Urban outbreak of acute Chagas disease in Amazon region of Brazil: four-year follow-up after treatment with benznidazole

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The objective of this report is to describe treatment outcomes over a four-year period of patients with acute Chagas disease in the Amazon region of Brazil. An outbreak of Chagas disease in a low-income district of urban Belém, in September 2000, affected 11 people simultaneously, indicating the likelihood of indirect, oral transmission of Trypanosoma cruzi. Prior to treatment, patients underwent physical and clinical tests; blood samples were processed with immunofluorescence assay (IFA) and quantitative buffy coat (QBC). Following treatment with benznidazole, parasitological and serologic tests (artificial xenodiagnosis and blood culture for T. cruzi), electrocardiogram, and echocardiogram were administered at intervals over a four-year period. Four years after treatment for acute Chagas disease, all patients presented with negative parasitological tests and persistent IgG anti-T. cruzi antibodies with lowered titers; three patients presented electrocardiogram abnormalities consistent with chronic Chagas disease or sequel of acute disease. The satisfactory response to treatment and relevance of serial parasitological examinations of patients with acute Chagas disease are discussed.

Benznidazole; Chagas cardiomyopathy; Chagas disease; disease outbreaks; disease transmission; immunologic tests; Trypanosoma cruzi; Brazil.

Despite efforts to eliminate American trypanosomiasis (Chagas disease) through vector control, the disease continues to be a public health problem in Latin America. The infection is caused by Trypanosoma cruzi, a parasite transmitted primarily by triatomine vectors found in Mexico and Central and South America. Chagas disease is a complex zoonosis, and the life cycle of the parasite involves a variety of mammal hosts. T. cruzi infection in humans manifests with acute symptomatic or asymptomatic phases and progressive chronic forms with myocardial, esophageal, and intestinal involvement.

An estimated 15 million people in Latin America are infected with T. cruzi, but acute cases are detected in only 1%–2% of those infected (1). Some authors point out that there has been an increase in the number of acute cases recorded in some Latin American countries, leading to predictions that the situation regarding Chagas at the beginning of the 21st century will be similar to that in the early years of the 20th century (2, 3).

Prior to 1996, acute Chagas disease was rarely reported in the Amazon re-
region of Brazil, despite evidence of the complete enzootic cycle of T. cruzi in the region. Outbreaks have since been reported in the region, characterized as short outbreaks involving 2 to 16 acute cases per episode (4). Only five chronic cases are considered autochthonous to the Amazon region. Two of the five patients were symptom-free, two had dilated cardiomyopathy, and one had the digestive form of Chagas disease (5–7).

Acute Chagas disease in the Amazon region of Brazil was first documented by Shaw et al. in 1969 in a low-income area of Belém, Pará state (8). The outbreak involved four family members who fell ill simultaneously in 1968. The absence of triatominina vectors in the family dwelling suggested oral transmission of T. cruzi for the first time in Brazil's Amazon region (8).

Belém is located between Guajará Bay and the Guaná River and has an urban area of 516 km² with some 1.3 million inhabitants. Preserved forest areas, such as Utinga National Park are on the outskirts of the city. Between 1967 and 1977, single adult insects infected with T. cruzi, particularly Panstrongylus geniculatus and Rhodnius pictipes, were found in households of poor, low-lying suburbs of Belém (9, 10). Mammals trapped in forest areas bordering the Pedreira district of Belém, where the 1968 outbreak occurred, had a high prevalence of T. cruzi-like trypanosomes (9, 10).

Outbreaks in the Amazon region are a target of epidemiological surveillance programs by the Brazilian Ministry of Health because of suspected oral transmission of the parasite. It is problematic to distinguish clinical features of acute Chagas disease in patients infected by vectors and those infected by the oral route. In part this is due to difficulties in obtaining data on acute cases from endemic areas where transmission typically occurs through vectors. Outbreaks involving oral transmission show prolonged febrile illness, a broad spectrum of symptoms, high mortality rates between outbreaks, and no inoculation sites on the body (11, 12).

When the acute phase of T. cruzi infection is not detected and treated, it can persist in the indeterminate phase for the life of a patient. Treatment of the acute infection with tripanocidal drugs (benznidazole) has moderate efficacy (60%) in eradicating parasites, mainly in patients with a prolonged subacute phase (11, 12). Tri-
examined for trypanosomes at 400× magnification one and two months after feeding. Leukocyte counts and hemoglobin concentration studies were made before and after treatment.

Standard 12-lead electrocardiograms (ECG) with the patient at rest and echocardiograms were performed during the first week of treatment and in the third month and fourth year of post-treatment follow-up.

Treatment procedures

The 11 confirmed cases in the study were treated with benznidazole at doses of 5 to 7 mg/Kg daily for 60 to 90 days (17). Ten patients received daily treatment for 60 days and, because of treatment failure, one patient received treatment for 90 days.

The ethics committee of the Evandro Chagas Institute approved the study, and all subjects gave informed consent for their participation in this investigation.

RESULTS

All 11 patients included in this study presented febrile illness and asthenia beginning 7 or 9 September 2000, lasting between 23 and 43 days. Other reported symptoms and signs were dyspnea, chills, abdominal pain, vomiting, paleness, myalgia, arthralgia, leg swelling, face swelling, cutaneous rash, coughing, and variable degrees of myositis, mainly in the females (Figure 1). Three patients had palpitations, tachycardia, and chest pain. Six patients developed myocarditis and five presented with myopericarditis during the acute phase. Two had serious cardiac manifestations during the acute phase of the disease and required hospitalization. Neither Romana sign nor other indication of insect inoculation was found on physical examination of the patients.

Parasitological tests made immediately after the completion of 30 days of treatment were negative in nine patients. Xenodiagnosis was positive for one 31-year-old female at the 30th day of treatment and positive for another 58-year-old female on the 60th day of treatment, indicating treatment failure (Table 1).

Follow-up serologic tests in all patients detected IgM antibodies for a short period and persistent IgG anti-*T. cruzi* antibodies four years after acute infection. No patients had negative serologic tests until September 2004, four years after treatment (Figure 2).

During the acute phase, five patients presented with anemia (hemoglobin 8.9–10.2 g/dL). Leukocyte counts increased in two patients who presented with acute pulmonary infections simultaneously with acute Chagas disease. Four patients had lymphocytosis (1 702–8 979 lymphocytes/mm³) during the acute illness, with improvement after two months. Three patients presented with leukopenia (3 200–4 700 leukocytes/mm³).

ECG and echocardiogram results during the acute illness and at four years post-treatment are shown in Table 2. Five patients had no ECG changes through the follow-up period. One patient had low QRS voltage due to pericardial effusion. Four patients presented non-specific ventricular repolarization with or without associated conduction disturbances. Of these four, the ECGs of two patients

![FIGURE 1. Manifestation of signs and symptoms in 11 patients with acute Chagas disease in Belém, Brazil, 2000](image)

<table>
<thead>
<tr>
<th>TABLE 1. Parasitological results in follow-up of treatment of 11 patients presenting acute Chagas disease, Belém, Brazil; 2000–2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Days following treatment</strong></td>
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<tr>
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<td></td>
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<tr>
<td>First day</td>
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<tr>
<td>30 days</td>
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<td>60 days</td>
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<tr>
<td>1 year</td>
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<tr>
<td>3 years</td>
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normalised, one 17-year-old female remained with atrioventricular (AV) dissociation and intermittent left bundle-branch block, and one 15-year-old female developed right bundle-branch block plus fascicular left bundle-branch block. Three patients presented pericardial effusion that resolved shortly after onset of treatment. One 28-year-old male had a moderate amount of fluid in the pericardium and significant myositis in both lower limbs. Echocardiography of a 70-year-old female with prior history of arterial hypertension showed abnormalities before and after treatment that were consistent with diastolic dysfunction and signs of hypertrophy due to her previous condition. None of the patients presented decreased ejection fraction either during acute illness or later (see Table 2).

All 40 contacts (relatives and neighbors) examined were asymptomatic and had negative serologic tests.

**DISCUSSION**

The signs and symptoms described in the Chagas outbreak reviewed in this study reveal a prolonged, febrile syndrome illness and positive parasitological and serologic tests. All patients showed persistent titers of IgG anti-*T. cruzi* antibodies four years after acute infection, but with an important decrease over time. While these lowered titers suggest a high possibility of cure, the outcomes for the patients remain uncertain.

Despite the low sensitivity of parasitological tests in cure assessment, we performed these tests during, before, and after treatment. Xenodiagnosis showed that two patients had persistent parasitemia at days 30 and 60 of treatment. Both continued medication for an additional 30 days. There was no difference in response to treatment between the pa-

**TABLE 2. Results of electrocardiograms and echocardiograms during acute phase and four years post-treatment in 11 Chagas disease patients in Belém, Brazil, 2000–2004**

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age (years)</th>
<th>Gender</th>
<th>Acute phase electrocardiogram results</th>
<th>Post-treatment electrocardiogram results (fourth year)</th>
<th>Acute phase echocardiogram results</th>
<th>Post-treatment echocardiogram results (fourth year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24</td>
<td>M</td>
<td>Low QRS voltage</td>
<td>Normal</td>
<td>Mild pericardial effusion; EF = 64%</td>
<td>Normal</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
<td>F</td>
<td>Normal</td>
<td>Normal</td>
<td>. . .</td>
<td>Normal</td>
</tr>
<tr>
<td>3</td>
<td>31</td>
<td>F</td>
<td>Left axis deviation</td>
<td>Left axis deviation, left anterior fascicular block</td>
<td>Normal; EF = 69%</td>
<td>Normal</td>
</tr>
<tr>
<td>4</td>
<td>70</td>
<td>F</td>
<td>Non-specific repolarization changes</td>
<td>Normal</td>
<td>Left ventricular hypertrophy; diastolic dysfunction; pericardial effusion; EF = 66%</td>
<td>Diastolic dysfunction; left ventricular hypertrophy</td>
</tr>
<tr>
<td>5</td>
<td>28</td>
<td>M</td>
<td>First-degree atrioventricular block; non-specific repolarization changes</td>
<td>Normal</td>
<td>Moderate pericardial effusion; EF = 63%</td>
<td>Normal</td>
</tr>
<tr>
<td>6</td>
<td>17</td>
<td>F</td>
<td>Non-specific repolarization changes; atrioventricular dissociation; left axis deviation</td>
<td>Atrioventricular dissociation; intermittent left bundle-branch block</td>
<td>Mild pericardial effusion; left ventricular dilatation with diffuse hypokinesia; moderate mitral regurgitation; EF= 56%</td>
<td>Normal</td>
</tr>
<tr>
<td>7</td>
<td>22</td>
<td>M</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal; EF= 66%</td>
<td>Normal</td>
</tr>
<tr>
<td>8</td>
<td>19</td>
<td>M</td>
<td>Normal</td>
<td>Normal</td>
<td>. . .</td>
<td>Normal</td>
</tr>
<tr>
<td>9</td>
<td>15</td>
<td>F</td>
<td>Non-specific repolarization changes</td>
<td>Right bundle-branch block, left posterior fascicular block</td>
<td>Normal; EF= 74%</td>
<td>Normal</td>
</tr>
<tr>
<td>10</td>
<td>24</td>
<td>F</td>
<td>Normal</td>
<td>Normal</td>
<td>Mild pericardial effusion; EF= 70%</td>
<td>Normal</td>
</tr>
<tr>
<td>11</td>
<td>58</td>
<td>F</td>
<td>Normal</td>
<td>Normal</td>
<td>Left ventricular hypertrophy; EF = 68%</td>
<td>Normal</td>
</tr>
</tbody>
</table>

QRS= QRS complex, EF = Ejection fraction; . . . = echocardiogram not carried out.
Patient receiving benznidazole for 90 days and the patient receiving it for 60 days. Four years after treatment, both of these patients showed low IgG antibody titers (1/40) and negative parasitological tests. We cannot be certain that these two patients followed the prescribed dosing schedules during the first 60 days of treatment.

Our findings show the potential benefits of benznidazole for clinical improvement of acute cases. However, the failure of benznidazole to clear parasitemia (as shown by xenodiagnosis and blood culture) in two patients by days 30 and 60 of treatment, suggests the need for new treatment schedules with longer duration. In addition, we do not know the significance of low IgG titers during the follow-up series of tests, but we hypothesize that it represents immunological memory rather than parasite persistence. More extensive follow-up or other effective tests are necessary to evaluate cure.

The rates of ECG abnormalities and cardiac disease during the acute phase reported in this study are similar to those reported in endemic areas (19, 20). Abnormalities compatible with acute Chagas disease showed rapid clinical improvement following treatment. One patient showed minimal echocardiography alterations consistent with acute myocarditis that disappeared after treatment. Similar results were encountered in a study of 37 patients with acute Chagas disease in outbreaks in the municipalities of Abaetetuba and Cametá, both in Pará state in Brazil’s Amazon region. In the Cametá outbreak, two deaths due to acute myopericarditis occurred (22, 23). In our study, three patients presented mild pericardial effusion without relationship either to ECG conduction disturbances or low ejection fraction in echocardiogram. This suggests that the presence of pericardial effusion may be part of a generalized process of inflammation with important repercussions for the pericardium rather than the myocardium. While myocarditis is more consistent with acute Chagas disease, pericarditis is described as a consequence of direct parasite lesions in acute cases from endemic areas, and should not be disregarded in cases in the Amazon region.

Epidemiologic investigation found no signs of triatomine vectors in the households of the patients and their contacts in our study. Onset of symptoms occurred within two to four days for all 11 of the affected individuals, suggesting oral transmission due to indirect contact with triatomine bugs. The presence of triatomines infected with T. cruzi in Pedreira district has been documented, as well as a 17.4% T. cruzi infection rate in wild mammals on the outskirts and in forests bordering Belém, mainly in the

FIGURE 3. Location of triatomine bugs collected in districts of Belém, Brazil, 1967–1977

Source: Adapted by N. Veiga from Lainson et al. 1979. Used with permission.
National Park of Utinga located near the Pedreira district (see the map in Figure 3) (9). This could be evidence of indirect and accidental human contact with this vector in this well-defined area of Belém, where acute cases of Chagas disease have occurred. The four families included in this study did not participate in gatherings where they would have shared food. It is improbable that infected triatomine bugs could infect three or more people concurrently, and that symptoms would present nearly simultaneously. We suggest that transmission of T. cruzi in this group of patients occurred orally, possibly involving an unprocessed beverage frequently consumed by this population. When prepared in unclean conditions this drink could be contaminated, as documented in a similar outbreak in Amapá state (24).

Brazilian researchers suggest that the increased risk for endemic Chagas disease in the Amazon is related to deforestation, population settlements, shifting cultivation, human colonization of the vector’s natural ecotopes, and human migration to the Amazon region from endemic areas. Chagas disease in humans has been described in limited geographic areas in the Amazon region, especially northeastern Pará state and southeastern Amapá state, related to sylvatic and port areas or areas that have experienced rapid urbanization and increased population density in the last 10 years (4, 25–29). In northeastern Pará state, an extensive highway project may have caused an important ecological imbalance that has contributed to disturbing triatomine ecotopes.

There are many unanswered questions regarding contact between sylvatic vectors and human hosts of Trypanosomiasis in the Brazilian Amazon. We know that acute infection is benign in the majority of cases of Chagas, but poor clinical outcomes are possible when delayed diagnosis and delayed host response occurs. Serious pericarditis may be lethal to patients in the acute phase of the disease.

Clinical outcomes of patients during this brief follow-up of an urban Trypanosomiasis outbreak suggest that chronic Chagas disease in the Amazon region may be underestimated, although all patients in this study were symptomatic during the acute phase, unlike those affected in endemic areas. The authors underscore the need for a strong surveillance system for Chagas disease in the Amazon region of Brazil.

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REFERENCES

El objetivo de este informe es describir los resultados del tratamiento para la enfermedad aguda de Chagas durante un seguimiento de cuatro años en pacientes de la región amazónica de Brasil. Un brote de la enfermedad de Chagas en un distrito de bajos ingresos de la parte urbana de Belém afectó simultáneamente a 11 personas en septiembre de 2000; al parecer, la transmisión de *Trypanosoma cruzi* fue indirecta por vía oral. Antes del tratamiento, los pacientes se sometieron a un examen físico y pruebas clínicas; las muestras de sangre se estudiaron mediante inmunofluorescencia indirecta y análisis cuantitativo de la capa leucocitaria (buffy coat). Después del tratamiento con benznidazol se realizaron pruebas parasitológicas y serológicas (xenodiagnóstico artificial y hemocultivo de *T. cruzi*), electrocardiogramas y ecocardiogramas periódicos durante cuatro años. Cuatro años después del tratamiento por enfermedad aguda de Chagas, todos los pacientes eran negativos en los análisis parasitológicos y disminuyeron los títulos de anticuerpos IgM anti-*T. cruzi* persistentes; tres pacientes presentaron alteraciones electrocardiográficas indicadoras de enfermedad crónica de Chagas o de secuelas de la enfermedad aguda. Se discute la respuesta satisfactoria al tratamiento y la importancia de los análisis parasitológicos seriados de los pacientes con enfermedad aguda de Chagas.

Cardiomiopatía chagásica, enfermedad de Chagas, brotes de enfermedades, transmisión de enfermedad, pruebas inmunológicas, *Trypanosoma cruzi*, Brasil.