individuals have been finally diagnosed with schistosomiasis, and to which extent additional exposed cases may have been missed. In fact, all exposed individuals were invited to come to the outpatient clinic and those who responded to the call had a diagnosis of acute schistosomiasis confirmed. We know that some did not come due to different reasons. The contact occurred during a private party and we do not expect that a large number of individuals were missed [2].

We called severe cases those patients who were hospitalized. All stayed in hospital for >30 days with a diagnosis of fever of undetermined origin [3]. Typhoid fever, liver abscess, AIDS, neoplasia, granulomatous diseases of the gut (ulcerative colitis, Crohn disease), autoimmune diseases (Wegener granulomatosis, Churg-Strauss syndrome), and tuberculosis were considered in the differential diagnosis of the 3 patients presenting with diarrhea [4–6]. Note that after a diagnosis of any disease has been confirmed, physicians tend to devaluate the difficulty that other physicians had to reach a diagnosis [7]. In addition, patients were not examined by the same physician in only 1 hospital, and we believe this was also a factor that impaired or delayed more rational clinical investigation.

In their letter, Soentjens et al mention that pulmonary distress in acute schistosomiasis has been regularly described. We agree on that. However, there are different degrees of lung involvement in acute schistosomiasis [8, 9]. To be fair, this is a truism. Pulmonary manifestations depend on the worm burden and host response to parasite invasion. In our case, the computed tomographic scan showed scattered nodules on both lung fields, and the patient underwent lung biopsy to clarify the diagnosis; this is not a regular presentation of acute schistosomiasis. The same applies to neurological involvement: the severity of symptoms varies greatly [10]. Besides, only after the advent of magnetic resonance imaging did it become possible to strongly associate Schistosoma mansoni infection with neurological involvement [11–13].

In regard to Katayama fever or syndrome, some investigators, including us, prefer to use the term acute schistosomiasis when the infection is caused by S. mansoni, because Katayama is a syndrome described for those infected with Schistosoma japonicum. Moreover, the clinical presentation of both syndromes is quite different.

Soentjens et al also suggest that real-time polymerase chain reaction (PCR) would be useful in diagnosing acute schistosomiasis; however, reading the articles Soentjens et al quoted on PCR, we found that the first PCR used seemed to diagnose infection by Schistosoma haematobium, but failed to diagnose 22 patients infected with S. mansoni. The second article found PCR for S. mansoni in 8 patients with acute schistosomiasis caused by S. mansoni, but PCR did not disappear from the serum even after 2 years posttreatment. This means that we still have much work to do before using PCR in our clinical laboratories.

We wish to thank Soentjens et al again for their attention and comments. We enjoyed very much the opportunity to discuss a disease that has been considered neglected, but, actually, one whose presence has been largely underestimated even in developed countries.

**Note**

**Potential conflicts of interest.** All authors: No reported conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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**Reply to Soentjens et al**

**To the Editor—**We thank Soentjens et al for their comments on our article [1, 2]. The authors ask whether all exposed

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