Seroepidemiology of *Toxoplasma gondii* infection in patients with liver disease in eastern China

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**SUMMARY**

The role of the protozoan parasite *Toxoplasma gondii* in the pathogenesis of liver disease has recently gained much interest. The aim of this study was to determine the prevalence and risk factors associated with *T. gondii* infection in patients with liver disease from three cities in Shandong and Henan provinces, China. A case–control study was conducted from December 2014 to November 2015 and included 1142 patients with liver disease and 1142 healthy controls. Serum samples were collected from all individuals and were examined with enzyme-linked immunosorbent assay for the presence of anti-*T. gondii* IgG and IgM antibodies. Information on the demographics, clinical, and lifestyle characteristics of the participants was collected from the medical records and by the use of a questionnaire. The prevalence of anti-*T. gondii* IgG was 19·7% in patients with liver disease compared with 12·17% in the controls. Only 13 patients had anti-*T. gondii* IgM antibodies compared with 12 control individuals (1·14% vs. 1·05%, respectively). The highest seroprevalence was detected in patients with liver cancer (22·13%), followed by hepatitis patients (20·86%), liver cirrhosis patients (20·42%), and steatosis patients (20%). Multivariate logistic regression analysis indicated that consumption of raw meat (odds ratio (OR) = 1·32; 95% confidence interval (CI) 1·01–1·71; \(P = 0·03\)) and source of drinking water from wells (OR = 1·56; 95% CI 1·08–2·27; \(P = 0·01\)) were independent risk factors for *T. gondii* infection in liver disease patients. These findings indicate that *T. gondii* infection is more likely to be present in patients with liver disease. Therefore, efforts should be directed toward health education of populations at high risk of *T. gondii* infection and measures should be taken to protect vulnerable patients with liver disease.

**Key words:** Case–control study, liver disease, risk factors, seroprevalence, *Toxoplasma gondii*.

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INTRODUCTION

Toxoplasmosis is a parasitic disease caused by infection with the intracellular apicomplexan protozoan parasite *Toxoplasma gondii*. This parasite has a worldwide distribution and is able to infect any warm-blooded animal [1]. Infections caused by *T. gondii* continue to impose a significant public health threat because it can cause hydrocephaly, retinochoroiditis, mental retardation, and even death in developing fetus and life-threatening encephalitis in organ transplant recipients, individuals with AIDS, or receiving immunosuppressive therapy [2–4]. *T. gondii* is one of the most successful protozoan parasites owing to its ability to manipulate the immune system and because of the various means (e.g. waterborne, foodborne, transplacental, or organ transplant) by which the parasite can infect the host and establish a latent infection [5–9].

Although *T. gondii* possesses neurotropic and ocular affinities, this parasite can also infect other organs, such as liver, spleen, pancreas, heart, and lymph nodes [10, 11]. Several relatively small studies have detected association between *T. gondii* infection and various hepatic pathologies, such as hepatitis, granuloma, necrosis, hepatomegaly, jaundice, and cirrhosis [12–18]. *T. gondii* infection has also been linked to abnormal liver function tests [19, 20]. Liver has been shown to be the major site of tissue pathology during acute, lethal toxoplasmosis in mice [21]. An association between the amount of *T. gondii* antigens and increased number of hepatic stellate cells (HSCs) has been reported in the liver of acutely infected mice, suggesting a role for HSCs in the pathogenesis of *T. gondii*-induced hepatitis [22]. *T. gondii* infection has also been shown to induce several transcriptomic and proteomic changes in the liver of infected mice [23, 24].

In recent years, interest in assessing and understanding the relationship between *T. gondii* infection and liver disease in humans has surged [25, 26], probably due to the huge global burden and public health importance of both *T. gondii* infection [27] and liver diseases [28]. As considerable results exist linking *T. gondii* infection to hepatic damage, and there are no available data about the correlation between liver disease and *T. gondii* infection in China, it is important to identify any evidence linking *T. gondii* infection to liver disease in humans in China. Therefore, the present study was conducted to investigate the seroprevalence of and risk factors associated with *T. gondii* infection in patients with liver disease from three major cities in Shandong and Henan provinces in eastern China using enzyme-linked immunosorbent assay (ELISA). Our study advances the literature of the association between liver disease and *T. gondii* infection.

MATERIALS AND METHODS

Ethics statement

The protocol of the study was reviewed and approved by the Ethics Committee of the Medical College of Qingdao University, Weihaiwei People’s Hospital and Henan Provincial People’s Hospital. Patients were informed about the aim of the study, and they all provided written consent for participation in the study. Informed consent was also provided by parents or guardians on behalf of all child participants. The control sera were collected with agreement from volunteers.

Study sites

The study was conducted in two provinces (Shandong and Henan) located in eastern China (Fig. 1). Two cities were selected in Shandong province, namely Qingdao and Weihai. Qingdao is located at the southeastern tip of Shandong province, eastern China (35°35’N–37°09’N, 119°30’E–121°00’E), and is a key economic center, famous for its cultural heritage and attractive scenery. Weihai is located at the eastern tip of Shandong province (36°41′N–37°35′N, 121°11’E–122°42’E). The annual average temperature is 12 °C and the average precipitation is over 800 mm. Zhengzhou (31°23’N–36°22’N, 110°21’E–116°39’E) is the capital of Henan province, which has a subtropical semi-humid monsoon climate with a hot, humid, and rainy summer; long and cold winter; and an annual average temperature of 14 °C.

Study design and data collection

A case–control study was designed to identify prevalence and risk factors associated with *T. gondii* infection. The study was conducted from December 2014 to November 2015 and included 1142 inpatients hospitalized for the diagnosis or treatment of liver disease. The clinical cases included patients with various forms of hepatic disease, including liver cirrhosis (*n* = 333), hepatitis (*n* = 326), liver cancer (*n* = 253), steatosis (*n* = 205), and other hepatic disease (*n* = 25). An equivalent number of seronegative control subjects (*n* = 1142), of similar
from each of the three geographic regions
were included in the study. Demographics, such as age,
gender, and area of residence, were obtained from the
computerized inpatient registry of cases or by asking
the control participants. A questionnaire was distributed
to all participants in order to obtain information about
their lifestyle and feeding habits, including the history
of close contact with cats or dogs at home (yes/no), con-
sumption of raw vegetables (yes/no), exposure to soil
(yes/no), consumption of raw/undercooked meat (yes/
no), and the source of drinking water (none, running
water, wells). All personal information was anonymized
and treated as strictly confidential.

Serum collection and serological testing
About 5 ml of venous blood were drawn from each
participant. Blood samples were kept overnight at
ambient temperature in order to allow clot formation
and were centrifuged at 1000 g for 10 min. The sera
were collected in 2 ml Eppendorf tubes and were
stored at 4 °C for 24–72 h until transportation in
an icebox to State Key Laboratory of Veterinary
Etiological Biology, Lanzhou Veterinary Research
Institute, Chinese Academy of Agricultural
Sciences, Gansu Province, where samples were kept
at −20 °C until analysis. Serum samples were ana-
lyzed for the presence of anti- *T. gondii* IgG and
IgM antibodies (using commercially available
ELISA kits; Demeditec Diagnostics GmbH,
Germany) according to the manufacturer’s instruc-
tions. Positive and negative serum controls were
included in every plate.

Statistical analysis
Comparison between cases and controls for continu-
ous variables, such as age, used one-way analysis of
variance and are reported as mean ± s.d. For categori-
cal variables, the χ² test or the Fisher’s exact test was
used and results are expressed either as percentage of
total (number of cases or control) or median (IQR).
as appropriate. To identify factors associated with T. gondii IgG seropositivity, a univariate approach was first used with a cut-off of $<0.10$ to identify contributing factors to include in a multivariate analysis. Logistic regression was then used to identify significantly contributing factors with all variables included from univariate analyses. Only variables significant at $P < 0.05$ were retained in multivariate analysis. The statistical model included age and gender (fitted first, to account for minor variation in the datasets; adjustment used the Mantel–Haenszel test). All statistical analyses were performed using Genstat v18 (VSNi, Rothampsted, UK). Odds ratios (ORs) with 95% confidence intervals (CIs) were calculated to indicate effect size of predictive variables. A $P$-value $<0.05$ was considered to be statistically significant.

RESULTS

T. gondii IgG antibodies were detected in 225 (19.7%) of patients with liver disease, which was significantly higher ($P < 0.001$) than the level detected in the control individuals (139; 12.17%). In contrast, T. gondii IgM antibodies were only detected in 13 patients and 12 controls (1.14% vs. 1.05%, respectively, $P = 0.84$). Table 1 describes the seroprevalence according to patients’ age, gender, geographic region, and residence area. The highest seroprevalence of T. gondii infection was found in patients with liver disease whose ages ranged from 41 to 50 (Table 1). The seroprevalence of T. gondii infection among patients with liver disease from rural areas (20.49%) vs. urban areas (20.30%) was not significantly different ($P = 0.71$).

Association of T. gondii infection with clinical liver disease is shown in Table 2. Patients with liver disease had a higher frequency of T. gondii infection per se, with those patients with a diagnosis of liver cancer > cirrhosis > hepatitis having greatest seropositivity. Multivariate analysis revealed that consumption of raw meat (OR = 1.32; 95% CI 1.01–1.71; $P = 0.03$) and source of drinking water from wells (OR = 1.56; 95% CI 1.08–2.27; $P = 0.01$) were the only independent risk factors for T. gondii infection in liver disease patients (Table 3). Other variables did not show any significant association with T. gondii infection.

DISCUSSION

The present work revealed a higher prevalence of anti-T. gondii IgG antibodies in patients with liver disease compared with the control subjects. It is possible that the immune-compromised status associated with liver disease might make the patients become more vulnerable to infection with T. gondii compared with healthy individuals [29, 30]. One previous study did not detect an association between T. gondii infection and liver disease in patients from Mexico [26]. However, the prevalence rate obtained in our study was lower than that reported in Egypt in patients

Table 1. Demographics of the study population and seroprevalence of Toxoplasma gondii infection

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cases with liver diseases ($n = 1142$)</th>
<th>Control group ($n = 1142$)</th>
<th>$P$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. tested</td>
<td>No. positive</td>
<td>Prevalence (%)</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 or less</td>
<td>103</td>
<td>23</td>
<td>22.33</td>
</tr>
<tr>
<td>31–40</td>
<td>153</td>
<td>29</td>
<td>18.95</td>
</tr>
<tr>
<td>41–50</td>
<td>309</td>
<td>74</td>
<td>23.95</td>
</tr>
<tr>
<td>51–60</td>
<td>243</td>
<td>38</td>
<td>15.64</td>
</tr>
<tr>
<td>61–70</td>
<td>190</td>
<td>36</td>
<td>18.95</td>
</tr>
<tr>
<td>&gt;70</td>
<td>144</td>
<td>33</td>
<td>22.92</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>595</td>
<td>114</td>
<td>19.16</td>
</tr>
<tr>
<td>Female</td>
<td>547</td>
<td>119</td>
<td>21.76</td>
</tr>
<tr>
<td>Geographic region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qingdao</td>
<td>395</td>
<td>87</td>
<td>22.03</td>
</tr>
<tr>
<td>Weihai</td>
<td>349</td>
<td>95</td>
<td>27.22</td>
</tr>
<tr>
<td>Zhengzhou</td>
<td>398</td>
<td>51</td>
<td>12.81</td>
</tr>
<tr>
<td>Residence area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>532</td>
<td>108</td>
<td>20.30</td>
</tr>
<tr>
<td>Rural</td>
<td>610</td>
<td>125</td>
<td>20.49</td>
</tr>
</tbody>
</table>

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with hepatic disease 65.5% vs. 27% in the controls [31], in late-stage cirrhotic patients 92.6% vs. 15% controls, and chronic HCV non-cirrhotic patients 76.9% vs. 40% controls [32]. Another study in patients with chronic liver disease form Egypt reported 30% vs. 6% in controls [25]. Differences in prevalence rates among these studies could be attributed to geographic variability, heterogeneity of the studied populations, or in the diagnostic approaches employed. In our study, the result of T. gondii IgM antibodies (1.14% vs. 1.05%, respectively, $P = 0.84$) was not significantly different between cases and control. This finding is consistent with the results reported in patients with liver disease in Egypt, where no significant difference ($P = 0.610$) in the level of anti-T. gondii IgM antibodies was detected in late-stage (13.6%) and early-stage (12.8%) patients compared with 7.5% controls [32].

Recent transcriptomic [23] and proteomic [24] findings showed that T. gondii infection can dysregulate several signaling pathways, especially immune response pathway in the liver of infected mice. Acute T. gondii can also reduce the activity of hepatic enzyme butyrylcholinesterase, which plays a role in immune response and lipid synthesis [33]. Additionally, infection with T. gondii RH strain can elicit strong inflammatory response and high levels of T helper cell type 1 cytokines, which damage the liver [21]. Therefore, it is sensible to assume that the pathogenesis of liver damage during T. gondii infection can be induced by parasite-derived factors that disrupt host signaling pathways and/or host-mediated factors (and other as yet unknown mechanisms).

Further, we found that patients with liver cancer had the highest T. gondii seroprevalence compared with other forms of liver diseases. This is expected

### Table 2. The seroprevalence of Toxoplasma gondii in patients with various hepatic disorders in China

<table>
<thead>
<tr>
<th>Clinical disease</th>
<th>No. tested</th>
<th>No. positive (%)</th>
<th>OR (95% CI)</th>
<th>$P$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1003</td>
<td>139 (13.86)</td>
<td>Reference</td>
<td>–</td>
</tr>
<tr>
<td>Liver cirrhosis</td>
<td>267</td>
<td>66 (24.72)</td>
<td>2.05 (1.46–2.86)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>259</td>
<td>67 (25.87)</td>
<td>1.85 (1.34–2.56)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Liver cancer</td>
<td>199</td>
<td>54 (27.14)</td>
<td>2.48 (1.69–3.65)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Steatosis</td>
<td>167</td>
<td>38 (22.75)</td>
<td>1.59 (1.06–3.39)</td>
<td>0.02</td>
</tr>
<tr>
<td>Other$^1$</td>
<td>25</td>
<td>0 (0)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>1920</td>
<td>364 (18.96)</td>
<td>1.91 (1.51–2.42)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

OR, odds ratio; CI, confidence interval.

$^1$ Include amoebic liver abscess, hepatic hemangioma, hepatic cyst, focal liver lesions, and hepatocellular liver disease.

### Table 3. Multivariate analysis of risk factors for Toxoplasma gondii infection in patients with liver disease

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number tested</th>
<th>Number positive</th>
<th>Prevalence (%)</th>
<th>Univariate analysis$^1$</th>
<th>Multivariate analysis$^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cats at home</td>
<td>744</td>
<td>35</td>
<td>4.7</td>
<td>1.08 (0.77–1.51)</td>
<td>1.08 (0.77–1.51)</td>
</tr>
<tr>
<td>Dogs at home</td>
<td>744</td>
<td>29</td>
<td>3.9</td>
<td>1.13 (0.78–1.63)</td>
<td>1.13 (0.78–1.63)</td>
</tr>
<tr>
<td>Consumption of raw vegetables</td>
<td>744</td>
<td>73</td>
<td>9.81</td>
<td>0.90 (0.69–1.18)</td>
<td>0.90 (0.69–1.18)</td>
</tr>
<tr>
<td>Exposure to soil</td>
<td>744</td>
<td>97</td>
<td>13.04</td>
<td>1.13 (0.87–1.46)</td>
<td>1.13 (0.87–1.46)</td>
</tr>
<tr>
<td>Consumption of raw/undercooked meat</td>
<td>744</td>
<td>81</td>
<td>10.89</td>
<td>1.30 (1.00–1.69)</td>
<td>1.32 (1.01–1.71)</td>
</tr>
<tr>
<td>Source of drinking water: none</td>
<td>398</td>
<td>48</td>
<td>12.06</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Running water</td>
<td>587</td>
<td>135</td>
<td>23.0</td>
<td>1.27 (0.95–1.68)</td>
<td>1.27 (0.95–1.68)</td>
</tr>
<tr>
<td>Wells</td>
<td>157</td>
<td>42</td>
<td>26.75</td>
<td>1.79 (1.26–2.54)</td>
<td>1.79 (1.26–2.54)</td>
</tr>
</tbody>
</table>

OR, odds ratio; CI, confidence interval.

$^1$ Statistical model tested individual effect, after correction for age, gender, and geographic region.

$^2$ Statistical model excluded factors not significant on univariate analysis, but included consumption of raw/undercooked meat and source of drinking water from wells, after correction for age, gender, and geographic region.
because patients treated with antineoplastic agents are more likely to be infected with *T. gondii* [34, 35]. The immune suppression associated with chemotherapy treatment of patients with malignancies can result in the reactivation of latent *T. gondii* infection [36]. An association between *T. gondii* seropositivity and consumption of sheep meat in patients with live disease has been reported in Mexico (OR = 8.69; 95% CI 1.02–73.71; *P* = 0.04) [26]. However, in our study, none of the lifestyle variables, including contact with cats or dogs at home, consumption of raw vegetables, consumption of raw/undercooked meat, or exposure to soil, was found to have a significant association with *T. gondii* seropositivity. Interestingly, multivariate analysis revealed only two independent risk factors for *T. gondii* infection, which were the consumption of raw meat (OR = 1.32; 95% CI 1.01–1.71; *P* = 0.03) and source of drinking water from wells (OR = 1.56; 95% CI 1.08–2.27; *P* = 0.01).

In China, cats are popular companion animals, but the public are not well informed of the risk of environmental contamination with *T. gondii* oocysts [37]. Humans can be infected with *T. gondii* oocysts through drinking water contaminated with cat feces [38], which has been identified as a public health threat [39]. Felids are the only definitive hosts for *T. gondii*, and primary infection results in shedding of millions of environmentally resistant non-sporulated oocysts within approximately 2 weeks. Oocysts become infectious within 1–5 days, depending on the climatic conditions [40]. The identification of the source of drinking water as one of the two independent risk factors for *T. gondii* infection in our study necessitates that measures should be taken to protect the public in general and immunocompromised individuals in particular from the risk of water-borne infection with *T. gondii* oocysts. Likewise, the identification of consumption of raw meat as a significant risk factor for *T. gondii* infection confirms the overwhelming evidence regarding the epidemiological relevance of meat-borne infection with *T. gondii* [2, 38, 41, 42]. There is a clear need for increased education of health professionals and the public about the potential transmission of *T. gondii* via drinking water from wells or consumption of raw meat in order to reduce the risk and burden of toxoplasmosis in China.

### CONCLUSION

To our knowledge, this is the largest study that specifically investigates the epidemiology of *T. gondii* infection in association with liver disease. Additionally, our study examined patients with various clinical forms of liver disease and utilized multivariate analysis to determine which factors are independently associated with the risk of *T. gondii* infection in patients with liver disease. Our results underscore the need for monitoring the presence of *T. gondii* infection in patients with liver disease, especially those with immunocompromised status. Efficient lifestyle and environmental intervention strategies are also needed in order to reduce the risk of water-borne and meat-borne transmission of *T. gondii* oocysts. Additional studies are needed to define which *T. gondii* genotype is most likely to be associated with hepatopathy in China.

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### DECLARATION OF INTEREST

None.

### REFERENCES