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Therapy of parasitic infections: a large task for few drugs

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The overall mortality rate of imported Plasmodium falciparum malaria in Europe is about 0.3%. Quinine has been the only option for parenteral therapy. However intravenous artesunate becomes a more widely available. It is more effective than quinine in severe malaria in endemic countries. Artesunate is a fast-acting acting drug, efficicient against several parasite stages including gametocytes with reduction of cytoadherence. However data on tolerability and safety are limited. As cases of late onset haemolysis have been reported in returning travellers, its use must be cautious. For Old World localized cutaneous leishmaniasis (LCL), the main treatment remains pentavalent antimonial agents given intralesionally +/- cryotherapy. Topical treatment with paromycine ointment could be an option in L.tropica. Pentavalent antimonials are the drug of choice for New World LCL. Nonetheless, liposomal amphotericine B, pentamidine isethionate and miltefosine could be attractive alternatives according to the culprit species. In case of acute schistosomiasis praziquantel does not prevent the chronic phase of the disease and is associated with exacerbation of signs in approximately 50% of cases. Corticosteroids may be recommended in severe forms. The most convenient treatment of Hookworm related cutaneous larva migrans is one single dose of ivermectin (200 mg/kg bodyweight) (cure rates: 94%-100%). Oral or topical albendazole is another option. Presumptive treatment for strongyloidiasis (in case of corticosteroid therapy in migrants and travellers) should be ivermectin (200 mcg/kg) for two days or repeated two weeks later. Oral albendazole (400–800 mg/d, at least for 3 days) is as an option. Treatments for neurocysticercosis include praziquantel and albendazole. Eradication of Taenia solium may also need treatment of tapeworm carriers with niclosamide (2 grams) or praziquantel (5mg/kg). Corticosteroids are indicated in situations at risk of severe complication (ocular cysticercosis, ventricular cysts or diffuse brain infections). Treatments for gnathostomiasis are albendazole (400 to 800 mg per day for 21 days) (cure rates : 78.5% to 94%) and ivermectin (0.2 mg/kg for two days)(cure rates : 100%). However albendazole was less effective in series of imported gnathostomiasis (cure rate 41.7%) than in autochthonous gnathostomiasis.