Cerebrospinal Fluid Involvement in a Case of Visceral Leishmaniasis Associated with Hemophagocytic Lymphohistiocytosis

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ABSTRACT Hemophagocytic Lymphohistiocytosis (HLH) implies a benign generalized histiocytic proliferate with erythrophagocytosis and it includes familial hemophagocytic lymphohistiocytosis and secondary hemophagocytosis. Spinal fluid changes like mild to moderate pleocytosis (most of the cells are lymphocytes and macrophages) and sometimes hemophagocytosis are seen in primary HLH but are not reported in secondary HLH. Here we report a case of a previously healthy 10 months old male infant who was diagnosed as familial HLH with evidence of CSF hemophagocytosis. He was started on the HLH 2004 treatment protocol with no improvement. A second bone marrow aspiration revealed leishmania donovani antibodies and he was started on anti-leishmania treatment with dramatic response. To the best of our knowledge, this is the first case of secondary HLH with evidence of hemophagocytosis in cerebrospinal fluid.

Key words: Lymphohistiocytosis, hemophagocytic; Leishmaniasis; Cerebrospinal fluid; Case Report; Oman.
presented with CNS symptoms as well as evidence of CSF haemophagocytosis.

**CASE REPORT**

A 10 month old Omani male infant, was referred to Sultan Qaboos University Hospital, (SQUH) Oman, from a peripheral Omani hospital as a suspected case of HLH. He was admitted to SQUH with a history of high grade fever associated with diarrhoea and vomiting for the previous two weeks. He was a product of a consanguineous marriage, with no past history of diseases or previous admissions to hospitals; however, there was the unexplained early infant death of one of his siblings in his family history.

On examination, he was sick looking, febrile, pale and had tachycardia. There was splenomegaly of 10 cm below the left costal margin and a large liver of 7 cm. After his admission, he developed generalized convulsions that responded to IV Phenytonin treatment (loading followed by maintenance).

His complete blood count showed evidence of pancytopenia with WBC 2.37x10⁹/L; absolute neutrophil count was 0.36x10⁹/L and platelets were 14.1x10⁹/L. Other laboratory investigations revealed: lactate dehydrogenase 829; erythrocyte sedimentation rate 47; C-reactive protein 65; albumin 24; serum ferritin 4687 ng/ml that increased to 25973 µg/ml within few days. Serum triglycerides were 3.0 mmol/L and fibrinogen was 1.9 g/L. Prothrombin time was 14 seconds and activated partial thromboplastin time was 55 seconds. Renal and liver function tests were within normal limits and hepatitis and HIV serology tests were negative. The bone marrow aspiration (BMA) was completely normal. The cerebrospinal fluid showed evidence of haemophagocytosis, Genetic study for perforin, Munc and syntaxin II genes were done in the SQUH genetic laboratory and found to be negative. The results of these tests usually come after one month. A provisional diagnosis of primary (familial) HLH was established on the basis of the young age of presentation, the unexplained death of a 6 months old sibling and the severe clinical course.

Subsequently, treatment with HLH 2004 Protocol was started for 2 weeks. The child’s fever continued to spike with no improvement. As per protocol, after 2 weeks, a second BMA was done and revealed *leishmania donovani* antibodies. The HLH 2004 protocol was stopped and IV Ambisome was started with no clinical improvement. Treatment was changed to Na-Stibogluconate (20mg/kg/day). He received a full course of 21 days and improved significantly with disappearance of the fever and organomegaly. The BMA showed no evidence of leishmania or haemophagocytosis. The patient was subsequently discharged home.

At a follow up visit after 6 months, he maintained his general well being and was completely normal.

**DISCUSSION**

HLH implies a benign, generalized histiocytic proliferation with erythrophagocytosis and it includes FHLH and secondary haemophagocytic syndrome associated with viral infections, protozoal infections and malignancy. These disorders are indistinguishable pathologically and are characterized as ‘reactive’ disorders of antigen-presenting and antigen-processing histiocytes. The hallmark of these disorders is marked haemophagocytosis in the lymphoreticular system. The symptoms are supposed to be due to hyperactivity of macrophages. The cause of the inappropriate immune activation in FHLH has been shown in some families to be due to the genetic encoding of perforin, Munc and syntaxin II. The
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Typical HLH is diagnosed on the basis of Henter et al’s guidelines: (a) Clinical criteria: fever and splenomegaly (both to be present); (b) Laboratory criteria: cytopenias (affecting 2 of 3 lineages in the peripheral blood); haemoglobin (<9 g/L); platelets (<100 x 10⁹/L); neutrophils (<1.0x10⁹); hypertriglyceridemia and/or hypofibrinogenemia fasting triglycerides ≥2.0 mmol/L or ≥3 SD of the normal value for age; fibrinogen (≥1.5 g/L or ≥3 SD); (c) Histopathological criteria: haemophagocytosis in the bone marrow or spleen or lymph nodes, cerebrospinal fluid (CSF) and no evidence of malignancy. Neurological symptoms may complicate and sometimes dominate the clinical course of the familial cases. Hepatic abnormalities, including elevated serum transaminases or hyperbilirubinemia, appear to be related to the degree of liver involvement. Elevated ferritin, lactate and coagulation derangement are also common during active disease. The haemophagocytosis mostly affects erythrocytes, but occasionally also platelets and leukocytes.

Infection by the protozoan pathogen leishmania is a public health problem in certain regions of Oman such as North Batinah. Although, there are a number of different species, all of which are transmitted by phlebotomine sand flies, there are only two primary types of clinical disease: cutaneous and visceral leishmaniasis (VL). Visceral leishmaniasis revealed by haemophagocytic syndrome (HS) is an extremely rare event that can cause considerable diagnostic difficulty. The first case of leishmaniasis revealed by a reactive HS was reported by Matzner et al and concerned a 22 year old adult. CNS involvement has been almost totally linked to primary FHLH. In a retrospective study on visceral leishmaniasis carried out on 33 Omani children from 1993 to 1999 at Sultan Qaboos University Hospital, Oman, there was no haemophagocytosis. Two children had CNS involvement in the form of encephalopathy, but there was no haemophagocytosis in the CSF.

In another study regarding the current status of HLH in infants and children from the Division of Pediatrics, Children’s Research Hospital, Kyoto, Japan, 82 cases of pediatric HLH without familial inheritance were studied. There were CNS symptoms in 32.3 cases, but none of them had spinal fluid haemophagocytosis. All of the cases revealed lymphohistiocytosis with the presence of haemophagocytosis in bone marrow and reticuloendothelial cells. From the Indian subcontinent, there are reports of secondary HLH following malaria and leishmaniasis (also called ‘kala-azar’). In 14 cases of secondary HLH following malaria and kala-azar there were no features of CSF haemophagocytosis. This is probably the first case of secondary HLH that presented with CNS symptoms with evidence of CSF haemophagocytosis.

References


