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Case Report: An Inadequate Management of A Severe Imported Malaria Case

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1. Letter to Editor

A 25-year-old man of Polish origin had spent one week in Sierra Leone without taking antimalarial prophylaxis. Upon his return to France, he was arrested at the airport and jailed due to his known involvement in drug trafficking. Six days after his return, he began experiencing symptoms of fever, asthenia, and vomiting, but did not receive immediate medical attention. Two weeks later, he was admitted to the intensive care unit with a severely altered general condition. Plasmodium falciparum malaria was diagnosed with a parasitaemia level of 19% and a venous lactate at 16 mmol/L indicating severe malaria. Treatment was started with 200 mg artesunate (2.4 mg/kg body weight/24 h) and continued daily at the same dosage until Day 7 [1]. The initial course was complicated by septic shock, requiring vasopressor support, orotracheal intubation and mechanical ventilation for two days. Severe haemolytic anaemia (6.2 g/dL) required the transfusion of three units of packed red blood cells. No oral follow-up artemisinin-combined therapy (ACT) was initiated. By Day 2, parasitaemia had decreased to 0.05% and was negative on Day 9 when the patient was discharged to jail. No further clinical or biological surveillance was performed.

On Day 40, the patient presented with severe asthenia, dizziness, and fever at 39°C. He was evaluated by the jail physician and referred to the emergency department. Laboratory findings revealed P. falciparum parasitaemia at 3% and a venous lactate at 2 mmol/L. He was admitted to the intensive care unit and treated with IV artesunate at 0, 12, and 24 hours followed by a full course of dihydroartemisinic-piperaquine therapy. The clinical evolution was rapidly favourable. Post-discharge biological surveillance was planned, including thick blood smears on Day 7 and Day 28 which revealed negative.

Recurrences of P. falciparum malaria can result from recrudescence (treatment failure) or from re-infection. In the present case, as the patient was detained in prison, another stay in endemic area was formally excluded. Nevertheless, as the prison was not far (5 km) from an important international airport, we verified by genotyping that the strain found at recurrence was identical to that found at the initial presentation, which was the case [2].

Cases of therapeutic failures due to resistance to ACTs are known in Southeast Asia and recently in some African countries [3]. In the present case, DNA sequencing of the Kelch 13-propeller gene showed no mutation and thus, a therapeutic failure due to a resistant P. falciparum strain was ruled out.

The recrudescence observed on Day 40 was probably due to the lack of follow-up ACT treatment. Previous studies indicate that artesunate-induced dormancy in some parasites can lead to recrudescence if not followed by oral therapy [4,5]. In the present case, the lack of monitoring beyond nine days after the initial treatment did not allow to detect early the recrudescence which turned into another severe malaria episode.

In conclusion, this case highlights the importance of effective management of severe cases, including the use of IV artesunate and oral follow-up treatment to prevent complications and recrudescence. Appropriate post-therapy surveillance is also crucial in particular to manage an eventual post-artesunate delayed hemolysis [1].

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