Hypoproteinaemia and Edema Due to Giardiasis

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Abstract
The present report describes a 5-years-old girl who presented with hypoproteinaemia and generalised oedema due to giardiasis. She recovered fully 2 weeks after treatment with oral metronidazole. The emphasis is on the importance of giardiasis in children with hypoproteinaemia of obscure aetiology.


Keywords • Giardiasis • hypoproteinaemia • edema • giardia

Introduction

Giardiasis due to Giardia intestinalis is one of the most common protozoan intestinal diseases worldwide. The parasite infests the human duodenum and generally results in asymptomatic intestinal colonisation; but in many cases it may cause chronic or acute diarrhea and malabsorption of fat; fat-soluble vitamins and disaccharides.1,2 However, in giardiasis hypoproteinaemia and oedema are very rarely reported.3,4 The present report describes a young child with generalised oedema and hypoproteinaemia due to giardiasis.

Case Presentation

A 5-year-old girl who lives in London with her parents was admitted to the Great Ormond University Hospital, London with swelling of the legs, face and abdominal distension which had been present for 4 days. She also had a 5-weeks history of abdominal discomfort and passing loose stools. Her relatives live in Shiraz, Iran where giardiasis is endemic and the girl had visited them 4 months prior to admission.

Physical examination revealed a pale, irritable child with generalised oedema and abdominal distension. She was 110 cm tall and weighed 15 kg. Respiratory and cardio-vascular examination proved normal. There was no ascites but her abdomen was distended and her spleen and liver were not palpable. Laboratory tests yielded the following results; A WBC count of 9800/ml, RBC distribution with 25%, 0.9% reticulocytes, haemoglobin level of 9.5 gr/dl, MCV 54 fl and a platelet count of 456000/ml. Hypochromia and microcytosis was observed in peripheral blood smear. The serum iron level was 35ug/dl(normal 45-140), TIBC 390 ug/dl(normal 20-350), serum ferritin 15 ug/dl (normal 20-300) and 10% transferrin saturation. The total serum protein and albumin level were 4.5 g/dl(normal 6-8) and 2.5 g/dl(normal 3.5-5) respectively. The prothrombin, activated partial thromboplastin times, serum transaminases, bilirubin, electro-
lytes, glucose, blood urea nitrogen, creatinine level, urinalysis and 24-hours urinary protein excretions were all normal. Tests for serum immunoglobulin A, anti-endomysial anti body, IgA and IgG anti-gliadin antibody were all negative. Sweat chloride concentration and serum IgA, IgG, IgM levels were normal.

Alpha-1-antitrypsin clearance was calculated from a 24-hour stool collection and found to be markedly elevated at 375 ml/24 (normal<30). Direct stool examination showed large numbers of G. intestinalis trophozoites.

Based on the clinical and laboratory findings, intestinal protein loss was obvious, caused either by giardiasis or gluten-sensitive enteropathy. She was treated with metronidazole for 10 days and kept on her regular diet. The generalised oedema began to disappear after 3 days of therapy and totally disappeared after 14 days. Serum total protein measured 5.8 g/dl (normal 6-8) and albumin 4.2 g/dl (normal 3.5-5 ). She was prescribed an 8- week course of 4 mg/kg oral iron at post –treatment examination because of iron deficiency anemia. Physical examination on completion of iron therapy was normal, as were serum immunoglobulin, total protein, albumin and hemoglobin levels.

Repeat testing also proved negative for anti-gliadin and anti-endomysium antibodies. The stool alpha-1-antitrypsin test was normal at the end of treatment period. Giardia cysts or trophozoites were not observed in the stool and the girl remained symptom free while on her regular diet during 4 months of follow-up.

Discussion

Although giardiasis has been suspected to be a potential cause of protein-losing enteropathy in children,\(^5, 3, 4\) this is the first case proved by laboratory findings. The patient presented with hypoproteinemia, oedema and anemia. Her normal liver function, urinalysis and normal dietary protein intake were suggestive of protein loss via the gastrointestinal tract and this was proven by stool alpha-1-antitrypsin determinations. Light microscopic studies of intestinal mucosa have shown that trophozoites of G. intestinalis attach to epithelial cells and mucous filaments in the intervillous space. This mechanically blocks and inflames the mucosa and may lead to protein malabsorption and loss of protein.\(^2\)

Giardiasis can be associated with low hemoglobin levels and antiparasitic treatment might improve iron levels in such cases.\(^6\) However, in the present case the oral iron therapy was necessary as the patient continued to have low hemoglobin levels after a course of metronidazole therapy. Impaired iron absorption and blood loss from the intestine are the possible underlying mechanisms of anemia in giardiasis.\(^5, 7\) The high prevalence of Giardia infection in children in developing countries makes giardiasis an important health problem and the present report suggest that it is important to keep giardiasis in mind as a possible cause of hypoalbuminaemia due to the protein-losing enteropathy.

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References


