRef]

32. Sandokji AM, Murshid KR, El-Badry AA, Al Ali KH, Shalaby SA. Infectious nosocomial diarrhea in the surgical wards: Role of parasites and microbes imply stool analysis. J T U Med Sc 2009; 4: 73-81. [CrossRef]

33. Tsutsui M, Nishiura H, Kobayashi T. Dementia-specific risks of scabies: Retrospective epidemiologic analysis of an unviled nosocomial outbreak in Japan from 1989-90. BMC Infect Dis 2005; 5: 85. [CrossRef]

34. Alrifai SB, Alsaaedi A, Mahmood YA, Ali AA, Al-Kaisi LA. Prevalence and etiology of nosocomial diarrhea in children < 5 years in Tikrit teaching hospital. East Mediterr Health J 2009; 15: 1111-8. [CrossRef]