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<td>Author(s)</td>
<td>Tada, Isao; Aoki, Yoshiki; Rimola, C. E.; Ikeda, T.; Matsuo, K.; Ochoa, A. J. O.; Recinos, C. M.; Sato, S.; Godoy, B. H. A.; Orellana, J. J. C.; Takahashi, H.</td>
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<tr>
<td>Citation</td>
<td>American Journal of Tropical Medicine and Hygiene, 28(1), pp. 67-71; 1979</td>
</tr>
<tr>
<td>Issue Date</td>
<td>1979-01</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/10069/21850">http://hdl.handle.net/10069/21850</a></td>
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<tr>
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<td>1979 by The American Society of Tropical Medicine and Hygiene</td>
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備考

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ONCHOCERCIASIS IN SAN VICENTE PACAYA, GUATEMALA*

I. TADA, Y. AOKI, C. E. RIMOLA, T. IKEDA, K. MATSUO, J. O. OCHOA A.,
M. RECINOS C., S. SATO, H. A. GODOY B., J. J. C. ORELLANA, AND H. TAKAHASHI
Department of Parasitic Diseases, Kumamoto University School of Medicine, Kumamoto, Japan,
Department of Parasitology, Institute for Tropical Medicine, Nagasaki University, Nagasaki, Japan,
Servicio Nacional de Erradicacion de la Malaria, Ministerio de Salud Publica, Guatemala,
Department of Medical Zoology, Kanazawa Medical University, Ishikawa, Japan, Department
of Medical Zoology, Kyoto Prefectural University of Medicine, Kyoto, Japan, and
Department of Medical Zoology, Faculty of Medicine, Nagoya City University, Nagoya, Japan

Abstract. An epidemiological survey for onchocerciasis was carried out in the San Vicente
Pacaya area of Guatemala. A total of 2,153 inhabitants were examined by a single skin snip,
and 664 (30.8%) were positive for microfilariae. Slit lamp examination of the anterior chamber
of the eye revealed microfilariae in 6.2%; the positive rate for microfilariae in the anterior
chamber was proportional to the microfilarial density in the skin. The altitude-dependent
character of onchocercal infection was shown in this mountainous area, suggesting that trans
mission occurs principally between 600 and 1,300 m. Of 1,217 persons examined simulta-
neously by skin snip and by palpation for nodules, 587 were positive by one or both methods;
101 infections were detected by onchocercal nodules only and these were usually in children
or persons living in areas of low endemicity. It was concluded that both the skin snip and
a search for nodules are required for accurately determining the prevalence of onchocerciasis
in Guatemala.

Since the discovery of endemic onchocerciasis
in Guatemala by Robles in 1915 the only control
measure practiced in the campaign against this
blindness-causing parasitic disease has been deno-
dulization. However, several previous reports
suggested that infection due to onchocerciasis was
not affected by this measure in the endemic areas
in Guatemala. Recently, the Ministry of Public
Health, Republic of Guatemala has evaluated the
past results of the denodulization campaign in this
country and concluded that a new research pro-
gram to control the disease should be launched.
For this research program, San Vicente Pacaya
was selected as the pilot area for epidemiological,
entomological, and clinical studies. Reported here
are results of epidemiological surveys for oncho-
cerciasis in this region carried out between June

MATERIALS AND METHODS

San Vicente Pacaya (SVP) is located at latitude
14°24'42" N and longitude 90°32'18" W on the

Accepted 10 June 1978.

* This study was supported by the Ministry of
Public Health, Guatemala and the Japan International
Cooperation Agency, Japan (GJCRCPO-MENSAP
series No. 7).
registered location of the houses and names, ages, and sexes of occupants according to routine procedures used in the malaria eradication program.

Inhabitants more than 3 years of age in 19 villages and plantations of SVP and several plantations of surrounding areas were examined for infection by a single skin snip taken from the left scapular region according to the technique of Tada et al., by slit lamp examination of the anterior chambers of both eyes, and by palpation for nodules. Skin snips 3–4 mm in diameter were taken by using a needle and a surgical knife. Unteased snips were incubated in physiological saline for 1 h at room temperature. The number of microfilariae in 1 mm² of a skin snip was expressed as the microfilanial density (MFD). The anterior chambers of both eyes were examined by an ophthalmologist with a Zeiss slit lamp after mydriatic, but without massage. Experienced paraprofessionals (brigadas) examined the whole body for onchocercal nodules by palpation. The location of onchocercal nodules was recorded individually and nodules were later removed.

As the prevalence of onchocerciasis in Guatemala has been determined primarily by the nodule rate, it was of interest to compare the prevalence as determined by that method with that obtained by skin biopsy. In this way the present survey would give for the first time a more accurate and complete picture of the prevalence of onchocerciasis in a large area.

RESULTS AND DISCUSSION

Prevalence of onchocerciasis in SVP

A total of 2,153 inhabitants were examined and 664 (30.8%) were positive for Onchocerca volvulus microfilariae in skin snips. The microfilarial rate ranged from 0–90% in individual regions. When the microfilarial rates were plotted against the altitude of individual regions it was clear that the microfilarial rate was highest in villages and plantations situated between 600 and 900 m above sea level (Fig. 1). In the lowlands below 500 m and in the one village examined on the plateau over 1,700 m the microfilarial rate was considerably lower and the majority of positives found in these regions were male adults. The results obtained in Aldea San Jose Bejúcal and Chilar were omitted in the figure because no microfilarial positives were found among 115 inhabitants of the former village (440 m altitude) and in the latter area the houses were widely distributed from a low to a high altitude on the mountain. The results suggest that onchocerciasis transmission occurs in relatively limited areas situated between 600 and 1,300 m above sea level.

Age and sex distribution of persons positive for microfilariae

Microfilaria-positive rates in males rose in proportion to age and the highest rate (65%) occurred in the 40- to 49-year age group (Fig. 2). In all age groups the rate in females was about one-half that in males.

Figure 3 depicts the difference of microfilarial densities by sex, according to the analytic method of Sasa. When the microfilarial density corresponds to 50% (equivalent to 5 in probit) and cumulative percentage is used as an index, MFD₅₀ is 0.9 for females and 3.2 for males, reading from the regression line. These data show that more frequent and heavier infections occur in males as compared with females. A similar tendency has been shown in previous reports from Guatemala.

The differences in prevalence and intensity of infection between males and females may be due to occupational differences that determine degree of exposure to black fly bites and/or differences in susceptibility of the sexes to filarial infection,
as shown by Ash for *Brugia pahangi* infection in jirds.8

**Relation between microfilaria rate and nodule rate**

There was a close correlation between microfilaria rate by single biopsy and nodule rate in the inhabitants of 18 villages and plantations of SVP and the surrounding areas (Fig. 4). The nodule-biopsy pattern obtained in SVP is similar to some extent to that shown by Buck for Guinea, West Africa.9 A 50% microfilaria rate corresponded approximately to a 35% nodule rate in SVP, while in Guiana a 50% microfilaria rate corresponded approximately to a 16% nodule rate. This indicates that in Guatemala, unlike Guinea, in spite of the denodulization campaign many persons have nodules in which microfilariae can be detected in the skin. In some villages the nodule rate was higher than the microfilaria rate, especially in children, indicating that a sensitive index of infection in areas of low endemicity, or in young children or those exposed for the first time, is to find onchocercal nodules.

**Examination of the anterior chamber of the eye**

Both eyes of 1,217 persons were examined with a slit lamp and their scapular regions by skin biopsy; 76 (6.2%) had microfilariae in their anterior chambers (MFAC). MFAC were found in 14.9% of male patients and 9.6% of females. A clear correlation was found between increasing age and a rise in the positive rate, especially in males. There was also a clear correlation between the density of microfilariae in the skin and the positive rate for MFAC (Table 1). Only 5 persons (0.7%) were positive for MFAC of 732 who were negative by single skin snip examination, while 13 (35.1%) were positive of 37 whose microfilarial density (no. microfilariae/snip) was
TABLE 1

<table>
<thead>
<tr>
<th>MFD</th>
<th>No. examined</th>
<th>No. with MFAC</th>
<th>% positive</th>
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<tr>
<td>0</td>
<td>732</td>
<td>5</td>
<td>0.7</td>
</tr>
<tr>
<td>1–10</td>
<td>166</td>
<td>5</td>
<td>3.0</td>
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<tr>
<td>11–50</td>
<td>151</td>
<td>23</td>
<td>15.2</td>
</tr>
<tr>
<td>51–100</td>
<td>63</td>
<td>13</td>
<td>20.6</td>
</tr>
<tr>
<td>101–200</td>
<td>52</td>
<td>13</td>
<td>25.0</td>
</tr>
<tr>
<td>201–300</td>
<td>16</td>
<td>4</td>
<td>25.0</td>
</tr>
<tr>
<td>301+</td>
<td>37</td>
<td>13</td>
<td>35.1</td>
</tr>
<tr>
<td>Total</td>
<td>1,217</td>
<td>76</td>
<td>6.2</td>
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301 or more. This shows that the number of microfilariae in the skin is closely related to the prevalence of microfilariae in the anterior chamber. In the ophthalmological survey, massage of the eyelids was not done before examination. This technique, initiated by Diallo and Loreal, would probably enhance the detection of microfilariae in the eye.

Location of onchocercal nodules

During the present survey a total of 500 persons were found to have onchocercal nodules (Fig. 5); 56.5% of the nodules were found on the head (25.2% in the occipital and 22.1% in the parietal regions), 38.9% on the trunk, and 4.6% in other locations. This finding is similar to the results reported previously by Estrada et al.

Comparison of diagnostic measures

We compared the diagnostic utility of three measures—single skin biopsy, palpation for nodules, and slit lamp examination of the anterior chamber of the eye. A total of 1,217 persons from SVP and surrounding areas were examined by all three techniques; 587 (48.2%) were found positive for onchocercal infection by at least one method (Table 2). Of those infected, the skin snip method detected 485 (82.6%) and palpation revealed 412 (70.2%). When both of these examinations are combined, 586 infections (99.8%) were diagnosed while only 0.2% of the infections were found by ophthalmological examination alone. While slit lamp examination of the anterior chamber is not a sensitive means of diagnosis of infection, the presence of microfilariae in the eye is an important sign of severe prognosis.

In the present survey, 101 (17.2%) infections were detected by nodules alone. In a separate study (Y. Aoki, unpublished), 801 nodules (91.8%) of 873 removed were of onchocercal origin microscopically.

The proportion of nodule positives among persons who were negative for microfilariae varied with the level of endemicity and with age. In areas of low endemicity (8–25% prevalence), 36.3% of all the positives had nodules alone, while the rate decreased to 17.5% in meso-endemic areas (35–50% prevalence) and to 9.2% in highly endemic areas (60+% prevalence) (Table 2). The frequency of persons showing only nodules decreased with increasing age: 45.0% in the age group below 4 years; 36.8% in children 5–9 years old; 23.1% in those aged 10–15 years; 14.8% in the group 16–30 years; and 12.2% in persons more than 31 years old.

In conclusion, diagnosis by single skin snip alone is not sufficiently sensitive, especially among
infected children or persons lightly infected. Therefore, in Guatemala special attention should be paid to the detection of onchocercal nodules by palpation.

**ACKNOWLEDGMENTS**

The authors are grateful to Mr. P. A. Molina and to all the members of his field team, and to Mrs. Lolita for their considerable assistance during surveys. The authors also wish to thank Dr. L. R. Ash of the University of California, Los Angeles for reading the manuscript.

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