Case of *Plasmodium knowlesi* Malaria in Poland Linked to Travel in Southeast Asia

Szymon P. Nowak, Pawel Zmora, Łukasz Pielok, Łukasz Kuszel, Ryszard Kierzek, Jerzy Stefaniak, Małgorzata Paul

Author affiliations: Poznań University of Medical Sciences, Poznań, Poland (S.P. Nowak, Ł. Pielok, Ł. Kuszel, J. Stefaniak, M. Paul); Institute of Bioorganic Chemistry, Polish Academy of Sciences, Poznań (P. Zmora, R. Kierzek)

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We report a case of *Plasmodium knowlesi* malaria imported to central Europe from Southeast Asia. Laboratory suspicion of *P. knowlesi* infection was based on the presence of atypical developmental forms of the parasite in Giemsa-stained microscopic smears. We confirmed and documented the clinical diagnosis by molecular biology techniques.

The simian malaria parasite, *Plasmodium knowlesi*, is an emergent public health threat for persons traveling to Southeast Asia (1). We report a case of *P. knowlesi* malaria imported to central Europe from Southeast Asia.

On June 25, 2018, a 27-year-old woman returned to Poland after an 8-month tourist stay in Southeast Asia (Appendix Figure 1, http://wwwnc.cdc.gov/EID/article/25/9/19-0445-App1.pdf). The patient did not use malarial chemoprophylaxis during her travels. While in Sumatra, Indonesia, she experienced 2 episodes of subfebrile body temperature of ≤38°C. After returning to Poland, she reported having general malaise, weakness, chills, and a low-grade fever. She consulted a family physician, who diagnosed pharyngitis and recommended empiric antimicrobial drug therapy, cephalosporin combined with a fluoroquinolone, which provided no clinical improvement. After another episode of fever (temperature 39°C), she sought treatment at the regional hospital in Racibórz, Poland. Basic laboratory tests revealed leucopenia, thrombocytopenia, and elevated levels of C-reactive protein and procalcitonin.

The patient did not have any chronic diseases or drug allergies. She was not pregnant, and her family history was unremarkable.

On July 5, 2018, the patient was transferred to the Department of Tropical and Parasitic Diseases, Poznań University of Medical Sciences, Poznań, Poland, because of high fever. At admission, on day 5 of her illness, she was conscious and responded logically. Her clinical status was stable. She was febrile (temperature 40°C) and experiencing hypotension (91/68 mm Hg), chills, headache, weakness, malaise, and tachycardia (110 bpm) but did not have signs of multiorgan failure. Laboratory analyses showed mild normocytic anemia (hemoglobin 10.3 g/dL, hematocrit 29.0%, and erythrocyte count 3.34 × 10¹² cells/L); low levels of platelets (22 × 10¹⁲/μL), leukocytes (2.13 × 10⁹/μL), neutrophils (0.76 × 10⁹/μL), and lymphocytes (1.01 × 10⁹/μL); marked elevation of inflammatory markers C-reactive protein (66.3 mg/L) and procalcitonin (0.67 ng/mL); a high concentration of D-dimers (6.48 × 10¹⁵ mg/mL); slightly prolonged prothrombin time (12.9 s); and elevated lactate dehydrogenase level (249 U/L).

Staff examining the first thick and thin blood films during screening in the emergency department reported an “atypical mixed infection with *P. vivax* and *P. malariae* with a strange morphology of the parasites” and a low parasitemia of 0.3%. A reference microscopic analysis performed at the Department of Tropical and Parasitic Diseases, Poznań University of Medical Sciences, showed infected erythrocytes of normal size and shape with a lack of Schuffner stippling and Maurer’s cleft. We observed multiple young trophozoites in the erythrocytes, with a delicate, thin ring of cytoplasm. Some also had narrow band shapes. In addition, we saw mature schizonts with <16 merozoites, large round gametocytes, and notable amounts of hemozoin pigment (Appendix Figure 2). ELISA revealed a high level of *Plasmodium* sp. IgM/IgG (52 U/mL), but we could not identify the *Plasmodium* species from these features. We later used PCR to confirm *P. knowlesi* infection from peripheral blood collected in EDTA tubes and frozen at −20°C. In brief, we extracted DNA from a 1.2-mL venous blood sample by using an automated nucleic acid extractor, MagCore HF16 Plus, with a MagCore genomic DNA large volume whole blood kit (RBC Bioscience Corp., https://www.rbcbioscience.com), according to standard protocol. To identify the *Plasmodium* species, we used nested PCR according to Komaki-Yasuda et al. (2). In patients with previously described *P. falciparum* malaria, we have observed a specific band for the parasite. We did not observe this band in the case-patient’s sample, suggesting infection with another *Plasmodium* species. The *P. vivax* primers did not yield amplification, but the *P. knowlesi* oligos resulted in clear bands, indicating that this patient was infected with *P. knowlesi* (Figure). In addition, the *P. knowlesi* band diminished after malarial therapy, demonstrating treatment efficacy.

On the basis of the patient’s travel history, clinical signs and symptoms, test results, and World Health Organization guidelines (3), we diagnosed uncomplicated *P. knowlesi* infection. The patient received oral artemether and lumefantrine combined with intravenous doxycycline and the parasites cleared in microscopic smears within 4 days. The patient’s fever subsided, her blood morphology...
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About the Author

Dr. Nowak is a physician and research fellow at the Department and Clinic of Tropical and Parasitic Diseases, Poznań University of Medical Sciences, Poznań, Poland. His research interest is in imported tropical diseases.

References


Address for correspondence: Szymon P. Nowak, Poznań University of Medical Sciences, Department and Clinic of Tropical and Parasitic Diseases, 49 Przybyszewskiego St, 60-355 Poznań, Poland; email: snowak@ump.edu.pl
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**Appendix**

Appendix Figure 1. Timeline of case-patient’s history of travel in Southeast Asia, onset of symptoms, and treatment for *Plasmodium knowlesi* malaria in Poland. *DCTPD, Department and Clinic of Tropical and Parasitic Diseases.*
Appendix Figure 2. Microscopic morphology of Plasmodium knowlesi in Giemsa-stained thin blood films from a patient returning to Poland from travel in Southeast Asia. A) Arrow indicates early trophozoites with a delicate, thin ring of blue cytoplasm. B) Arrow indicates mature trophozoite. C) Arrow indicates immature schizont forming an equatorial band shape. D) Arrow indicates macrogametocyte with eccentric compact chromatin and scattered dark pigment of hemozoin in a blue cytoplasm.