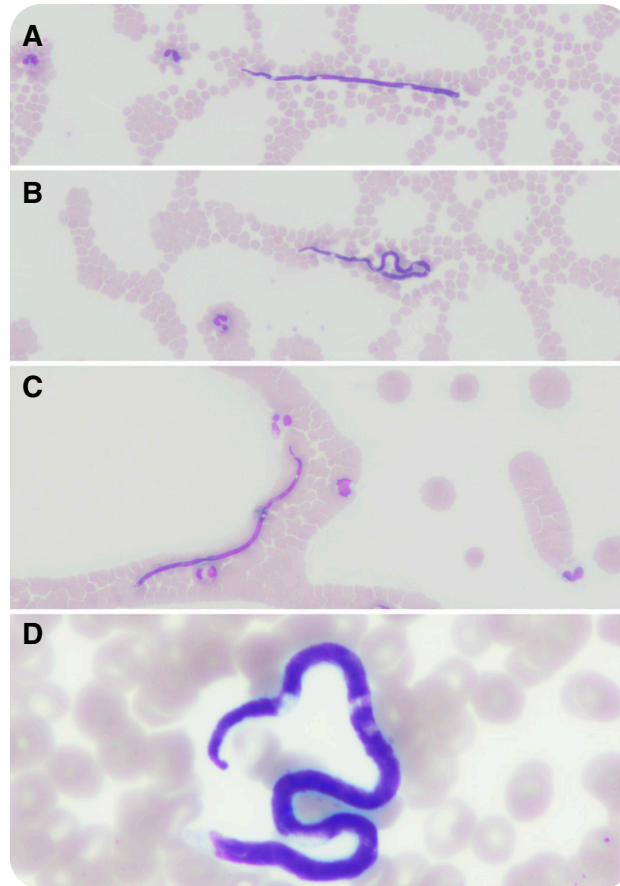


A clandestine worm

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An allegedly 15-year-old male was seen at the emergency unit on 1 January 2018 for cold sweats, hyperthermia, cough, and fatigue occurring for 1 week. This Senegalese migrant had traveled across Libya and Italy before arriving in France 11 weeks before, where he resided in a migrant settlement with several persons who had the same symptoms. Physical examination disclosed centimetric cervical and axillary adenopathy. Chest radiography and thoracic scan ruled out influenza and tuberculosis. Complete blood count was normal. An “atypical lymphocyte” on the Sysmex XN-10 analyzer prompted a blood smear. This disclosed $2.78 \times 10^9/L$ neutrophils, $1.51 \times 10^9/L$ lymphocytes with 3% of activated lymphocytes, $0.19 \times 10^9/L$ monocytes, and no eosinophilia ($0.09 \times 10^9/L$) or basophilia. Yet attentive examination

at low magnification ($\times 10$) detected microfilaremia, identified as *Mansonella perstans* by microscopy and serology (panels A-D, May-Grunwald Giemsa stain; original magnification $\times 10$ [panels A-C]; original magnification $\times 50$ [panel D]). HIV seropositivity was later diagnosed, explaining the superficial lymphadenopathy. Treatment with ivermectin and doxycycline was initiated.

The absence of hypereosinophilia, usually present in such parasitemia, is surprising. Microfilaremia is an endemic vectorized helminthiasis (*Culicoides*) in sub-Saharan Africa, usually asymptomatic in non-immunocompromised patients. A blood smear examination is recommended for sick migrants, even if the differential count is normal, to avoid delaying treatment in immunocompromised patients.