Review Article

Current Evidence on the Use of Antifilarial Agents in the Management of Bancroftian Filariasis

Sumadhya Deepika Fernando, Chaturaka Rodrigo, and Senaka Rajapakse

1 Department of Parasitology, Faculty of Medicine, University of Colombo, Colombo 08, Sri Lanka
2 University Medical Unit, National Hospital of Sri Lanka, Colombo 08, Sri Lanka
3 Department of Clinical Medicine, Faculty of Medicine, University of Colombo, Colombo 08, Sri Lanka

Correspondence should be addressed to Chaturaka Rodrigo, chaturaka.rodrigo@gmail.com

Received 25 September 2010; Accepted 29 November 2010

Many trials have explored the efficacy of individual drugs and drug combinations to treat bancroftian filariasis. This narrative review summarizes the current evidence for drug management of bancroftian filariasis. Diethylcarbamazine (DEC) remains the prime antifilarial agent with a well-established microfilaricidal and some macrofilaricidal effect. Ivermectin (IVM) is highly microfilaricidal but minimally macrofilaricidal. The role of albendazole (ALB) in treatment regimens is not well established though the drug has a microfilaricidal effect. The combination of DEC+ALB has a better long-term impact than IVM+ALB. Recent trials have shown that doxycycline therapy against Wolbachia, an endosymbiotic bacterium of the parasite, is capable of reducing microfilaria rates and adult worm activity. Followup studies on mass drug administration (MDA) are yet to show a complete interruption of transmission, though the infection rates are reduced to a very low level.

1. Introduction

There are nine filarial nematodes causing disease in humans. According to the location of the parasite and the pathogenesis, the disease can be classified as lymphatic, subcutaneous, and serous cavity filariasis. Two filarial worms, namely, Wuchereria bancrofti and Brugia malayi cause lymphatic filariasis. The World Health Organization (WHO) considers lymphatic filariasis to be a global health problem affecting approximately 120 million people in over 80 countries [1]. One-third of affected individuals are from South Asia and another one third is from Africa [1]. One sixth of the world population is at risk of infection [1].

The adult W. bancrofti worms live within the human lymphatic system. They have a long life span of 4–6 years. Females are viviparous and release thousands of microfilaria into the blood stream of the host after mating. These are taken up by vector mosquitoes during feeding, and the parasite undergoes several moults within the intermediate host to become the L3 larva which is the infective stage. During a feed, this larva enters the human blood stream and migrates to the lymphatics where it molts to become an adult worm [2]. There is a range of clinical manifestations in bancroftian filariasis with asymptomatic microfilaremia being at one end of the spectrum. Symptomatic patients may have acute (lymphangitis, lymphadenitis), chronic (elephantiasis, lymphoedema, hydrocoele, chyluria), or atypical (funiculitis, mastitis) manifestations [3]. Some may suffer from tropical pulmonary eosinophilia (TPE) due to the immunological hyperresponsiveness to the parasite [4].

The disease burden of lymphatic filariasis is significant. Chronic disease causes serious disfiguration and incapacitation of the patient with resultant stigma and marginalization. It is a disease of the poor, and it significantly affects their ability to earn an income. Many chronically ill patients are nonproductive for the rest of their life and become a burden to family and society [1, 5, 6]. This review focuses on the drug treatment of lymphatic filariasis caused by W. bancrofti.

2. Search Strategy and Methods

A MEDLINE search was carried out for all articles with the key word “Wuchereria bancrofti” in any field. The search was
restricted to articles published in English within the last 10 years (1999–2009), as they would contain more recent data. There were 659 abstracts in the original search with these restrictions. The software, Endnote X1.01 was used to filter articles. Bibliographies of cited literature were also searched. All abstracts were read through independently by the three authors, and relevant ones were identified for review of the full papers. Related papers were also included. Where the full paper was not available online or as hard copies, we contacted the authors and obtained the articles. Suitable data was available in 73 papers.

Sources were screened for a well-described methodology, accurate statistical analysis, and an adequate sample size where relevant. Coding was done by three reviewers independently blinded to each other. Interreviewer agreement for final review was 100%. Data sources included reviews published in core clinical journals, cohort studies, interventional studies, case control studies, cross-sectional analysis, and epidemiological data. We reviewed 64 (87.6%) full papers from a selected 73. A summary of the cited literature is shown in Tables 1 and 2.

One of the main issues that arose in evaluating the efficacy of therapies for bancroftian filariasis was the differences in outcome measures of treatment used in different trials. Of these we identified the following key outcome measures: (a) microfilaricidal effect, (b) clearance of antigenemia, (c) macrofilaricidal effect, and (d) prevention of clinical effects or complications of filariasis. The key pharmacological regimens in the management of lymphatic filariasis are, diethylcarbamazine (DEC), albendazole (ALB), and ivermectin (IVM) either used alone or in combination. We assessed the efficacy of each of these drugs or drug combinations in achieving the above-mentioned outcome measures. The value of these drugs in treatment of the individual and with regards to mass treatment, were considered separately.

3. Standard Treatment with DEC

DEC has been used to treat lymphatic filariasis for over 50 years. Its mechanism of action is still not fully understood. Earlier studies suggested that DEC had no direct effect on microfilaria as exposure to high concentrations of DEC left them unharmed [7]. Later, evidence from in vitro studies suggested that DEC blocks the cyclooxygenase pathway in parasites and leads to death of microfilaria [8]. Peixoto et al. [9] have demonstrated that DEC induces apoptosis in W. bancrofti microfilariae following exposure. Due to this microfilaricidal activity of DEC, the blood is cleared of microfilariae and the opportunity for mosquito borne transmission to occur is reduced. Further, filaria-associated haematuria and proteinuria are reversed. The macrofilaricidal action of DEC is not intended to reverse existing lymphatic damage but prevent further adult worm associated lymphatic damage and dysfunction [10]. The 12-day regimen of 72 mg/kg of DEC treatment remained effective as the older standard 12-day course of DEC, but has fewer adverse effects and results in enhanced population compliance and decreased delivery costs [15]. Single-dose therapy with DEC has been assessed in several trials (Table 1).

In a prospective study in Egypt, a single dose of DEC achieved a microfilaria-clearance rate of 69% (n = 20) after 1 year while the reduction in antigenemia was less satisfactory (n = 86, 40.7%) [16]. A prospective trial in Sri Lanka recorded a 74–80% reduction in microfilaria density (19–28% microfilaria-clearance rate) with a single dose of DEC 6 mg/Kg, 1 year after treatment [17]. However, the benefit of a single dose therapy may not be long lasting, as shown in a 10-year followup study in Orissa, India [18]. In this study of 44 patients, only 57% and 18% tested negative for microfilaria and antigenemia, respectively, at the end of the followup period of 10 years after a single standard dose of DEC. Similar evidence comes from Freedman et al. [19] who demonstrated significant levels of antigenemia (clearance rate of only 12%) at two years despite a more aggressive treatment regimen with DEC (repeated dosing with 6 mg/kg for 12 days at 0, 6, 12, 18 months).

Pani et al. [20] demonstrated that either single dose administration of DEC, ALB, or combination therapy were not different from each other with regard to microfilaria-clearance rates and reducing antigenemia (P > .05). Marked reduction in mean geometric parasite density (P < .05) as well as antigenemia optical density (P < .01) was seen in all groups at followup in 1 year.

Ivermectin is the third drug used in the treatment of bancroftian filariasis. Regarding monotherapy with IVM, Stolk et al. [21] demonstrated that single dose IVM alone can achieve a high microfilaria kill rate and a worm productivity loss at 1 year (96% and 82% on average, resp.). In comparison, the rates for the DEC treated group were very much lower (57% and 67%, resp.). Interestingly a similar trial by Reddy et al. [22] (with high-dose IVM) who followed up patients for two years suggests that both the tolerability and efficacy of the two drugs (IVM, DEC) were not significantly different between gender, age, and weight classes of patients at two years, although IVM showed a better macrofilaricidal and long term microfilaricidal efficacy, and this has been discussed. The 12-day course of DEC provides more rapid short-term microfilarial suppression, but when other factors are considered, including cost, convenience, and patient compliance it seems feasible to recommend single-dose treatment for individual patients with W. bancrofti infection. Single-dose treatment can be repeated every 6–12 months for persons who remain infected. However the 12-day regimen which reduces microfilarial density more rapidly is recommended for patient with TPE or hematuria, both of which are associated with microfilariae rather than the adult worm [12]. DEC is not used in areas endemic for onchocerciasis due to an increased side effect profile [13, 14].

4. Evidence from Clinical Trials on Antifilarial Agents

4.1. Single-Dose Treatment. Single dose treatment with DEC is as effective as the older standard 12-day course of DEC, but has fewer adverse effects and results in enhanced population compliance and decreased delivery costs [15].
<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study design</th>
<th>Drug doses</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bockarie et al.</td>
<td>2007</td>
<td>Randomized controlled clinical trial</td>
<td>Single-dose DEC at 6 mg/kg versus DEC plus ALB 400 mg single dose</td>
<td>No difference in microfilaricial effect but combination therapy had more macrofilaricial effect.</td>
</tr>
<tr>
<td>Fox et al.</td>
<td>2005</td>
<td>Randomized placebo-controlled trial four arms</td>
<td>(i) DEC 6 mg/kg single dose (ii) ALB 400 mg single dose (iii) Combination of both (iv) Placebo</td>
<td>Combination therapy has a significant microfilaricial effect than either DEC or ALB used alone.</td>
</tr>
<tr>
<td>Hussein et al.</td>
<td>2004</td>
<td>Prospective study two arms</td>
<td>(i) DEC 6 mg/kg and ALB 400 mg single dose (ii) Same repeated daily for 7 days</td>
<td>Combination therapy reduced adult worm activity by 90% after 1 year. No benefit of multiple dosing versus single dosing beyond 3 months.</td>
</tr>
<tr>
<td>El Setouhy et al.</td>
<td>2004</td>
<td>Randomized clinical trial two arms</td>
<td>(i) DEC 6 mg/kg and ALB 400 mg single dose (ii) Same repeated daily for 7 days</td>
<td>Greater and significant microfilaricial effects 1 year after treatment (effect on adult worms were similar) for multiple dose combined therapy.</td>
</tr>
<tr>
<td>Pani et al.</td>
<td>2002</td>
<td>Double-blind hospital based clinical trial three arms</td>
<td>(i) DEC 6 mg/kg single dose (ii) ALB 400 mg single dose (iii) Combination of both</td>
<td>Single dose administration of DEC, ALB, or combination therapy were not different from each other with regard to microfilaria-clearance rates and reducing antigenaemia.</td>
</tr>
<tr>
<td>Dreyer et al.</td>
<td>2006</td>
<td>Randomized controlled clinical trial two arms</td>
<td>(i) DEC 6 mg/kg single dose (ii) DEC 6 mg/kg + ALB 400 mg single dose</td>
<td>Significant reduction in macrofilaricial effect in the combined regime compared to DEC alone ( (P = .016) ) with no additional effect on microfilaria rates.</td>
</tr>
<tr>
<td>Ramzy et al.</td>
<td>2002</td>
<td>Prospective study</td>
<td>Single-dose DEC 6 mg/kg</td>
<td>DEC single dose therapy achieved a microfilaria-clearance rate of 69% in one year with a 40.7% reduction in antigenaemia.</td>
</tr>
<tr>
<td>Weerasooriya et al.</td>
<td>1998</td>
<td>Prospective study</td>
<td>Single-dose DEC 6 mg/kg</td>
<td>A reduction in microfilaria density by 74–80% and a 19–28% microfilaria clearance rate at 1 year after treatment.</td>
</tr>
<tr>
<td>Weerasooriya et al.</td>
<td>2002</td>
<td>Prospective study</td>
<td>A 12-day course of DEC 6 mg/kg</td>
<td>Microfilaria clearance achieved in 78% of infected people. However, 76.1% of them remained positive for the Og4C3 antigen at end of 17 months.</td>
</tr>
<tr>
<td>Beuria et al.</td>
<td>2002</td>
<td>Prospective study</td>
<td>DEC 6 mg/kg for 12 days</td>
<td>Only 57% and 18% tested negative for microfilaria and antigenaemia, respectively at the end of the followup period of 10 years.</td>
</tr>
<tr>
<td>Freedman et al.</td>
<td>2001</td>
<td>Prospective study</td>
<td>DEC 6 mg/kg for 12 days at 0,6,12,18 months</td>
<td>Only 12% clearance rate of antigenaemia at the end of a followup period of 2 years.</td>
</tr>
<tr>
<td>Beach et al.</td>
<td>1999</td>
<td>Randomized placebo-controlled clinical trial four arms</td>
<td>(i) IVM 200–400 ( \mu )g/kg single dose (ii) ALB 400 mg single dose (iii) Combination of both (iv) Placebo</td>
<td>Combined therapy with ALB and IVM reduces microfilaraemia more than placebo or individual drugs.</td>
</tr>
<tr>
<td>Richards et al.</td>
<td>2005</td>
<td>Prospective entomological survey</td>
<td></td>
<td>The combination of ALB and IVM appears to be superior to IVM alone for reducing the frequency of \textit{W. bancrofti} infection in mosquitoes.</td>
</tr>
<tr>
<td>Dunyo et al.</td>
<td>2000</td>
<td>Double-blind placebo-controlled field trial two arms</td>
<td>(i) IVM 150–200 ( \mu )g/kg single dose (ii) IVM 150–200 ( \mu )g/kg + ALB 400 mg single dose</td>
<td>Both IVM and combination treatment appeared effective for control of \textit{W. bancrofti} infections, but the difference in efficacy between the 2 treatments after 12 months appeared to be minimal.</td>
</tr>
</tbody>
</table>
4.2. Single Dose versus Combination Therapy. There are several studies comparing single drug therapy with combination therapy. Dreyer et al. [25] report a significant reduction in macrofilaricidal effect in the combined regime of DEC and ALB compared to DEC alone ($P = .016$) with no additional effect on microfilaria reduction rates. In a large randomized controlled clinical trial, Bockarie et al.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study design</th>
<th>Drug doses</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Ismail et al.   | 1996 | Double-blind clinical trial two arms | (i) 400 μg/kg of IVM 12 fortnightly doses  
(ii) 10 mg/kg of DEC 12 fortnightly doses | IVM has higher microfilarial (mf) clearance, and DEC has higher antigenaemia (ag) clearance. Both therapies had residual mf and ag levels comparable with each other following 1 and 3 months of dosing, respectively. |
| Ismail et al.   | 1998 | Blinded four-arm clinical trial  | (i) ALB 600 mg single dose  
(ii) ALB 600 mg + IVM 400 μg/kg  
(iii) ALB 600 mg + DEC 6 mg/kg  
(iv) IVM 400 μg/kg + DEC 6 mg/kg | All 4 treatments significantly reduced mf counts, but ALB/IVM was the most effective regimen for clearing mf from night bleed. All 4 treatments had significant activity against adult W. bancrofti with DEC+ALB having the greatest effect (Followup: 15 months). |
| Ismail et al.   | 2001 | Blinded three-arm clinical trial | (i) ALB 400 mg + IVM 200 μg/kg  
(ii) ALB 400 mg + DEC 6 mg/kg  
(iii) ALB 600 mg + IVM 400 μg/kg | All 3 treatments significantly reduced mf counts, with the ALB-DEC-treated group showing the lowest mf levels at 18 and 24 months after-treatment. All 3 treatments had significant activity against adult W. bancrofti; ALB-DEC combination had the greatest activity. |
| Makunde et al.  | 2003 | Crossover, double-blind design two groups | For group with coinfection with W. bancrofti and O. volvulus—single dose of IVM 150 μg/kg + 400 mg ALB versus placebo. Treatment was crossed over after 5 days of initial dosing  
For group with only W. bancrofti infection—Single dose of ALB 400 mg versus ALB+IVM 150 μg/kg | There was no significant difference in the reduction of microfilaraemia following treatment with ALB and IVM in groups with single or coinfection. IVM plus ALB is a safe and tolerable treatment for coinfection of bancroftian filariasis and onchocerciasis. |
| Stolk et al.    | 2005 | Prospective two-arm study two arms | (i) 400 μg/kg IVM single dose  
(ii) 6 mg/kg DEC single dose | IVM on average killed 96% of Mf and reduced Mf production by 82%. DEC killed 57% of Mf and reduced Mf production by 67%. |
| Reddy et al.    | 2000 | Double-blind two-arm clinical trial | (i) 400 μg/kg IVM single dose  
(ii) 6 mg/kg DEC single dose | Tolerability and efficacy of the two drugs (IVM, DEC) were not significantly different between gender, age, and weight classes of patients at two years. |
| Debra et al.    | 2006 | Double-blind placebo-controlled trial | Doxycycline 200 mg/d for 6 weeks followed by IVM 150 μg/kg + 400 mg ALB single dose 4 months later | Wolbachia load, microfilaraemia, antigenaemia, and frequency of filarial dance sign were significantly reduced in microfilaraemic patients up to 24 months in the doxycycline group compared to the placebo group. |
| Debra et al.    | 2009 | Double-blind placebo-controlled trial | Doxycycline 200 mg/d for 6 weeks followed by IVM 150 μg/kg + 400 mg ALB single dose 4 months later | Six-week regimen of doxycycline treatment showed improvement of clinical features of hydrocele patients with active infection. |
| Taylor et al.   | 2005 | Double-blind placebo-controlled randomized trial | Doxycycline 200 mg/d for 8 weeks | An 8-week course of doxycycline is a safe and well-tolerated treatment for lymphatic filariasis with significant activity against adult worms and microfilaraemia. |

response at one year. IVM is avoided in areas endemic for Loa loa [23, 24].
[26] demonstrated that single dose DEC (6 mg/Kg of body weight) has no superiority over combination therapy (DEC with ALB 400 mg single dose) in reducing microfilaria rates over a followup period of 2 years. Nonetheless, combination therapy had a significant macrofilaricidal effect ($P < .003$) compared to DEC alone at the end of followup (the antigen Og4C3 prevalence was used to measure adult worm activity). Fox et al. [27], in a large scale ($n = 990$) randomized placebo-controlled trial, showed that combination therapy has a significant macrofilaricidal effect compared to DEC or ALB used alone ($P < .03$). In a smaller prospective study, Hussein et al. [28] ($n = 58$) demonstrated that ultrasonographic evidence of adult worm nests showed a 90% reduction after 1 year from start of combination therapy with DEC+ALB. It was also shown that single dose therapy versus multiple doses (over 7 days) had no additional benefit in this regard. Conflicting evidence comes from El Setouhy et al. [29] who report significantly greater macrofilaricidal and macrofilaricidal effects at 1 year for multiple doses of combined therapy with ALB+DEC. IVM is usually administered in combination with ALB. Two studies have shown that the combination is more effective in killing microfilaria in humans and reducing infection rates in the vector than individual drugs or placebo [30, 31]. There is some speculation that IVM affects the reproductive capacity of female worms [32]. Five clinical trials in Sri Lanka [33, 34], Ghana [35, 36], and Tanzania [37] with a followup for 1-2 years have demonstrated the efficacy of ALB and IVM combination on microfilaria clearance. Two studies [33, 34] had an arm treated with high-dose IVM (400 μg/Kg) and ALB (Table 1). The Sri Lankan trials also compared the efficacy of IVM and ALB with DEC and ALB. Almost all regimens with IVM demonstrated a rapid kill rate of microfilaria with higher doses showing a greater reduction in microfilaria rates. A subsequent mathematical-model-based analysis based on these 5 trials has shown that the reduction of microfilaria with DEC and ALB is slower but long lasting [38]. While constructing the model, the authors have tried to assess the trends in microfilaria densities in several trials after starting treatment with different antifilarial drug combinations. Since the study populations were from endemic areas, it was assumed that before the start of treatment the microfilarial densities were at an equilibrium (production matched by elimination) and the effect of drugs were described in two terms; microfilaria loss (fraction of microfilaria killed) and worm productivity loss (fraction of microfilaria permanently rendered incapable of reproducing). As the maximum followup was 2 years in the studies entered into the model, new infections were thought not to affect the equilibrium as they would not yield microfilaria during this period due to the long premature period of the worm. By using this model authors have also tried to estimate how the microfilarial densities would change in the posttreatment period. From observed data, DEC- and ALB-based trials had an almost 100% worm productivity loss at both high and low doses of ALB while only the high-dose combinations of IVM and ALB recorded similar results. Even after allowing for acquisition of new infections, the efficacy estimates did not vary between the trial arms. Ismail et al. [33] recommend that ALB and DEC are a better option for mass chemotherapy for endemic populations, based on the high rates of microfilarial clearance.

Bockarie et al. [39–41], in a prospective study, recruited nearly 2500 people to receive four rounds of annual treatment in Papua New Guinea. They were randomly assigned to two treatment groups to receive either DEC and IVM or DEC alone. After four rounds of treatment (77%–86% compliance rate), microfilaria positive infections were reduced by 86–98%. Chronic manifestations such as lymphoedema and hydrocoele were also significantly reduced in the population ($P = .04, <.001$, resp.). There was no difference in the two drug regimens with regard to efficacy. However, the combination of IVM and DEC rapidly reduced microfilaria positivity, especially in high-transmission areas. Still, at the end of the four years, the odds of microfilaria transmission were the same for both regimens.

A double-blind clinical trial on a head-to-head comparison of high-dose IVM and DEC showed that IVM has a higher microfilarial clearance and DEC has a higher antigenaemia clearance [42]. Both therapies had residual microfilaria and Ag levels comparable with each other following 1 and 3 months of dosing, respectively. 4.3. Treating the Masses: Evidence from Mass Treatment Programmes. In 1997, WHO drew the blueprint to eliminate lymphatic filariasis by 2020 [1]. Mass drug administration (MDA) in endemic areas/countries was considered to be more cost effective than detecting and treating infected individuals. The low side effect profile of drugs and the pledge by two pharmaceutical companies to provide them free of charge, as long as necessary, made MDA a good elimination strategy. Currently, an estimated 754 million people in 81 countries are targeted for MDA and 546 million are already receiving it. Sixty-one countries have completed mapping of endemic areas, and in another 16 it is in progress. China and South Korea have already declared the elimination of lymphatic filariasis as a public health priority [43]. The use of MDA in filariasis gives the unique opportunity to see how the results of smaller clinical trials are valid when the drugs are administered to masses of general population. Currently there are three regimens approved for MDA, namely, DEC with ALB, IVM with ALB, and DEC- medicated salt [43].

In Burkina Faso, MDA with IVM alone (for onchocerciasis) has shown an indirect benefit by lowering *W. bancrofti* microfilaria rates. Kyelem et al. [44] reported that, in comparison to nonendemic and, therefore, nontreated communities, the treated communities had significantly lower microfilaria rates after six rounds of annual treatment. However, the rates of hydroceles and lymphoedema did not differ in the two communities. Furthermore, an entomological survey by Richards et al. [45] did not find significantly lower rates of infection in mosquitoes with *W. bancrofti* larvae in treated and untreated communities with IVM in Nigeria (MDA for onchocerciasis). All communities had good compliance with MDA, but only two rounds of treatment were completed in three of the five communities.
### Table 2: Summary of followup studies on cohorts receiving mass drug administration.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year published</th>
<th>Design</th>
<th>Drug regimen</th>
<th>Followup</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bockarie et al., Papua New Guinea</td>
<td>2002</td>
<td>Prospective controlled randomized clinical trial</td>
<td>(i) DEC 6 mg/kg single dose (ii) DEC 6 mg/kg + IVM single dose</td>
<td>5 years</td>
<td>Microfilaria positive infections were reduced by 86%–98%. Chronic manifestations such as lymphoedema and hydrocele were also significantly reduced in the population. No difference in two regimens at end of followup.</td>
</tr>
<tr>
<td>Kyelem et al., Burkina faso</td>
<td>2003</td>
<td>Prospective two-arm study</td>
<td>Communities receiving IVM 150 μg/kg annually compared with communities not receiving MDA</td>
<td>6 years</td>
<td>Long-term IVM (given for onchocerciasis) significantly reduced <em>W. bancrofti</em> and <em>M. perstans</em> microfilaraemia.</td>
</tr>
<tr>
<td>Richards et al., Nigeria</td>
<td>2005</td>
<td>Cross-sectional entomological survey</td>
<td>Communities receiving IVM 150 μg/kg annually</td>
<td>2-3 annual rounds of chemotherapy completed</td>
<td>Annual therapy with IVM for onchocerciasis has not interrupted transmission of <em>Wuchereria bancrofti</em>.</td>
</tr>
<tr>
<td>Ramaiah et al., 2007</td>
<td></td>
<td>Community-based followup study with two arms</td>
<td>DEC 6 mg/kg, single dose annual therapy versus IVM 400 μg/kg single dose annual therapy</td>
<td>10 years</td>
<td>DEC had the potential to interrupt transmission while the capability of IVM to do so was less.</td>
</tr>
<tr>
<td>Liang et al., 2008</td>
<td></td>
<td>Followup study</td>
<td>DEC + ALB standard dosing</td>
<td>6 years</td>
<td>The antigenaemia prevalence dropped from 11.5% in 2001 to 0.95% in 2006 (<em>P</em> &lt; .0001).</td>
</tr>
<tr>
<td>Mataika et al., Fiji</td>
<td>1995</td>
<td>Followup study</td>
<td>Annual single dosing of DEC 6 mg/kg</td>
<td>5 years</td>
<td>MDA with DEC alone led to a statistically significant reduction in microfilaria rates irrespective of the pretreatment mf rates.</td>
</tr>
<tr>
<td>Freeman et al., Haiti</td>
<td>2001</td>
<td>community-based trial</td>
<td>DEC medicated salt</td>
<td>1 year</td>
<td>DEC and Iodine fortified salt lowered the prevalence and intensity of microfilaraemia by 95%. Impact on adult worms was less.</td>
</tr>
<tr>
<td>Meyrowitsch et al., Tanzania</td>
<td>1996</td>
<td>community-based trial</td>
<td>Comparison of four strategies of community treatment with DEC 6 mg/kg (i) 12 day regimen (ii) Semiannual single dose treatment (iii) Monthly low dose regimen (iv) DEC medicated salt</td>
<td>2 years</td>
<td>Strategies III and IV were equally effective, and superior in clearing microfilaraemias and in reducing mf geometric mean intensities compared to strategies I and II.</td>
</tr>
<tr>
<td>Meyrowitsch et al., Tanzania</td>
<td>2004</td>
<td>community-based trial</td>
<td>Followup of above-study</td>
<td>10 years</td>
<td>Microfilaria rates were reaching pretreatment values in all communities.</td>
</tr>
<tr>
<td>Fan et al., China</td>
<td>1990</td>
<td>Community-based trial</td>
<td>DEC medicated salt</td>
<td>12 years</td>
<td>Microfilaria rates and infection rates were reduced from 9.6% to 0.3% and 9.1% to 0.8%, respectively.</td>
</tr>
<tr>
<td>Liu et al., China</td>
<td>1992</td>
<td>Community-based trial</td>
<td>DEC medicated salt</td>
<td>4 years</td>
<td>Microfilaria rates dropped from a range of 1.56–11.81% to 0.05% in the communities studied.</td>
</tr>
<tr>
<td>Sunish et al., India</td>
<td>2002</td>
<td>Community-based trial with three arms</td>
<td>Group A: MDA with annual single dose of IVM 400 μg/kg + DEC 6 mg/kg Group B: MDA with vector control Group C-Placebo</td>
<td>3-4 years</td>
<td>The improvement with MDA was sustained in the second group while resurgence occurred in the first group.</td>
</tr>
</tbody>
</table>
4.4. The Role of DEC-Fortified Salt. DEC-medicating cooking salt has been used to facilitate mass treatment and has proved successful in more limited trials in India, Brazil, and Tanzania [49–52]. All of them have demonstrated effective microfilaria kill rates [49, 51, 54–56]. A large community-based trial in Haiti, over a period of 1 year, has shown that DEC- and Iodine-fortified salt lowered the prevalence and intensity of microfilaraemia by 95% [57]. However, the impact on adult worms was less (60% reduction in Oq4C3 antigenaemia and a nonsignificant reduction in motility of worm nests detected by ultrasound).

5. Resurgence after MDA: Is Eradication Possible?

WHO aims to achieve cessation of transmission of infection after 4–6 rounds of therapy yearly (which corresponds to the fecundity of the adult worms) provided the compliance is good. However, initial small-scale trials failed to completely clear microfilaria rates with either combination of drugs, though the ALB+DEC combination had a lasting effect. The followup studies after several MDA rounds confirm this. Meyrowitsch et al. [58] report that after 10 years of MDA with DEC (given in three regimens) the microfilaria levels were reaching the pretreatment value in all communities. Many of the recurrences were in previously microfilaria positive individuals indicating the possibility of reproduction from surviving female adults. A three-arm community-based trial in India assessed the impact of two rounds of annual MDA after 3 years since the last dosing. The improvement with MDA was sustained when therapy was combined with vector control [59, 60]. The importance of vector control and understanding of local transmission dynamics are also underscored by Simonsen et al. [61], who have shown that after two rounds of MDA, mosquitoes carrying infective larvae were not reduced, though mf rates in the community were significantly less. The most suitable cohort to study the impact of long-term MDA is the Maupiti cohort of French Polynesia where semiannual MDA has been combined with vector control since 1955. Two surveys in 1985 and 1989 showed a 0% microfilaria rate which gave hope that eradication was complete. Nonetheless, Esterre et al. [62] in two repeated cross-sectional analyses in 1997 and 1999 have shown residual microfilaraemia and antigenaemia (0.4% and 4.6%, resp.) with a 14% infectivity rate in vector population. There are several plausible explanations for this...
observation: efficiency of the vector, resistance to DEC, and prolonged longevity of adult worms. These findings cast doubt on the possibility of a complete “eradication” of filariasis with MDA.

In this background, Micheal et al. [63, 64] suggest that plans to control lymphatic filariasis should be more pragmatic, flexible, economically sensitive, and sequential. They suggest that the first target in an elimination programme should be to achieve an infection rate at which chronic manifestations of infection (causing more productivity loss and DALYs) become negligible despite ongoing infection. Using a mathematical model based on available data it is suggested that a microfilaria rate of 3.55% at a blood sampling volume of 1 ml will achieve this. This target is both achievable and sustainable with current MDA regimens.

6. Resistance to Drugs

One factor linked to resurgence of infection following MDA is the resistance to drugs. It is impossible to assess the resistance to DEC as its mechanism of action is still obscure. However, resistance to IVM and ALB has been reported in nematodes in veterinary practice. In 2004, resistance to IVM was reported in the human parasite *Oncocerca volvulus* [65]. There are yet no confirmed reports of resistance in *W. bancrofti* for IVM.

The main cause for concern, however, is resistance to Benzimidazoles (BZ), namely, ALB. The resistance to BZs (ALB, Mebendazole) is seen in many nematode parasites due to single nucleotide polymorphisms (SNP) [66]. Two SNPs substituting tyrosine for phenylalanine of the β tubulin protein of nematodes confer resistance to ALB in veterinary practice. Schwab et al. [67, 68] have demonstrated that similar SNPs exist in *W. bancrofti* in untreated populations, and such mutations are selected for after mass treatment. The impact of this may not be felt immediately in the population as microfilarial rates drop rapidly with combined chemotherapy. Still, if resurgence occurs in future, resistant genotypes with a selection advantage may predominate in the parasite population making ALB resistance a significant problem. However, as some authors point out, the real problem is not related to *W. bancrofti* at all it is the possibility of other intestinal nematodes developing resistance to BZs due to large scale exposure to ALB during MDA that could pose a serious threat to health of children and adults in endemic areas [69].

7. The Place for Targeting Wolbachia with Doxycycline in Treatment Regimens

*Wolbachia* is an intracellular symbiotic bacterium of filarial parasites. It plays an essential role in larval moulting, adult worm survival, and female worm fertility. Killing the bacterium with doxycycline has shown promise in many studies by reducing adult worm activity [70, 71]. Though doxycycline therapy has been experimented with for treating infections with other filarial worms, the first trial with regard to *W. Bancrofti* was conducted in 2005 by Taylor et al. [72] after 8 weeks of doxycycline 200 mg/d, microfilaraemia was almost eliminated (P < .001), antigenaemia was halved (P = .015), and ultrasonographically demonstrated adult worm activity was significantly less (P < .0001) in the treatment group versus placebo group (after 14 months of followup). There were no serious side effects with treatment. Subsequent studies with shorter courses of doxycycline (6, and 4 weeks, resp.) have shown a similar effect. In these studies antibacterial therapy was followed up with IVM+ALB combined therapy [73, 74]. However, a 3-week course of the drug failed to show an adequate macrofilaricidal effect [75].

In addition to killing the endosymbionts and reducing the filarial worm load, doxycycline also improves clinical manifestations of filariasis. The levels of vascular endothelial growth factor C (VEGF-C) and soluble vascular endothelial growth factor receptor-3 (sVEGFR-3), which has been shown to be important in pathogenesis of filariasis in animal models, were lowered in test subjects following doxycycline therapy [76]. The macrofilaricidal effect of doxycycline is slow compared to DEC, and the side effects seen after DEC treatment (abscesses, etc.) are not seen. Addition of doxycycline to treatment regimens will have a beneficial effect especially in Onchocercia endemic areas where DEC is contraindicated. IVM used in these areas have no or minimum macrofilaricidal effect.

8. Limitations

This review was limited to articles published in English within 1999–2009 time period. While attempts were made to search related literature as well, it is possible that important studies published in other languages and outside the search limits were missed.

9. Conclusions

WHO has outlined two objectives for its campaign of MDA: to interrupt transmission and to reduce morbidity of disease [1]. The best combination of drugs for an MDA programme was still not clarified by the time the programmes were launched in endemic areas. Clearly, one of the main difficulties in determining the efficacy of individual drugs is that different endpoints have been used in different trials (microfilaria-clearance rates, antigenaemia-clearance rates etc.), and correlating efficacy based on these endpoints and actual clinical efficacy is difficult. As individual drugs, IVM reduced the microfilaria rates rapidly, but DEC had more macrofilaricidal effects with a higher clearance of antigenaemia. The only available large-scale community-based trial to evaluate IVM versus DEC, showed that the latter was more effective in interrupting transmission [46]. The evidence for benefits of combination therapy is also conflicting but many studies favour it. Only two studies quoted above show no difference between single and combination therapy while Dreyer et al. [25] actually report a loss in macrofilaricidal effect of DEC when given in combination. However, this study uses ultrasound evidence to assess outcome rather than the antigen clearance. It may be difficult to correlate
antigenaemia to macrofilaricidal effects as shown by a large scale study in Sri Lanka. After a 12-day course of DEC, 78% showed microfilaria clearance. However, of 76% of those “cured” parasitologically were still positive for the Og4C3 antigen at 17 months [77]. The ALB+DEC regimen was considered a better option for nononchocercaria endemic areas than the ALB+IVM regimen. Nonetheless, large-scale randomized clinical trials are not available to formulate evidence-based guidelines for chemotherapy, and currently only recommendations can be made in treating bancroftian filariasis based on available evidence.

Despite 50 years of research into filariasis control, still many questions remain unanswered. These include basic issues like mechanism of action of DEC, best combination of drugs for elimination strategies, and evidence-based recommendations to treat lymphatic filariasis. Differences in the end-points of treatment studied add confusion to the benefits of the different drugs and drug combinations. Much of the recommendations for therapy are based on microfilaremia and antigenaemic clearance; evidence of reduction of clinical manifestations has not been studied adequately in either large-scale population surveys or clinical studies. The need to identify clear endpoints in future clinical trials and population surveys cannot be overemphasised. The policies of MDA also need to be reviewed, and, as community-based studies have shown, despite intensive therapy, that infection rates have not been reduced to zero. It is important to combine vector control with MDA and develop elimination strategies that are flexible and achievable in local context. Perhaps it is more important to target an infection rate that reduces the impact of lymphatic filariasis as a public health problem rather than aim towards total eradication, as eventually what matters is that the clinical manifestations of lymphatic filariasis are prevented.

References


[47] J. L. Liang, J. D. King, K. Ichimori, T. Handzel, M. Pa’au, and P. J. Lammie, “Impact of five annual rounds of mass drug administration with diethylcarbamazime and albendazole...


[74] A. Y. Debrah, S. Mand, Y. Marfo-Debrekyei et al., “Reduction in levels of plasma vascular endothelial growth factor-A and improvement in hydrocele patients by targeting endosymbiotic Wolbachia sp. in Wuchereria bancrofti with doxycycline,”


Submit your manuscripts at
http://www.hindawi.com