

Epidemiology

Chagas disease (American trypanosomiasis) is caused by the protozoan parasite *Trypanosoma cruzi*, and transmitted to humans by infected triatomine bugs, and less commonly by transfusion, organ transplant, from mother to infant, and in rare instances, by ingestion of contaminated food or drink.¹⁻⁴ The hematophagous triatomine vectors defecate during or immediately after feeding on a person. The parasite is present in large numbers in the feces of infected bugs, and enters the human body through the bite wound, or through the intact conjunctiva or other mucous membrane.

Vector-borne transmission occurs only in the Americas, where an estimated 8 to 10 million people have Chagas disease.⁵ Historically, transmission occurred largely in rural areas in Latin America, where houses built of mud brick are vulnerable to colonization by the triatomine vectors.⁴ In such areas, Chagas disease usually is acquired in childhood. In the last several decades, successful vector control programs have substantially decreased transmission rates in much of Latin America, and large-scale migration has brought infected individuals to cities both within and outside of Latin America.^{4,6,7}

Infected triatomine vectors and *T. cruzi*-infected domestic and wild animals are found across the southern half of the United States, and rare cases of autochthonous vector-borne transmission have been documented.⁸⁻¹⁰ However, the risk of vector-borne infection within the United States appears to be very low, probably because of better housing conditions and less efficient vectors.¹¹ *T. cruzi* also can be transmitted in blood; screening of blood donations for anti-*T. cruzi* antibodies was introduced in 2007 after the U.S. Food and Drug Administration approved a serological test for that purpose.^{12,13} Currently an estimated 90% of the U.S. blood supply is screened.

For these reasons, the vast majority of the estimated 300,000 individuals in the United States with Chagas disease are thought to be immigrants who acquired the infection while living in endemic areas in Latin America.¹⁴ In patients chronically infected with *T. cruzi* as a result of prior infection, profound immunosuppression (e.g., due to advanced HIV disease) may lead to reactivation disease characterized by parasitemia, associated with increased intracellular parasite replication and lack of immunological control of the infection.¹⁵⁻¹⁷

Clinical Manifestations

The acute phase of *T. cruzi* infection, which typically goes unrecognized, lasts up to 90 days and is characterized by circulating trypomastigotes detectable on microscopy of fresh blood or buffy coat smears.^{2,4} If the portal of infection was the conjunctiva, patients may develop the characteristic Romaña's sign—unilateral painless swelling of the upper and lower eyelids—which usually lasts several weeks. The other symptoms of acute infection are usually limited to a non-specific febrile illness. In a small proportion of patients, however, acute, life-threatening myocarditis or meningoencephalitis may occur.^{2,4} At the end of the acute phase, typically 60 to 90 days after infection, parasitemia falls below levels detectable by microscopy, and in the absence of effective etiologic treatment, *T. cruzi* infection passes into the chronic phase.^{2,18}

Most patients with chronic *T. cruzi* infection have no signs or symptoms, and are said to have the indeterminate form of the disease. Over the course of their lives, 20% to 30% of them will progress to clinically evident Chagas disease, most commonly cardiomyopathy.^{2,18} The earliest manifestations are usually conduction system abnormalities, such as right bundle branch block, alone or in combination with frequent premature ventricular contractions, which may develop years to decades after infection.^{4,19} Over time, the disease may progress to higher-grade heart block and complex ventricular arrhythmias. In patients with more advanced cardiomyopathy, congestive heart failure, ventricular aneurysm, and complete heart block are poor prognostic signs, associated with high rates of short-term mortality, including sudden death.²⁰ Chagas digestive disease is much less common than cardiomyopathy, and seen predominantly in infected patients

in parts of Brazil and Bolivia.²¹ Dysphagia is the characteristic symptom of megaesophagus, and prolonged constipation is the most common complaint associated with megacolon.

T. cruzi reactivation during the chronic phase of Chagas disease is characterized by a return to high levels of parasite replication and parasitemia, usually detectable by microscopy, and can occur in the settings of immunosuppressive therapy to prevent transplant rejection and cancer chemotherapy, as well as in HIV-infected patients.^{16,22-26} Even in the absence of symptoms, patients with chronic Chagas disease who are HIV-co-infected have significantly higher levels of *T. cruzi* parasitemia than their immunocompetent counterparts.²⁵ Most cases of clinically apparent reactivation occur in patients with CD4 T lymphocyte cell counts <200 cells/mm³, a history of prior opportunistic infections, or both.¹⁶

The clinical features of reactivated Chagas disease in patients with HIV infection differ from those observed in individuals who are immunosuppressed for other reasons. The most common manifestations consist of *T. cruzi* meningoencephalitis, with or without brain abscesses (chagomas).^{15,16,27,28} The presentation may be confused with central nervous system (CNS) toxoplasmosis and should be considered in the differential diagnosis of AIDS patients with CNS symptoms or mass lesions on imaging. The second most frequently reported manifestation of reactivation in HIV-infected patients is acute myocarditis, sometimes superimposed on pre-existing chronic Chagas heart disease.^{16,17} Patients may present with new arrhythmias, pericardial effusion, acute cardiac decompensation or rapid progression of existing chronic cardiomyopathy.^{16,29} Less frequent manifestations of reactivation include skin lesions, erythema nodosum, and parasitic invasion of the peritoneum, stomach or intestine.^{16,29}

Diagnosis

Most patients infected with Chagas disease, including those in the United States, are in the chronic phase and typically unaware of their infection. Screening for infection in patients with the indeterminate or early clinical forms of chronic Chagas disease is important to identify those who might benefit from antiparasitic treatment and counseling regarding potential transmission of *T. cruzi* to others (e.g., blood donation, organ donation). This is particularly important for HIV-infected patients because of the risk of reactivation disease. Diagnosis of chronic infection relies on serological methods to detect immunoglobulin G antibodies to *T. cruzi*, most commonly enzyme-linked immunosorbent assay (ELISA) and immunofluorescent antibody assay (IFA). No available assay has sufficient sensitivity and specificity to be used alone; a single positive result does not constitute a confirmed diagnosis. Two serological tests based on different antigens (i.e., whole parasite lysate and recombinant antigens) and/or techniques (e.g., ELISA and IFA) are used in parallel to improve the accuracy. In some cases, the infection status remains difficult to resolve even after a third test, because there is no true gold standard assay for chronic *T. cruzi* infection.^{30,31} Data suggest that the sensitivity of serological assays varies by geographical location, possibly because of *T. cruzi* strain differences and resulting antibody responses.^{32,33} Options for *T. cruzi* serological testing in the United States include diagnostic ELISA kits based on parasite lysate or recombinant antigens.^{30,34} In general, polymerase chain reaction (PCR) is not a useful diagnostic test for chronic *T. cruzi* infection. The sensitivity is highly variable and depends on patient characteristics as well as PCR primers and methods.^{35,36}

In HIV-infected patients with epidemiologic risk factors for Chagas disease, co-infection with *T. cruzi* and reactivation disease should be considered in the differential diagnosis of CNS mass lesions, meningoencephalitis, arrhythmias or heart failure.^{16,26,27} The imaging pattern of brain chagoma is similar to that of cerebral toxoplasmosis, although chagomas tend to be larger than *Toxoplasma* lesions.^{17,27,28} Computed tomography and magnetic resonance imaging show subcortical hypodense lesions that enhance with contrast or gadolinium. These lesions most often involve brain white matter. Histopathology shows inflammation and the presence of *T. cruzi* amastigotes in glial cells, and less often, in neurons. Cerebrospinal fluid (CSF) shows a mild pleocytosis (lymphocyte predominance), increased protein, and *T. cruzi* trypomastigotes.^{16,17,27,28} In a case series that included 15 HIV and *T. cruzi*-co-infected patients with clinical meningoencephalitis, trypomastigotes were visualized in CSF in 85%.^{15,16,27,28}

A definitive diagnosis of re-activation is established by identification of the parasite or its products in tissue, such as on brain biopsy, in CSF or in blood.¹⁶ Circulating parasites are rarely detected microscopically in immunocompetent patients with chronic Chagas disease or in HIV-co-infected patients in the absence of reactivation.²⁵ If observed in an HIV-*T. cruzi*-co-infected patient, circulating parasites suggest reactivation and the need for treatment. Blood concentration techniques, such as capillary centrifugation, can improve sensitivity.³⁷ In centrifuged blood, *T. cruzi* trypomastigotes are found just above the buffy coat. Centrifugation and microscopic examination of CSF also can be employed for patients with suspected CNS Chagas disease. Parasites also may be observed in lymph nodes, bone marrow, skin lesions, or pericardial fluid. Hemoculture is somewhat more sensitive than direct methods, but takes 2 to 8 weeks to demonstrate parasites.

Conventional PCR is not useful for diagnosing re-activation, because the method can yield a positive result in chronic *T. cruzi* infection in the absence of re-activation.^{35,36} However, quantitative PCR assays (real-time PCR) performed on serial blood specimens that show rising parasite numbers over time provide the earliest and most sensitive indicator of reactivation.^{38,39} Few published data exist on PCR of CSF, but it would be expected to have high sensitivity for the diagnosis of reactivation in the CNS.⁴⁰

Preventing Exposure

Travelers to endemic countries may be at risk for infection with *T. cruzi* if they visit rural areas and stay in rustic lodging. The triatomine vector typically infests cracks in walls and roofing of poor-quality buildings constructed of adobe brick, mud, or thatch.⁴¹ Because the insects feed at night, individuals who live in or visit Chagas disease-endemic areas should avoid sleeping in such dwellings or outdoors. Control programs in endemic areas rely on spraying infested dwellings with residual-action insecticide. If sleeping outdoors or in suspect dwellings cannot be avoided, sleeping under insecticide-treated bed nets provides significant protection.⁴²

Most blood products in the United States are screened routinely for *T. cruzi* but screening is not universal in the United States or in others areas, including parts of Latin America.⁴³

Although transfusion-acquired cases have been uncommon in the United States, transfusion with infected blood products remains a risk for acquiring Chagas disease. No drugs or vaccines for preventing *T. cruzi* infection are available.

Preventing Disease

Clinical manifestations of Chagas disease in HIV-positive patients usually represent reactivation and not acute infection with *T. cruzi*. All HIV-infected patients with epidemiologic risk factors for Chagas disease should be tested for antibody to *T. cruzi* to detect latent infection.¹⁸ A single course of treatment with benznidazole or nifurtimox can be considered for *T. cruzi*-infected individuals who have not been previously treated and who do not have advanced Chagas cardiomyopathy (**CIII**). However, the efficacy of currently available drugs in the chronic phase is suboptimal, there is no useful test of cure, and treated individuals are still considered at risk for reactivation.^{31,44} Although direct data are lacking, optimization of antiretroviral therapy (ART) may help prevent Chagas reactivation in co-infected patients (**BIII**). Most symptomatic reactivation cases have occurred in patients who were not taking ART.¹⁶

Treating Disease

Chemotherapy for Chagas disease with benznidazole or nifurtimox is effective in reducing parasitemia and preventing clinical manifestations or slowing progression in patients with acute, early-chronic, and re-activated disease.^{44,45} These drugs have limited efficacy, however, in achieving parasitological cure. Consultation with a specialist should be sought. Benznidazole (5 to 8 mg/kg/day for 30 to 60 days) is the initial treatment most commonly recommended (**BIII**). Nifurtimox (8 to 10 mg/kg/day, administered for 90 to 120 days) is an alternative (**CIII**). The duration of therapy with either of these agents has not been studied in patients co-infected with HIV. Mortality is high for symptomatic reactivated *T. cruzi* infection,

even in patients who receive chemotherapy.^{16,27} Limited data suggest that early recognition and treatment of reactivation may improve prognosis.¹⁶

Benznidazole is approved by FDA for use in children 2–12 years of age and is commercially available at <http://www.benznidazoletablets.com/en/>. Nifurtimox is not currently FDA approved and is available from the Centers for Disease Control and Prevention (CDC) Drug Service for use under an investigational protocol. Consultations and nifurtimox requests should be addressed to Division of Parasitic Diseases and Malaria Public Inquiries line (404-718-4745); parasites@cdc.gov, the CDC Drug Service (404-639-3670), and for emergencies after business hours, on weekends, and federal holidays through the CDC Emergency Operations Center (770-488-7100).

Special Considerations with Regard to Starting Antiretroviral Therapy

As with other parasite infections that localize in the CNS, the decision to initiate antiretroviral therapy (ART) must be carefully considered in HIV-infected patients with reactivated *T. cruzi* infection involving the brain. Only anecdotal information exists on the consequences of starting ART after a diagnosis of CNS Chagas disease, but there are no cases of Chagas-related immune reconstitution inflammatory syndrome (IRIS) that have been well described. Therefore, there is no known contraindication to starting or optimizing ART in patients with CNS Chagas disease as soon as their CNS disease is clinically stable (**AIII**).

Monitoring of Response to Therapy and Adverse Events (Including IRIS)

Patients undergoing treatment should be monitored closely because both benznidazole and nifurtimox are associated with significant toxicities.⁴⁶ Benznidazole causes peripheral neuropathy, rash, and granulocytopenia. Nifurtimox causes anorexia, nausea, vomiting, abdominal pain and weight loss, restlessness, tremors, and peripheral neuropathy. The adverse effects of both drugs wane when the drugs are discontinued.

As stated above, no reports are available regarding *T. cruzi* infection and IRIS.

Managing Treatment Failure

Although no efficacy data are available, retreatment with benznidazole or nifurtimox is recommended for HIV-infected patients with *T. cruzi* reactivation who fail to respond or who relapse after initial antitrypanosomal therapy (**AIII**). A publication documents a single case of a *T. cruzi*-infected patient on immunosuppressive therapy for systemic lupus erythematosus who had a good response to posaconazole after failure of benznidazole treatment; failure of benznidazole and response to posaconazole were documented by real-time PCR assays in serial specimens.⁴⁷ However, the results of a randomized clinical trial comparing the efficacy and safety of low and high dose posaconazole to that of benznidazole demonstrated that posaconazole was not efficacious for treatment of chronic Chagas disease.⁴⁸

Preventing Recurrence

Patients with HIV infection are at risk for recurrent or relapsing clinical manifestations because of intermittent reactivation of chronic infection.¹⁶ The drugs are only partially effective in the chronic phase of *T. cruzi* infection and may be suppressive rather than curative.⁴⁴ Because the drugs are toxic and experience with their use in HIV-infected patients is limited, expert advice should be sought.⁴⁵ Whether secondary prophylaxis or chronic maintenance therapy should be used in HIV-infected patients with latent Chagas disease is unclear, particularly when potent ART is used.

Special Considerations During Pregnancy

As recommended for all individuals with epidemiological risk of Chagas disease, screening of pregnant women who have lived in endemic areas should be considered to identify maternal infection and possible risk of infection in their offspring. In pregnant women in areas where the disease is endemic in Latin America, the seroprevalence of *T. cruzi* infection can be as high as 30%.^{14,49} In the United States, a 1999 study of 3,765 pregnant women in Houston, Texas, confirmed antibody to *T. cruzi* in 0.4% of Hispanic women and 0.1% of

non-Hispanic women and a 2013 study of 4,000 predominantly Hispanic women in the same city found 0.25% with confirmed infection.^{50,51}

From 1% to 10% of infants of *T. cruzi*-infected mothers are born with acute *T. cruzi* infection.^{14,49} Most congenital *T. cruzi* infections are asymptomatic or cause non-specific signs; laboratory screening is required for detection of these cases. Studies from the 1980s suggest that congenital transmission of *T. cruzi* may increase the risk of spontaneous abortion, stillbirth, and low birthweight.⁵² In a small proportion of patients, congenital infection causes severe morbidity, including low birthweight, hepatosplenomegaly, anemia, meningoencephalitis, and/or respiratory insufficiency, with high risk of mortality.⁴⁹ Limited data suggest that the rate of congenital transmission is higher for HIV-infected women than in immunocompetent mothers.^{16,53} Infants co-infected with HIV and *T. cruzi* also may be more likely to have symptoms, especially neurologic symptoms.^{54,55}

Minimal data are available on potential reproductive toxicity of benznidazole and nifurtimox, although both drugs have been associated with increased detection of chromosomal aberrations in children being treated for Chagas disease.^{56,57} Benznidazole crosses the placenta in rats and covalently binds to fetal proteins.⁵⁸ Because of the toxicity and limited experience with use of these drugs in pregnancy, treatment of acute *T. cruzi* infection in pregnant women should only be undertaken in consultation with a specialist in this area, and treatment of chronic disease should be considered only after completion of the pregnancy. For HIV-infected pregnant women with symptomatic reactivation of *T. cruzi* infection, ART should be initiated (**AIII**) as initial treatment. Two cases of treatment of Chagas disease in pregnancy with benznidazole have been reported. One report was of an acute infection with treatment continued for the first few weeks of an subsequently diagnosed pregnancy, with normal infant outcome,⁵⁹ and one was of treatment of an HIV-infected woman with severe immunosuppression with Chagasic encephalitis in the third trimester of pregnancy.⁶⁰ The infant was small for gestational age but otherwise healthy and without evidence of *T. cruzi* infection. All infants born to *T. cruzi*-infected women should undergo appropriate testing for congenitally acquired *T. cruzi* infection and be treated promptly if infection is confirmed.^{14,61}

Recommendations for Preventing and Treating Chagas Disease (American Trypanosomiasis)

Preventing Clinical Disease

Indication

- Individuals with epidemic risk factors for Chagas disease and tested positive for antibody to *T. cruzi*, have not been previously treated, and do not have advanced Chagas cardiomyopathy.
 - A single course of benznidazole or nifurtimox can be considered (doses and duration same as for treatment of disease) (**CIII**). However, the efficacy of this therapy is suboptimal, and treated patients are still at risk of reactivation.
 - Initiation or optimization of ART may prevent reactivation of Chagas disease (**BIII**)

Treating Chagas Disease

Note: Treatment is effective in reducing parasitemia and preventing clinical manifestation or slowing progression in patients with acute, early-chronic, and re-activated disease. They have limited efficacy, however, in achieving parasitological cure.

Preferred Therapy for Acute, Early Chronic, and Re-Activated Disease:

- Benznidazole 5–8 mg/kg/day PO in 2 divided doses for 30–60 days (**BIII**) (commercially available at <http://www.benznidazoletablets.com/en/>).

Alternative Therapy

- Nifurtimox 8–10 mg/kg/day PO for 90–120 days (**CIII**) (not commercially available in the United States. Contact the CDC Drug Service at 404-639-3670 or drugservice@cdc.gov; for emergencies, call 770-488-7100)

Note:

- Optimal duration of therapy has not been studied in HIV-infected patients.
- Initiation or optimization of ART in patients undergoing treatment for Chagas disease, once the patient is clinically stable (**AIII**)
- Even with treatment, mortality is high in patients with symptomatic reactivation.

Key to Acronyms: ART = antiretroviral therapy; CDC = Centers for Disease Control and Prevention; PO = orally

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