Study of Cryptosporidium infection in Liver Cirrhosis and animal model.

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Study of Cryptosporidium Infection in Liver Cirrhosis and Animal Model
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ABSTRACT
Background: Cryptosporidium is a parasite that infects man especially immunocompromised patients. Liver cirrhosis reduced cellular immunity. Methods were used for diagnosis of cryptosporidium including coproscopy and copro-nested (copro-n) PCR assay. Aim of the study: Detection of the molecular and genotypic prevalence of Cryptosporidium species in fecal samples of Egyptian patients with cirrhotic liver and exploring the possibility of association between Cryptosporidium and grades of liver cirrhosis, besides assessment their histopathological changes. Patients and Methods: This cross-sectional study was carried out on 60 patients with chronic liver disease (HCV and HBV positive) classified according to Child-Pugh score and 60 subjects free of any known liver diseases as a control group. Stool samples were taken for coproscopy using acid-fast (AF) stain and copro-nPCR assay. We designed animal model for studying the effect of Cryptosporidium infection by assessing histopathological changes in intestine of immunosuppressed and non-immunosuppressed rats. Results: There is low prevalence of cryptosporidial infection in patients with liver cirrhosis (3.3%) by using copro-nPCR corresponding to 0% by coproscopy. The prevalence among patients with hepatocellular carcinoma (HCC) and grade C liver cirrhosis were (6.9%) and (5.3%) respectively. The predominant genotype was Cryptosporidium parvum. Regarding animal study, there were no significant intestinal histological changes except a decrease in goblet cells count in immunosuppressed rats. Conclusion: Copro-nPCR is more powerful than coproscopy for detection of cryptosporidial infection. The prevailing genotype was C.parvum. There is no strong association between liver cirrhosis and cryptosporium infection but chance for infection may increase with the development of HCC or when patients become decompensated. Demographic, environmental, and clinical data are not associated with cryptosporidial infection.

Keywords: Cryptosporidium; Liver Cirrhosis; Copro-nPCR, animal study.

INTRODUCTION
Cryptosporidium is a protozoan parasite which causes diarrhea in humans by infecting epithelial cells in the small intestine. It is a developing zoonosis having reservoirs in cattle, domesticated animals, and fecal polluted environments with a global distribution.1

Ingestion of Cryptosporidium oocysts by polluted food or water (drink and recreation water) or direct human-to-human and animal-to-human contact results in transmission via the fecal-oral pathway. These small-sized oocysts (4-6 μm) are highly resistant to common household disinfectants.2

The risk factors for such protozoans, such as demographic, ecological, and environmental data, reveal that zoonotic transmissions as well as water transmission methods are the main infection routes.3

In patients having good immunity, diarrhea would be frequently mild and self-limiting. In patients with compromised immunity, though, it can be severe, long-lasting, and life-threatening.4

Previous research has found a link between severe hepatic injury and hepatic failure and a reduction in cellular immunity.5 The Cryptosporidium was found in 32% of sick people having hepatocellular carcinoma and diarrhea in recent times, comparable to 22% of sick people having liver cirrhosis without ascites and 36% of sick people having liver cirrhosis with ascites. Cryptosporidium oocysts have been found in the stools of 20 % of people with hepatic illness.6

This type of Cryptosporidium-related diarrhea is not uncommon. As a result, laboratory diagnostic tests must be used to make the diagnosis. Cryptosporidium infection is not routinely diagnosed in most clinical laboratories, despite significant developments in diagnostic technology.7 Few microscopic techniques are routinely employed to detect Cryptosporidium in
feces, depending on the oocysts’ characteristic morphology. A complicated clinical specimen like feces, on the other hand, makes identification difficult. It would be also time-consuming and tiresome, and it necessitates a significant deal of expertise.\(^8\)

Neither microscopy nor coproantigen assays are capable of achieving this goal. As a result, various PCR-based assays for detecting and characterizing Cryptosporidium DNA in feces have been recently developed.\(^9\)

The application of molecular epidemiologic methods has revealed fresh information about the variety of Cryptosporidium species that infect animals and humans.\(^10\) There are a total of 26 Cryptosporidium species known so far.\(^11\) C. hominis and C. parvum are responsible for the majority of human cases.\(^10\) Many other Cryptosporidium species, such as C. felis, C. meleagridis, C. cuniculus, C. canis, and C. ubiquitum, are found in human beings at a lesser frequency.\(^10\) A new species, C. viatorum, has recently been discovered in ten passengers returning from the Indian subcontinent to the United Kingdom.\(^12\)

This study was done for Detection of the molecular and genotyping prevalence of Cryptosporidium spp. in stool specimens of Egyptian patients with cirrhotic liver and to investigate the potential for a link between Cryptosporidium spp and grades of liver cirrhosis, also to assess their demographic, clinical, and environmental data for risk assessment through a case-control study design. Besides assessing the histopathological changes in rats.

**PATIENTS AND METHODS**

**Study population**

This cross-sectional study included 60 patients (33 men and 27 women) with chronic liver disease (HCV and HBV positive) and 60 participants (32 men and 28 women) without any known liver disorders as a control group, who were matched for ethnicity, gender, and age.

Patients from El Hussein University Hospital and Kasr Al-Ainy University Hospital were chosen. Stool samples were collected from September 2017 to January 2020.

Positive anti-HCV and reverse transcription-polymerase chain (PCR-RT) were used to diagnose hepatitis C virus (HCV), while positive hepatitis B surface antigen (HBsAg) and PCR were used to diagnose hepatitis B virus (HBV). A history, clinical examinations, abnormal liver function testing, and abdominal ultrasonography were used to diagnose cirrhosis of the liver.

Using a modified Child-Pugh score, the patients have been further categorized in order to determine the relationship between Cryptosporidium infection and the liver disease severity. The Child-Pugh score is made up of 5 clinical parameters that are used to evaluate the diagnosis of chronic liver illnesses based on ascites degree, bilirubin and albumin plasma concentrations, prothrombin time, and encephalopathy degree. The overall points for every item are represented by the Child-Pugh score. Patients are classified into Child-Pugh grades based on the sum of these points. Grade A (well-compensated disease) is defined as a total score of 5 to 6; grade B (severe functional compromise) is defined as a total score of 7 to 9, and grade C is defined as a total score of 10 to 15 (decompensated disease).

Depending on clinical, analytical, and epidemiological data, all known causes of liver diseases other than HCV and HBV were excluded, as were all patients with immunosuppression (such as diabetes and HIV infection) were excluded. In summary, participants were selected from the outpatient clinics of the Departments of Gastroenterology, Infectious Diseases at Al-Azhar University Hospitals in Cairo. The study followed the 1975 Declaration of Helsinki’s medical ethics, and all subjects gave written informed consent.

**Sample and data collection.**

Each subject provided a single faeces sample, which was collected and labelled in a clean, dry, leak-proof plastic container. With each sample, a questionnaire covering demographic, clinical, and environmental data was acquired. The designed questionnaire was modified from Da’as \(^13\) and Mor et al.\(^14\)

**Work plan and sample processing.**

All collected fecal samples were examined coproscopically, then subjected for copro-molecular assays.

Each specimen was broken down into 3 portions: A) A small part of each specimen for direct smear examination. B) Another part of the specimens was preserved in tight containers using formalin saline 10% fixative for coprosopic inspection and staining. C) The remainder of the sample was preserved in eppendorf tubes at -20°C for molecular study.

Coproscopy was performed at Cairo University’s Kasr Al-Ainy Faculty of Medicine's Diagnostic and Research Unit of Parasitic Diseases (DRUP). The lab of Molecular Medical Parasitology (LMMMP), Medical Parasitology Department, Kasr Al-Ainy Faculty of Medicine, Cairo University, Egypt, conducted the copro-nPCR assay.

**Parasitological Coproscopic Examination:**
Macroscopic examination of all collected fecal samples was conducted at first regarding physical characteristics, presence of blood, mucus, and macroscopic parasite elements. Then, samples were subjected to wet mounting examination prior to and following formalin-ethyl acetate concentration technique for detection of parasites.

**Direct wet smear.**

Wet smears were examined directly using saline and a drop of iodine was added to another slide.

**Concentration using modified Ritchie’s biphasic method.**

This is a modification of formol ethyl-acetate concentration method according to Garcia.¹⁵

**Specialized staining of Cryptosporidium spp. Oocysts Cold kinyoun’s AF stain.**

All fecal samples were permanently stained to detect Cryptosporidium spp. oocyst utilizing cold kinyoun’s AF stain according to Garcia. ¹⁵

**Copro-nPCR / RFLP assays.**

**Genomic DNA extraction from stool samples.**

The stool DNA isolation Mini Kit from Favor Prep was used (Favorgen Biotech corporation ping-Tung 908, Taiwan, Cat. No. FASTI001).

**Principle**

This is a solid phase spin column method. It involves; cell disruption with digestion of proteins and their degradation under denaturing conditions during 95°C incubation with proteinase K. Buffering conditions were then adjusted to be of a high ionic strength to allow adsorption of DNA onto the silica membrane. Washing away impurities (stays of digested proteins as well as other impurities that could hinder PCR and other downstream enzymatic operations) using a prepared alcohol solution. Under low ionic strength conditions equilibrated to room temp, pure and concentrated DNA was extracted from the Mini spin column.

**Amplification of extracted genomic DNA (Copro n-PCR).**

**Principle**

In vitro, PCR is a technique for enzymatically amplifying a particular DNA region which sits between two known DNA sequence areas. It is based on thermal cycling, which involves heating and cooling the reaction repeatedly for DNA melting and enzymatic replication of the DNA with thermostable DNA polymerase (after which the method was named), primer sequence (complementary to the targeted area in the template DNA) and deoxynucleotide triphosphates (dNTPs) (the building units). As PCR advances, the DNA created is employed as a template for replication, exponentially amplifying the DNA template by up to one billion times.¹⁶

Two sequential sets of primers were employed in two consecutive reactions in extended (nested) PCR. A pair of external primers are utilized to create DNA products in the first PCR.

The products from the first PCR are then used as templates in a second PCR, using two different primers whose binding sites are located (nested) within the first set (are internal to the first primer pair), thus increasing specificity. Nested PCR is often more successful in specifically amplifying long DNA products than conventional PCR.¹⁷

**Detection of PCR products**

Following ethidium bromide staining, PCR products have been visualized using gel electrophoresis and a UV transilluminator on a 1.5 % agarose gel.¹⁸

**RFLP analysis and molecular characterization of the amplified products.**

The DNA sample is fragmented and digested with restriction enzymes, with the resultant restriction fragments separated by gel electrophoresis as per their lengths.

After ethidium bromide staining, the amplified products of nPCR of positive samples were digested using restriction enzymes according to the manufacturer's instructions and resolved with 3% Mataphore.

**Experimental animals**

The animal model for this study was 30 adult healthy albino rats weighing from 150 to 200 grams each. They were kept in suitable cages (30x32x30 cm for every five rats) at room temp and on a natural light/dark cycle. They were fed standard food as well as bread and green vegetables and were given unlimited access to water. Rats have been randomly assigned to one of two groups: control (CNT) and Cryptosporidium oocysts inoculated (Cry) group. Using 18–20 gauge feeding tubes, oocysts were inoculated to rats in the Cry group via oral-gastric gavage. Each rat was given 200 μl liters of PBS with various 10⁷ oocysts¹⁸. Cry group were subdivided into two subgroups. Two weeks before Cryptosporidium oocysts inoculation, one subgroup (Cry-AZ) was given drinking water that contains azathioprine as immunosuppressant drug (Sigma Aldrich A4638) has been dissolved at 0.04 mg/mL and the estimated dose was 6-20 mg/kg body weight per day, as stated by others before ²⁵. The rest of the rats in Cry group did not receive any treatment. The CNT group was given PBS as a control vehicle. Rats were followed up to 50 days. On day 51, all rats were sacrificed.

**Histopathology study**
Sections of the duodenum were imbedded in a 10% formaldehyde solution for the fixation method, and tissues were treated with graded alcohols, xylene, and paraffin. Afterwards, in a transverse plane, 5-μm-thick sections of blocked duodenal tissue were produced with a rotary microtome. For examination under light microscopy at 100x, all the sections were placed on glass slides and stained with hematoxylin and eosin (H&E). As Bethune et al. did, we calculated the villus height/crypt depth (V:C) ratios from linear measurements of 5 villus heights divided by the corresponding crypt depths. Villus height was measured linearly from the top of the villi to the mouth of the Lieberkuhn crypt, and crypt depth was measured from the mouth of the Lieberkuhn crypt to the upper border of the intestinal lamina muscularis.

We performed quantitative histological studies for goblet cells. Sections were stained by PAS and H&E then viewed under light microscopy at 400x. The total number of PAS positive cells and number of epithelial cells were counted in a blinded fashion for 15 to 25 longitudinal sections of villi and crypts. We express the number of goblet cells as number of PAS positive cells per 100 as demonstrated by Katz’s lab.

We also evaluate inflammatory cells in longitudinal sections of intestinal villi. The frequency of inflammatory cells infiltrate was assessed as 1 for mild infiltrate, 2 for moderate infiltrate and 3 for sever infiltrate.

The image analysis was performed using Image J software.

**Statistical Analysis**

The data was gathered, edited, coded, and entered into IBM SPSS version 23 (Statistical Package for Social Science). When parametric data was used, mean, standard deviations, and ranges were used to present the quantitative data. Qualitative variables were also provided as numbers and percentages. When the predicted count in any cell was < 5, the Chi-square test and/or Fisher exact test were used to compare groups' qualitative data. The Independent t-test was used to compare quantitative data and parametric distribution between two groups, whereas the One-Way ANOVA test was used to compare more than two groups. The margin of error accepted was set to 5%, with a 95% confidence interval.

**RESULTS**

<table>
<thead>
<tr>
<th>Patients group No. = 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryptosporidium by acid fast stain</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cryptosporidium by PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 1: Cryptosporidium by acid-fast stain and cryptosporidium by PCR among the patient's group.

<table>
<thead>
<tr>
<th>Patients group No. = 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV or HBV</td>
</tr>
<tr>
<td>HCV</td>
</tr>
<tr>
<td>HBV</td>
</tr>
<tr>
<td>HCC</td>
</tr>
<tr>
<td>No HCC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child A</td>
</tr>
<tr>
<td>Child B</td>
</tr>
<tr>
<td>Child C</td>
</tr>
</tbody>
</table>

Table 2: APBI in the studied patients’ groups pre- and post-operative.

<table>
<thead>
<tr>
<th>Cryptosporidium by PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV or HBV Test value P-value Sig.</td>
</tr>
<tr>
<td>HCV</td>
</tr>
<tr>
<td>No 49 (96.1%) 0.365 0.546 NS</td>
</tr>
<tr>
<td>Yes 2 (3.9%)</td>
</tr>
<tr>
<td>HBV 9 (100.0%)</td>
</tr>
<tr>
<td>0 (0.0%)</td>
</tr>
</tbody>
</table>

Table 3: Relation of cryptosporidium detection by PCR to HCV or HBV in patients’ group. (P-value > 0.05: Nonsignificant; P-value < 0.05: Significant; P-value < 0.01: Highly significant*: Chi-square test; *: Independent t-test).
Table 4: Relation of cryptosporidium detection by PCR to HCC in patients’ group. (P-value > 0.05: Nonsignificant; P-value < 0.05: Significant; P-value < 0.01: Highly significant*: Chi-square test; •: Independent t-test).

<table>
<thead>
<tr>
<th>Cryptosporidium by PCR</th>
<th>HCC</th>
<th>No HCC</th>
<th>Test value</th>
<th>P-value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>27 (93.1%)</td>
<td>31 (100.0%)</td>
<td>2.212*</td>
<td>0.137</td>
<td>NS</td>
</tr>
<tr>
<td>Yes</td>
<td>2 (6.9%)</td>
<td>0 (0.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Relation of cryptosporidium detection by PCR to Child score in patients’ group. (P-value > 0.05: Nonsignificant; P-value < 0.05: Significant; P-value < 0.01: Highly significant*: Chi-square test; •: One Way ANOVA test).

<table>
<thead>
<tr>
<th>Cryptosporidium by PCR</th>
<th>Child A</th>
<th>Child B</th>
<th>Child C</th>
<th>Test value</th>
<th>P-value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>4 (100.0%)</td>
<td>18 (100.0%)</td>
<td>36 (94.7%)</td>
<td>1.198*</td>
<td>0.549</td>
<td>NS</td>
</tr>
<tr>
<td>Yes</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>2 (5.3%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6: Relation of the prevalence of cryptosporidium by PCR to demographic and environmental data in patients’ group. (P-value > 0.05: Non significant; P-value < 0.05: Significant; P-value < 0.01: Highly significant).

<table>
<thead>
<tr>
<th>Cryptosporidium by PCR</th>
<th>Control group</th>
<th>Patients group</th>
<th>Test value*</th>
<th>P-value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No. = 60</td>
<td>No. = 60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No. = 58</td>
<td>No. = 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7: Relation of clinical data, macroscopic results to the prevalence of cryptosporidium by PCR in patients group. (P-value > 0.05: Non significant; P-value < 0.05: Significant; P-value < 0.01: Highly significant).

<table>
<thead>
<tr>
<th>Cryptosporidium by PCR</th>
<th>Main complaint</th>
<th>Stool content</th>
<th>Stool consistency</th>
<th>Test value</th>
<th>P-value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Diarrhea</td>
<td>Normal</td>
<td>Formed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Abdominal discomfort</td>
<td>Blood</td>
<td>Soft</td>
<td>29 (50.0%)</td>
<td>55 (94.8%)</td>
<td>27 (46.6%)</td>
</tr>
<tr>
<td>No</td>
<td>Abdominal pain</td>
<td>Mucus</td>
<td>Watery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24 (41.4%)</td>
<td>Blood and mucus</td>
<td>Formed</td>
<td>29 (50.0%)</td>
<td>55 (94.8%)</td>
<td>27 (46.6%)</td>
</tr>
<tr>
<td>No</td>
<td>5 (8.6%)</td>
<td>2 (3.4%)</td>
<td>23 (39.7%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1 (50.0%)</td>
<td>1 (0.0%)</td>
<td>1 (50.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>24 (41.4%)</td>
<td>1 (0.0%)</td>
<td>0 (0.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 (8.6%)</td>
<td>2 (3.4%)</td>
<td>0 (0.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Comparison between control group and patients’ group regarding cryptosporidium by PCR. (P-value > 0.05: Nonsignificant; P-value < 0.05: Significant; P-value < 0.01: Highly significant).

<table>
<thead>
<tr>
<th>Cryptosporidium by PCR</th>
<th>Control group</th>
<th>Patients group</th>
<th>Test value*</th>
<th>P-value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No. = 60</td>
<td>No. = 60</td>
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<tr>
<td>Yes</td>
<td>No. = 60</td>
<td>No. = 60</td>
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</tbody>
</table>

53
Regarding histological studies in our animal model, we assessed the villus height and crypt depth (V/C) in the duodenum. We found a reduction in V/C ratios in Cry and Cry+AZ groups compared to the CNT group which indicates villus atrophy, but it wasn’t statistically significant (F= 2.99, P= 0.0634, One way ANOVA) (Figure 1 & 2).

We performed Periodic Acid Schiff (PAS) staining for detection and making quantitative analysis for goblet cells. There was a mild significant decrease in goblet cells count in Cry+AZ group while in Cry group there was no change (F= 6.23, P= 0.01, One way ANOVA, Tukey’s multiple comparisons test: CNT vs Cry+AZ p<0.05) (Figure 1 & 3).

We studied inflammatory cells infiltrate in intestinal villi. There were some changes between Cry and Cry+AZ and CNT groups but without statistically significance (F= 0.326, P= 0.73, One way ANOVA) (Figure 1 & 4).

![Graphs showing V/C ratio, goblet cells count, and inflammatory cells infiltrate](image)

**Fig 1:** (A) V/C ratio in the duodenum of CNT, Cry and Cry+AZ groups. It shows no significant changes between the groups. (B): It shows goblet cells count in each 100 epithelial cells. There was a significant reduction in goblet cells count in Cry+AZ group. (C) Score grades for inflammatory cells infiltrate in the duodenum of CNT, Cry and Cry+AZ groups. There were no significant changes between the groups.

![Images of H&E-stained duodenum showing normal morphology and atrophy](image)

**Fig 2:** Representative images of H&E-stained duodenum showing normal morphology of the villi in the control group (Image A) with atrophy of some villi in Cry group (Image B) and Cry+AZ group (Image A) (100X, scale bar 100 μm).

![Images of PAS-stained goblet cells](image)

**Fig 3:** Representative images of PAS-stained goblet cells in the duodenum. There was no statistically significant difference in goblet cells count between Control (Image A) and Cry group (Image B). There was a mild decrease in goblet cells count in Cry+AZ group (Image A) vs control (100X, scale bar 100 μm).
DISCUSSION

The key goal of our study was detection of the molecular and genotyping prevalence of Cryptosporidium spp. in fecal samples of Egyptian patients with cirrhotic liver and exploration of the possibility of association between Cryptosporidium spp and grades of liver cirrhosis, also assessment of their demographic, clinical and environmental data for risk assessment through a case-control study design.

Cryptosporidium infection was documented in individuals ranging in age from 3 days to 95 years old all over the world. In Egypt, the prevalence of C. parvum ranged from 0%–47%. Cryptosporidium parvum prevalence among Egyptian military recruits was 31.1%. Previous research has linked severe liver injuries and liver failure to decreased cellular immunity. In people with chronic liver disease, decreased cellular immune function may increase their vulnerability to infection, which include infection with Cryptosporidium. Cryptosporidium oocysts were found in the faeces of 20% of liver disease patients.

Regarding the methods of detection, the obtained results of the current research were in accordance with many studies. Similar findings were obtained by Kaushik et al. when Cryptosporidium oocysts were detected in 4.6% (7), 3.9% (6), and 13.7% (21) (n= 153). by AF stain, ELISA, and PCR, respectively in children suffering from diarrhea.

The obtained results were in disagreement with another one in Cairo, Egypt that reported the most sensitive method in detecting the incidence of Cryptosporidium infection in diarrhea patients was ICT as the rate was 5.9%, 5.1% or 4.6%, by ICT, microscopy, and PCR respectively. While prior studies have shown that fecal PCR has a high sensitivity rate, the existence of bilirubin, bile salts, as well as other pollutants in feces might hinder DNA extension in PCR reactions, rendering detection less reliable, according to the author.

Several authors considered PCR to be the gold standard because of its higher sensitivity. In the present study we nominated nPCR assay as our gold standard.

Also, the fact that mixed infections, re-infections, as well as cross-infections with intestinal and gastric Cryptosporidium species may occur in human cryptosporidiosis could be an added explanation why we got a higher sensitivity using molecular detection methods than parasitological and immunological ones in our study.

The most common genotypes in people are C. hominis and C. parvum. In our study revealed only that the genotype was C. parvum. This finding matched those of another study conducted in Egypt, which found that C. parvum predominated over C. Hominis. However, this contradicts the findings of another study in Egypt, which found a higher incidence of C. hominis than C. Parvum.

In terms of the lower prevalence 3.3% (2/60) in sufferers having chronic liver cirrhosis and (0%) in the control group, our study agreed with study in Human province, China found that the frequency of cryptosporidium infection was present in 0.8 % (1/122) of chronic HBV infection cases. Also another study was done in Ahmed Maher Teaching Hospital, Cairo, Egypt found that the prevalence of cryptosporidium among HBV chronic infection cases was only 2.5% (3/120).

Our study was in disagreement with another study done in Egypt, which showed that the incidence of Cryptosporidium infection in sufferers having chronic liver diseases was 30% (45/150) compared to 14% (7/50) in controls.

Regarding hepatocellular carcinoma, grades of liver cirrhosis to the prevalence of cryptosporidium, we found that only two patients who harbored Cryptosporidium had hepatocellular carcinoma (6.9%) and were Child C (5.3%) compared to (0%) in patients without HCC or in patients with Child A or B, so study showed that cryptosporidium infection increased with development of hepatocellular carcinoma and chronic liver disease progressed from
Child-Pugh class A to Child-Pugh class C but the prevalence was low.

This finding could be explained by the fact that people with liver cirrhosis have a weakened cellular immune response.1 In a recent study in Egypt, Cryptosporidium was discovered in 32 % of people suffering hepatocellular carcinoma and diarrhea, and 36 % of people suffering liver cirrhosis and ascites.2,3

Many studies have been conducted to investigate the epidemiology and diagnosis of Cryptosporidium infection in malignancy patients. Indian research of 560 individuals with cancer and diarrhea discovered a low frequency of Cryptosporidium; oocysts were detected within just seven subjects (1.3 %). Five of the seven individuals were diagnosed with hematological cancer.4

Environmental, clinical, and host behavioral factors including gender, age, symptomatic/asymptomatic, drinking water and interaction with animals having feces consistency may have an important role in the risk of cryptosporidiosis exposure or incidence.

These factors may affect susceptibility to infection but have no effect on pathogenicity or disease progression. However, the exact mechanisms behind the increased risk of illness in children are not yet fully clear.5,6

Regarding gender, we found no association between gender and the prevalence of cryptosporidium.

The age of the host is a major factor in epidemiology of cryptosporidiosis. Cryptosporidium impacts people of all ages, but there is a high prevalence of the disease in this age range.7 According to Abdel-Messih et al.,8 children under the age of 12 are responsible for 61.9 % of instances in Egypt; however, there are no evident discrepancies between the ages of 2 and 5, as earlier observed for Egypt.

The type of water supply was reported by all study participants. However, none of the drinking water sources in our research were substantially related to the probability of developing cryptosporidiosis. This may be attributed to that most of study individuals (both symptomatic and asymptomatic) depend mainly on tape and bottled water as the main source of water supply. Water supplies are a well-known risk factor for cryptosporidiosis.9 Al-Ward et al.10 in the North of Baghdad confirmed that there was a significant relation between water source and the prevalence of Cryptosporidium.

The minimum infectivity rate was observed in patient who drunk boiled water, while the maximum level was recorded among the patients drinking tap water. These results were not very different from those reported by Beach11 and Garvey and McKeown12 in a study in Ireland.

Regarding to contact with animals, we found no association between it and prevalence of cryptosporidium. Nevertheless, Iqbal et al.13 suggests contact with infected animals as a possible mode of infection transmission. However, there have been several studies that have failed to find an animal contact association.14,15,16

Regarding complaint and macroscopic examination, there was no significance between prevalence of cryptosporidium and these elements.

Many studies have found a link between Cryptosporidial infection and diarrhea, abdominal pain, flatulence, itch, vomit, or appetites loss.17,18

We hypothesized diarrhea that is presented in some patients may be related to pathological changes in the intestine which may be adding as a tool for diagnosis of Cryptosporidial infection. It was difficult for us to make this part of the study in patients, so we designed animal models of Cryptosporidial infection, and we studied also the effect induced by Azathioprine as immunosuppressant drug in infected models. We found intestinal atrophy in infected groups with and without Azathioprine treatment but did not reach to be significant when compared with control. It may be related to the duration of infection and Azathioprine treatment in our animal models. Also, diarrhea that occurred in some patients may be related to other factors.

These results were matching with previous study that explained Cryptosporidium infection either in immunocompetent and immunocompromised patients induces a limited degree of apoptosis in intestinal epithelium as the parasite in the early stage of infection depends on the host cell for growth and development.19

Goblet cells secrete mucus which is composed of mucus glycoproteins that form a viscous film at intestinal epithelial surface. One of its main functions is to maintain the normal commensal bacteria in the gut lumen besides its role in intestinal barrier function. We found a significant decrease in intestinal goblet cells counts in immunosuppressed rats while in the other group there was no change. This result may reflect the intestinal injury induced by Cryptosporidium infection and immunosuppression. Regarding inflammatory cells infiltration, we didn’t find significant changes between groups.

Our results were in agree with another study that found an obvious decrease in goblet cells count in immunosuppressed animals.20
CONCLUSION

Copro-nPCR is more powerful than coproscopy for detection of cryptosporidial infection. The prevailing genotype was C. parvum. There is no strong association between liver cirrhosis and cryptosporidial infection but chance for infection may increase with the development of HCC or when patients become decompensated. Demographic, environmental, and clinical data are not associated with cryptosporidial infection. Diarrhea that is presented in some cryptosporidial infected and immunocompromised patients is related to change in intestinal mucus production which reflect the decrease in goblet cells count.

REFERENCES


