

## Extravascular dermal trypanosomes in suspected and confirmed cases of gambiense Human African Trypanosomiasis

Alseny M'Mah Soumah, Nono-Raymond Kuispond Swar, Mariame Camara, Alseny M'mah Soumah, Hamidou Ilbouldo, Christelle Travaillé, Caroline Clucas, Anneli Cooper, Nono-Raymond Kuispond Swar, Oumou Camara, et

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1	Extravascular dermal trypanosomes in suspected and confirmed cases of gambiense Human
2	African Trypanosomiasis.
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4	Mariame Camara <sup>1</sup> , Alseny M'mah Soumah <sup>1,2</sup> , Hamidou Ilbouldo <sup>1,3,4</sup> , Christelle Travaillé <sup>5</sup> ,
5	Caroline Clucas <sup>6</sup> , Anneli Cooper <sup>6</sup> , Nono-Raymond Kuispond Swar <sup>6,7</sup> , Oumou Camara <sup>1</sup> , Ibrahim
6	Sadissou <sup>4</sup> , Estefania Calvo Alvarez <sup>5</sup> , Aline Crouzols <sup>5</sup> , Jean-Mathieu Bart <sup>4</sup> , Vincent Jamonneau <sup>4</sup> ,
7	Mamadou Camara <sup>1</sup> , Annette MacLeod <sup>6</sup> , Bruno Bucheton <sup>1,4</sup> and Brice Rotureau <sup>5</sup> *
8	
9	<sup>1</sup> Programme National de Lutte contre la Trypanosomiase Humaine Africaine, Ministère de la
10	Santé, Conakry, Guinea
11	<sup>2</sup> Service de Dermatologie, Hôpital de Donka, Conakry, Guinea
12	<sup>3</sup> Institut de Recherche en Sciences de la Santé (IRSS) - Unité de Recherche Clinique de Nanoro
13	(URCN), Nanoro, Burkina-Faso
14	<sup>4</sup> Institut de Recherche pour le Développement, Unité Mixte de Recherche IRD-CIRAD 177
15	InterTryp, Campus International de Baillarguet, Montpellier, France
16	$^{5}$ Trypanosome Transmission Group, Trypanosome Cell Biology Unit, INSERM U1201 &
17	Department of Parasites and Insect Vectors, Institut Pasteur, Paris, France
18	<sup>6</sup> Wellcome Centre for Molecular Parasitology, College of Medical, Veterinary and Life
19	Sciences, Henry Wellcome Building for Comparative Medical Sciences, Glasgow, Scotland,
20	United Kingdom
21	<sup>7</sup> Department of Parasitology, National Institute of Biomedical Research (INRB), Kinshasa,
22	Democratic Republic of the Congo
23	* Corresponding author: Brice Rotureau, PhD, Trypanosome Transmission Group,
24	Trypanosome Cell Biology Unit, INSERM U1201 & Department of Parasites and Insect Vectors,

25	Institut Pasteur, 25 rue du Docteur Roux, 75015 Paris, France, rotureau@pasteur.fr, Tel +33
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34	Key points
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36	Live trypanosomes can remain undetected in the blood of individuals seropositive for sleeping
37	sickness. Here, we show that they could be infected with parasites in their extravascular

38 dermis, highlighting the skin as a potential reservoir for trypanosomes.

#### 40 Abstract

#### 41 (238/250 words)

42 Background: The diagnosis of *gambiense* Human African Trypanosomiasis (gHAT) typically 43 involves two steps: a serological screen, followed by the detection of living trypanosome 44 parasites in the blood or lymph node aspirate. Live parasites can, however, remain undetected 45 in some seropositive individuals, who we hypothesize are infected with *Trypanosoma brucei* 46 *gambiense* parasites in their extravascular dermis.

47 Methods: To test this hypothesis, we conducted a prospective observational cohort study in 48 the gHAT focus of Forecariah, Republic of Guinea. Of the 5,417 subjects serologically screened 49 for gHAT, 66 were enrolled into our study and underwent a dermatological examination. At 50 enrolment, 11 seronegative, 8 unconfirmed seropositive and 18 confirmed seropositive 51 individuals had blood samples and skin biopsies taken and examined for trypanosomes by 52 molecular and immuno-histological methods.

Results: In seropositive individuals, dermatological symptoms were significantly more frequent, relative to seronegative controls. *T.b. gambiense* parasites were present in the blood of all confirmed cases (n=18) but not in unconfirmed seropositive individuals (n=8). However, *T. brucei* parasites were detected in the extravascular dermis of all unconfirmed seropositive individuals and all confirmed cases. Skin biopsies of all treated cases and most seropositive untreated individuals progressively became negative for trypanosomes 6 and 20 months later.

Conclusions: Our results highlight the skin as a potential reservoir for African trypanosomes,
with implications for our understanding of this disease's epidemiology in the context of its
planned elimination and underlining the skin as a novel target for gHAT diagnostics.

#### 63 Introduction

The number of new cases of gambiense Human African Trypanosomiasis (gHAT or sleeping 64 sickness) has never been so low in the known epidemiological history of the disease, with only 65 ~1,500 new cases reported in 2017 [1, 2], and the World Health Organization (WHO) has 66 67 targeted gHAT elimination by 2030 [3]. This objective has been encouraged by the success of 68 active surveillance efforts that relies on a two-step diagnosis: an initial serological screen, 69 followed by microscope observation of blood, lymph or cerebrospinal fluid (CSF) to detect 70 extracellular trypanosomes and to confirm the serological diagnosis. However, some 71 seropositive individuals remain without a confirmed parasitological diagnosis for years and 72 have been recently described as being latent cases, raising the question as to whether 73 reservoirs of live parasites persist in these individuals [4].

74 T. brucei s. I. parasites are found in the extravascular compartment of various tissues of their 75 mammalian hosts, including the skin, albeit mostly under experimental conditions in animal 76 models rather than during the natural progression of the disease [5]. Recent studies have 77 revealed that substantial quantities of trypanosomes persist within the extravascular dermis 78 following experimental infection in mice with T.b. gambiense or T. b. brucei. These parasites 79 can be transmitted to the tsetse vector, even in the absence of detectable parasites in the 80 host's blood [6]. This study also reported a retrospective screening of archived skin biopsies 81 from a gHAT endemic region, which revealed the presence of some extravascular skin-82 dwelling trypanosomes [6]. However, the species of these parasites was not identified and no clinical records were available for the screened samples. 83

These observations raise the question as to whether *T.b. gambiense* might be found in the skin of confirmed gHAT cases, as well as in unconfirmed seropositive individuals, in regions of active disease transmission. To address this question, we performed a prospective

87 observational study in the Forecariah district in the Republic of Guinea, which is one of the
88 most active gHAT foci in Western Africa.

#### 89 Methods

90 More details for material and methods are provided as Supplementary Data.

#### 91 <u>Ethical approval</u>

- All investigations were conducted in accordance with the Declaration of Helsinki and with the
  approval of the National Ethical Committee of the Republic of Guinea (Study Diag-Cut-THA
  032/CNERS/17 and amendment 038/CNERS/19).
- 95 Study enrolment, screening and case definitions

96 From May 2017 to February 2019, a total of 5,417 individuals were screened by the HAT 97 National Control Programme using the card agglutination test for trypanosomiasis, first on 98 whole-blood (CATTwb), then on plasma (CATTp) for validation, in 43 villages in the active gHAT 99 focus of the Forecariah District, Republic of Guinea. All subjects were classified as 100 seronegative, unconfirmed seropositive or confirmed seropositive according to the diagnostic 101 process presented in Table 1. All parasitologically confirmed cases were diagnosed and 102 treated by the HAT National Control Programme according to WHO recommendations and as 103 described previously [7]. All confirmed cases (CATTp  $\geq 1/4$  with parasitological confirmation) 104 and all unconfirmed seropositive individuals (CATTp ≥1/4 without parasitological 105 confirmation) were proposed for study enrolment. In total, 40 seronegative controls (39 106 CATTwb-negative and 1 CATTwb-positive CATTp<1/4) were randomly selected from the 5,417 107 population, of which the first 29 individuals, enrolled in 2017, were only included in the 108 epidemiological and clinical analysis, and the last 11 individuals, enrolled in 2019, were 109 subjected to the entire protocol. Children under 16 years of age and pregnant women were excluded from the study. Each participant was informed about the study's objectives andprovided written informed consent.

#### 112 Field procedure and sampling

113 Participants underwent an epidemiological interview and a clinical examination, during which 114 dermatological symptoms including pruritus (skin itch) and dermatitis (skin inflammation), 115 were assessed at enrolment as well as at each subsequent follow-up at 6 and 20 months after 116 enrolment/treatment. Epidemiological and clinical parameters are detailed in Supplementary 117 Data. The absence of dermatitis lesions at the skin sampling site was verified and a 2mm 118 blood-free skin punch biopsy was sampled from the right back shoulder of all confirmed 119 seropositive cases, all unconfirmed seropositive individuals, and for the final 11 seronegative 120 controls. Touch preparations were obtained by gently rolling the biopsy on a clean glass slide 121 and Giemsa staining in the field. The positivity of a given slide was defined by the detection of 122 at least three trypanosomes. Biopsies were fixed for immuno-histochemistry and molecular 123 analyses. Plasma aliquots from blood samples were also obtained for serological trypanolysis 124 tests [8].

#### 125 Immunohistochemical detection

126 Skin biopsy sections were stained with hematoxylin-eosin (HE) and Giemsa stains, and 127 immunolabelled with the T. brucei-specific anti-ISG65 antibody that targets the Invariant 128 Surface Glycoprotein 65 expressed at the surface of the mammalian host stages of T. brucei 129 s.l. parasites [9], and the T. brucei-specific anti-Hsp70 antibody that recognizes the 130 endoplasmic reticulum molecular chaperone heat-shock protein 70 homologue [10]. Slides 131 were blindly assessed by at least two readers. Slides from seronegative controls were mixed 132 with slides from seropositive cases in order to guarantee blind reading. The positivity of a 133 given skin-section slide was defined by the detection of at least three trypanosomes.

134 <u>PCR detection</u>

DNAs were extracted from paraffin-embedded biopsies and blood samples with tissue-specific commercial kits (Qiagen, Germany). For each sample, at least two PCRs were performed with TBR primers targeting a DNA satellite repeated sequence (10,000 copies per cell) [11], and TgsGP primers directed against the single copy *TgsGP* gene [12], for detecting *T. brucei s. l.* and *T.b. gambiense* DNAs, respectively.

140 Data analyses

For epidemiological, clinical and diagnostic parameters, differences between seronegative controls versus unconfirmed seropositive individuals and confirmed cases were assessed using the following two-sided tests at 5% confidence: Fisher's exact tests for qualitative data (Tables 2 and 3) and/or Mann-Whitney tests for quantitative data (age in Table 2). For the follow-up analyses, differences between results at enrolment versus results at 6 months and 20 months after treatment/enrolment were assessed for each group using two-sided Fisher's exact tests at 5% confidence (Table 4).

#### 148 Results

#### 149 Epidemiological and clinical results

Results of the initial screening of 5,417 individuals are shown in Table 1. Out of 5,377 seronegative subjects (CATTwb-negative or CATTp<1/4), 40 were enrolled as seronegative controls, of whom 11 provided skin biopsies. A total of 40 seropositive individuals (CATTwbpositive and CATTp  $\geq$ 1/4) were identified during the survey, of which 12 tested negative upon parasitological examination (0.22%) and 28 were confirmed as HAT cases (0.52%). Eight nonconfirmed seropositive individuals and 18 confirmed HAT cases had no exclusion criteria and accepted to be enrolled in the study.

157 As shown in Table 2, the occurrence of dermatitis was significantly more frequent in confirmed 158 HAT cases (15/18, 83%, P<0.0001) and non-confirmed seropositive individuals (5/8, 63%, 159 P=0.0166) as compared to seronegative controls (7/40, 18%). Pruritus was the most frequent 160 dermatological sign in confirmed HAT patients (11/18, 61%), as compared to seronegative 161 controls (3/40, 8%). Among the various observed clinical manifestations of localized 162 dermatitis, we unambiguously identified typical cases of intertrigo (in 4/18 confirmed cases 163 versus 2/40 seronegative controls), pityriasis (in 3/18 versus 2/40), scabies (in 3/18 versus 164 1/40), dermatophytosis (in 3/18 versus 1/40), molluscum (in 3/18 versus 1/40), and ulceration 165 (in 3/18 versus 1/40). The main clinical manifestation in non-confirmed seropositive 166 individuals were eczema (3/8), intertrigo (2/8) and pityriasis (1/8). Apart from general pruritus 167 and intertrigo, all dermatological signs were observed in upper regions of the body, especially 168 on the thorax and arms.

169 <u>Biological results</u>

Plasma from all confirmed and unconfirmed seropositive cases, and from 11/40 seronegative controls, was assessed using the trypanolysis test, which detects complement-mediated immune responses activated by *T.b. gambiense*-specific antigens. All confirmed cases were positive for the LiTat 1.3 antigen, and 89% (16/18) of these cases were positive for both the LiTat 1.5 and 1.6 antigens (Table 3). Only 25% (2/8) of the unconfirmed seropositive individuals were positive for all antigens, while the others remained negative for all three variants, as seronegative controls.

A skin punch biopsy was sampled from all enrolled confirmed and unconfirmed seropositive cases and from 11/40 seronegative controls. Dermal touch preparations were then generated in the field and full-length trypanosomes were observed on slides from 81% (13/16) of the confirmed cases and from 33% (2/6) of the unconfirmed seropositive individuals (Table 3 and

181 Supplementary Fig.1). One of the unconfirmed seropositive individuals who tested positive in182 this dermal test, also tested positive in the trypanolysis test.

183 The skin biopsy samples were processed for immunohistochemistry analyses (IHC) in the lab. 184 Skin samples obtained from the seronegative controls (11/11) did not test positive for 185 trypanosomes (Table 3). By contrast, all unconfirmed seropositive individuals (8/8) and all 186 confirmed cases (18/18) were found to be positive at least following staining by a T. brucei-187 specific anti-ISG65 antibody (Fig.1, Supplementary Fig.2 and Table 3). In addition, all samples 188 from non-confirmed seropositive individuals and confirmed cases were also found to be 189 positive following either unspecific Giemsa staining and/or unspecific HE staining and/or 190 labelling with a *T. brucei*-specific anti-Hsp70 antibody (Fig.1, Supplementary Fig.2 and Table 191 3). In positive skin sections, *T. brucei* parasites were evenly distributed in the reticular dermis, 192 and were occasionally associated with edema. No other parasites were detected in any of the 193 skin samples.

194 To confirm the identity of these skin-dwelling parasites, *T. brucei*-specific PCR (TBR-PCR) 195 assays were performed on total DNA extracted from fresh blood and from paraffin-embedded 196 skin samples. Both blood and skin DNA samples from the seronegative controls (11/11) were 197 found to be negative by the TBR-PCR assays. By contrast, 100% of blood (18/18) and 78% of 198 skin samples (14/18) from confirmed cases tested positively in the TBR-PCR assays. Parasite 199 DNA was only detected in the skin of unconfirmed seropositive individuals (6/8, 75%) but not 200 in their blood (0/8) (Table 3). T.b. gambiense-specific TgsGP-PCR assays were performed on 201 the same DNA samples and were positive for only 67% (12/18) of the blood samples of 202 confirmed cases (Table 3). We reasoned that the use of fresh skin biopsies would be more 203 appropriate than paraffin-embedded skin samples for TgsGP-PCR due to the low sensitivity of 204 this method targeting a single-copy gene. To test this hypothesis, we obtained fresh skin

samples from an outgroup of nine additional confirmed cases, who were identified in 2018 in
the same district by using the same study protocol (Supplementary Table 1). The fresh skin
samples from 89% (8/9) of these confirmed cases were found positive to TBR-PCR, and 33%
(3/9) were also found positive to TgsGP-PCR (Supplementary Table 1).

209 Follow-up results

210 The same panel of analyses were repeated at 6 and 20 months after study enrolment of the 211 unconfirmed seropositive individuals or after treatment of the confirmed cases (Table 4). In 212 total, 17/18 and 12/18 confirmed cases were followed-up at 6 months and 20 months after 213 treatment, respectively, with 12/18 confirmed cases followed-up 2 times, 5/18 followed-up 214 one time and 1 loss to follow-up (Table 4). Most of the clinical symptoms associated with the 215 stage-2 cases at enrolment, including dermatological signs, significantly decreased in 216 frequency during the first 6 months after treatment. Whereas all parasitological observations 217 and PCR results became negative within 6 months after treatment in all confirmed cases 218 (17/17), trypanosomes were still detected by histological methods in up to 38% of them (5/13)219 by IHC anti-ISG65). Twenty months after treatment, all CATTp and histological tests became 220 negative (12/12), with 2/3 confirmed cases remaining positive to the trypanolysis test (Table 221 4).

In total, 5/8 and 4/8 unconfirmed seropositive individuals were followed-up at 6 months and 20 months after enrolment, respectively, with 4/8 unconfirmed seropositive individuals followed-up 2 times, 1/8 followed-up one time and 3/8 losses to follow-up (one death, one pregnancy and one resignation) (Table 4). In 80% (4/5) of the unconfirmed seropositive individuals who were monitored after enrolment, dermatological signs progressively disappeared (Table 4). The four unconfirmed seropositive individuals who were negative to the trypanolysis test at enrolment, became negative to CATTp, TBR-PCR on skin and IHC anti-

ISG65 at the same period. In contrast, the only trypanolysis-positive individual who could be monitored at 6 months maintained a serological reactivity to CATTp. No parasite DNA was detected by TBR-PCR in either blood or skin but the skin biopsy remained positive by IHC-ISG65. Although this individual was lost to follow-up for the 20-month time-point, he was diagnosed as a stage 1 case (CATTp 1/8, mAECT-BC +, CSF - and WBC 4) during an active surveillance campaign that was led in November 2019 (i.e. after the end of this study) and was treated accordingly.

#### 236 Discussion

Here, we set out to investigate whether *T.b. gambiense* parasites might be found in the skin of confirmed gHAT cases, as well as in unconfirmed seropositive individuals, in regions of active disease transmission. Although this study is somewhat limited to a restricted population and to the detection methods used, 100% of the confirmed cases and unconfirmed seropositive subjects were found to carry extravascular trypanosomes in their skin.

#### 242 Dermatological signs in gHAT

243 Our results indicate that dermatological symptoms might be an important aspect of gHAT's 244 clinical presentation. The few reports that exist on this topic in the literature describe a wide 245 array of skin pathologies associated with sleeping sickness, including pruritus, chancre, rashes 246 and localized edemas [13, 14]. However, detailed dermatological profiles of HAT cases have 247 mostly been derived from light-skinned travelers with imported HAT [14]. Whereas chancres 248 and rashes remain anecdotal, pruritus was the most commonly observed dermatological sign 249 in endemic cases (in up to 57% of stage-2 cases) [14]. Here, we observed a higher occurrence 250 of pruritus and dermatitis in unconfirmed seropositive individuals and in confirmed cases, 251 relative to seronegative controls (Table 2). The observed dermatitis profiles included some

conditions the etiologies of which might not be directly related to a trypanosome infection.
However, it could be hypothesized that the immune status of the infected host skin is
somehow altered by the presence of trypanosomes in a way that promotes the outcome of
dermatitis caused by other pathogens and/or increases skin sensitivity.

#### 256 <u>Trypanosome detection</u>

257 The direct detection of trypanosomes in the human skin is not well documented in the 258 literature [13]. As there is no gold-standard approach for that purpose, we implemented seven 259 distinct molecular and immuno-histological methods in parallel, yet with their own specific 260 strengths and weaknesses. Here, dermal touch preparations were generated in the field in 261 sub-optimal ambient conditions (31°C at 75% humidity on average), which could explain the 262 unusual morphology of some trypanosomes that were probably altered by osmotic shock 263 while drying. Then, only a limited portion of each parasite is visible in the 2.5µm skin sections 264 because entire trypanosomes do not necessarily lie in the section plan. For the same reason, 265 the parasite nucleus, kinetoplast and flagellum are rarely all visible in the same given cell 266 section. However, the specificities of the anti-ISG65 and anti-Hsp70 antibodies enable to 267 unambiguously detect most *T. brucei* parasites within the extracellular dermal matrix, and this 268 is confirmed by TBR-PCR assays. Considering that *T.b. brucei* are non-infectious to humans and 269 killed within a couple of hours by human serum, the dermal parasites detected here, at least 270 in confirmed cases, are likely to be T.b. gambiense parasites, as confirmed by the positivity of 271 some direct TgsGP-PCR assays performed on fresh skin samples from an outgroup. However, 272 further genetic studies would be necessary to rule out the hypothesis of infections with a 273 peculiar T.b. brucei strain.

The detection of skin-dwelling parasites at enrolment in most of the 2mm skin punch biopsies
sampled from seropositive individuals indicates that skin-dwelling parasites might be present

over a considerable proportion of the skin surface. However, the precise dynamics of parasite
load and distribution in the extravascular dermal compartment over the course of an infection
remains unknown. According to historic (reviewed in [5]) and more recent [6] studies in
experimental animal models, skin-dwelling parasites could theoretically be detected in almost
the entire skin surface, yet with a variable distribution and at variable local densities.

281 <u>A dermal reservoir of trypanosomes in non-confirmed seropositive individuals</u>

282 One possible explanation for the persistence of disease foci in certain regions is the presence 283 of animal reservoirs [15]. Another possibility, as increasing evidence suggests, is that 284 traditionally used diagnostic approaches do not detect some *T.b. gambiense* infections among 285 seropositive cases [15]. Indeed, bloodstream parasite numbers in T.b. gambiense infections 286 can periodically fluctuate to less than 100 trypanosomes/ml, falling below the detection limit 287 of the most sensitive methods currently in use [16]. Another study estimated that 20-30% of 288 gHAT cases are missed in active case detection by standard parasitological techniques and are 289 left untreated [17]. These infected individuals might ultimately progress to clinical disease or 290 remain almost asymptomatic until undergoing a possible self-cure [15].

291 Here, routine molecular analyses confirmed the presence of *T. brucei* parasites in the skin of 292 unconfirmed seropositive individuals, including those testing negative to the LiTat 1.3 293 trypanolysis test known to be highly specific of T.b. gambiense. As previously observed in the 294 same transmission focus [7], trypanolysis-negative individuals rapidly became negative to 295 CATTp and this was associated with the disappearance of detectable dermal trypanosomes. 296 In such subjects, dermal infections could be transient and too short to allow T.b. gambiense 297 to invade the bloodstream and express the LiTat 1.3 antigen. Alternatively, these infections 298 could possibly be caused by other trypanosome species cross-reacting with the CATT. More 299 sensitive and extensive molecular analyses will be required to solve this question.

300 Only two unconfirmed seropositive individuals were positive to the LiTat 1.3 trypanolysis test 301 in this study. One died before the first follow-up and the other was lost to follow-up after six 302 months. Nevertheless, it is noteworthy that this last individual, who was still positive to 303 histological tests at six months, was eventually diagnosed as a stage 1 case during a medical 304 survey almost 2.5 years after enrolment. Systematic characterization and follow-up of dermal 305 trypanosomes in unconfirmed seropositive individuals testing positive to the LiTat 1.3 306 trypanolysis test would be required to better address the role of these individuals in the 307 transmission of *T.b. gambiense*.

#### 308 <u>Transmission and epidemiological contribution of dermal trypanosomes</u>

309 Mathematical modelling recently predicted that, in the absence of any animal reservoirs, 310 these unconfirmed seropositive individuals could contribute to disease transmission by 311 maintaining an overlooked reservoir of skin-dwelling parasites [18]. The infected skin of 312 seropositive unconfirmed individuals could provide a population of parasites that are readily accessible to the tsetse fly. Indeed, this mode of transmission has been demonstrated in 313 314 experimental animal models, in which skin-dwelling trypanosomes were efficiently 315 transmitted to the tsetse vector, even in the absence of detectable parasitemia [6, 19, 20]. 316 However, the presence of the stumpy parasite forms that are assumed to be most adapted 317 for development in tsetse flies were not investigated here. This is an important question for 318 future studies to address, in order to estimate the actual infectivity potential of human skin-319 dwelling parasites. Our reported observations should also be confirmed in a larger number of 320 unconfirmed seropositive individuals (including RDT-positive subjects), and the study scaled-321 up to include other endemic transmission foci in Africa, in order to confidently determine the 322 actual prevalence of dermal trypanosomes.

323 Our results raise questions about the strategies used to diagnose this disease, which currently 324 focus on detecting parasites in the blood and lymph. If the human skin is indeed a reservoir 325 for trypanosomes, it could represent a novel target for diagnostics, and it could: (i) allow more 326 carriers to be treated; (ii) help to determine a more accurate estimate of the true prevalence 327 of the disease; and (iii) help to identify as yet undetected reservoirs in both human and animal 328 populations. The development of less invasive and field-adapted diagnostic methods to detect 329 extravascular dermal trypanosomes, such as the serological detection of skin-related 330 biomarkers or the identification of specific bio-physical profiles by skin scanning, would 331 benefit to these goals. The current WHO recommendation, based on risk-benefit analyses, is 332 to not treat unconfirmed seropositive individuals without knowing if they have an active 333 infection [1]. Importantly, we observed that the routinely administered trypanocide 334 treatments (Pentamidine for stage-1 and NECT for stage-2 cases) efficiently targeted both bloodstream and dermal trypanosomes in all the patients followed-up over 20 months. With 335 336 the promise of new cheaper, less toxic and easier to administer drugs on the horizon, the 337 policy of treating unconfirmed seropositive individuals could possibly be reconsidered. 338 Indeed, the new drug Acoziborole, that requires a single oral administration, could hopefully 339 be the next revolutionary treatment against gHAT. As gHAT approaches its elimination targets, 340 we propose from our findings that the current algorithms, used to identify and manage 341 disease cases, could be adapted to include the detection of skin-dwelling parasites, which 342 likely represent a previously unaccounted for anatomical reservoir.

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#### 357 Author contributions

MarC, AMS and NRKS conduced the clinical study in the field and commented on the manuscript. HI, IS, CT, CC, ACo, ACr, OC, ECA and JMB performed sample analyses and commented on the manuscript. MamC and VJ held logistical aspects, analyzed part of the data and commented on the manuscript. AML, BB and BR designed the study, organized logistical aspects, analyzed the data and wrote the manuscript as co-last authors.

#### 363 **Competing interest**

All authors declare no financial relationships with any organizations that might have an interest in the submitted work in the previous three years, no other relationships nor activities that could appear to have influenced the submitted work, and no other relationships or activities that could appear to have influenced the submitted work.

368	Data a	and material availability
369	Upon	request, the original protocol and associated forms, as well as an anonymized dataset,
370	could	be obtained from the corresponding author rotureau@pasteur.fr.
371	Trans	parency statement
372	The le	ad author affirms that the manuscript is an honest, accurate and transparent account
373	of the	study being reported, that no important aspect of the study has been omitted, and that
374	any di	screpancies from the study as originally planned have been explained.
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#### 428 Figures

#### 429 Fig. 1. Extravascular trypanosomes in the dermal matrix of human skin biopsies.

For each enrolled study subject, paraffin-embedded skin biopsy sections were stained either with (A) a specific anti-ISG65 antibody (brown) or (B) with Giemsa (purple) and screened at a 100x magnification. Representative trypanosome sections from confirmed stage-1 (subject and stage-2 cases (subjects 1035, 1036, 1037, 1039 and 1042), as well as from unconfirmed seropositive individuals (subjects 1046, 1065 and 1066) are shown. The scale

- 435 bars represent 10μm. More images of extravascular *T. brucei* parasites in human skin biopsies
- 436 are available in Supplementary Fig2.

#### 437 Tables

- 438 **Table 1. Diagnostic process, number of subjects and results.**
- 439 CATTwb / CATTp: card agglutination test for trypanosomiasis on whole blood / plasma; mAECT
- 440 BC / LN aspirate: mini anion-exchange column technique on buffy coat / lymph node aspirate;
- 441 WBC: white blood cells; CSF: cerebrospinal fluid; ND: not determined. \*Highest plasma
- dilution with a positive result.

			Diagnostic pro	cess			No. subjects	
Groups	I	1- Serological screening	2- Serological validation	3- Parasitological confirmation	4- Staging	Comonad	E mollod	Followod un
		CATTwb / RDT	CATTp*	mAECT BC / LN aspirate observation	Parasites in No. WBC CSF in CSF			dn-nomou
Conon ogo tivo			ND	ÛN	CI X	LLC 3	10	
oci uneganve		+	< 1/4	<b>CIN</b>	ON	1100	40	
<b>Seropositive</b>		+	$\geq 1/4$	ı	ND	12	8	5
	Stage 1				no 0-5	8	4	4
Confirmed	Stage 2	+	≧ 1/4	+	yes >5	18	14	13
	ND				ND	2	0	0
	All					28	18	17
Total						5 417	99	22

4	4	4
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#### 445 **Table 2. Epidemiological and clinical characteristics of case subjects.**

For each group and each parameter, total values correspond to the numbers of subjects for which a value was available (n/total). p values were obtained by comparing one by one the parameters of each group of seropositive subjects (unconfirmed and all confirmed) to those of seronegative controls using two-sided Fisher's exact tests or \* two-sided Mann-Whitney tests at 5% confidence. LN: lymph nodes.

				Grou) (n=60	ps ()			
						Confirme	pa	
Danamatana		Seronegative	Seroposit	ive		(n=18)		
		(n=40)	(n=8)		Stage 1	Stage 2	All All	
					(11-4)	(11-14)	(01_11)	
		n/total (%) or mean (SD)	n/total (%) or mean (SD)	p values	n/total (%) or mean (SD)	n/total (%) or mean (SD)	n/total (%) or mean (SD)	p values
Epidemiological	Age (n=66)	37.9 (14)	36.6 (18)	0.7647*	31.0 (17)	35.6 (15)	34.6 (15)	0.3502*
	Male sex (n=66)	22/40 (55%)	3/8 (38%)	0.4538	2/4 (50%)	5/14 (36%)	7/18 (39%)	0.3950
	HAT case(s) in the family since $2010 (n=65)$	11/40 (28%)	2/7 (29%)	>0.9999	2/4 (50%)	5/14 (36%)	7/18 (39%)	0.5404
	Occupational risk (n=66)	17/40 (43%)	4/8 (50%)	0.7155	2/4 (50%)	5/14 (36%)	7/18 (39%)	>0.9999
Clinical	Swollen LN (n=65)	5/39 (13%)	6/8 (75%)	0.0010	4/4 (100%)	13/14 (93%)	17/18 (94%)	<0.0001
	Any dermatological symptoms (n=66)	8/40 (20%)	5/8 (63%)	0.0252	4/4 (100%)	13/14 (93%)	17/18 (94%)	<0.0001
	Dermatitis (n=66)	7/40 (18%)	5/8 (63%)	0.0166	4/4 (100%)	11/14 (79%)	15/18 (83%)	<0.0001
	Pruritus (n=66)	3/40 (8%)	2/8 (25%)	0.1887	0/4 (0%)	11/14 (79%)	11/18 (61%)	<0.0001
	Asthenia (n=65)	17/39 (44%)	4/8 (50%)	>0.9999	4/4 (100%)	14/14 (100%)	18/18 (100%)	<0.0001
	Fever (n=63)	6/38 (16%)	1/7 (14%)	>0.9999	2/4 (50%)	9/14 (64%)	11/18 (61%)	0.0013
	Weight loss (n=61)	6/39 (15%)	3/8 (38%)	0.1672	2/4 (50%)	6/10 (60%)	8/14 (57%)	0.0046
	Eating disorders (n=66)	4/40 (10%)	1/8 (13%)	>0.9999	0/4 (0%)	7/14 (50%)	7/18 (39%)	0.0250
	Headache (n=65)	23/39 (59%)	6/8 (75%)	0.6918	3/4 (75%)	13/14 (93%)	16/18 (89%)	0.0322
	Circadian rhythm disruptions (n=66)	3/40 (8%)	1/8 (13%)	0.5303	0/4 (0%)	5/14 (36%)	5/18 (28%)	0.0925
	Sexual dysfunctions (n=65)	4/39 (10%)	1/8 (13%)	>0.9999	0/4 (0%)	5/14 (36%)	5/18 (28%)	0.1236
	Behaviour changes (n=63)	4/39 (10%)	0/2 (0%)	>0.9999	0/4 (0%)	3/13 (23%)	3/17 (18%)	0.6624

#### 453 Table 3. Serological, molecular and histological analysis results from blood and skin samples.

For each group and each parameter, total values correspond to the numbers of subjects for which a value was available (n/total). p values were obtained by comparing one by one the parameters of each group of seropositive subjects (unconfirmed and all confirmed) to those of seronegative controls using two-sided Fisher's exact tests at 5% confidence. VAT: variable antigen type; PCR: polymerase chain reaction; TgsGP: *Trypanosoma brucei gambiense* surface glycoprotein; HE: haematoxylin-eosin; IHC: immuno-histochemistry; Hsp70: heat shock protein 70; ISG65: invariant surface glycoprotein 65; ND: not determined.

				Gro	ups (n=37)			
		Seronegative (n=11)	Seroposit (n=8)	ive		Confirme (n=18)		
rarameters					Stage 1 (n=4)	Stage 2 (n=14)	All (n=18)	
		n/total (%)	n/total (%)	p values	n/total (%)	n/total (%)	n/total (%)	p values
Trypanolysis	LiTat 1.3 positive (n=36)	0/10 (0%)	2/8 (25%)	0.1830	4/4 (100%)	14/14 (100%)	18/18 (100%)	<0.0001
	LiTat 1.5 positive (n=36)	0/10 (0%)	2/8 (25%)	0.1830	4/4 (100%)	12/14 (86%)	16/18 (89%)	<0.0001
	LiTat 1.6 positive (n=36)	0/10 (0%)	2/8 (25%)	0.1830	4/4 (100%)	12/14 (86%)	16/18 (89%)	<0.0001
	Positive for all VATs (n=36)	0/10 (0%)	2/8 (25%)	0.1830	4/4 (100%)	12/14 (86%)	16/18 (89%)	<0.0001
	Negative for all VATs (n=36)	10/10 (100%)	6/8 (75%)	0.1830	0/4 (0%)	0/14 (0%)	0/18 (0%)	<0.0001
PCR on blood	TBR positive $(n=37)$	0/11 (0%)	0/8 (0%)	>0.9999	4/4 (100%)	14/14 (100%)	18/18 (100%)	<0.0001
	TgsGP positive (n=37)	0/11 (0%)	0/8 (0%)	>0.9999	2/4 (50%)	10/14 (71%)	12/18 (67%)	0.0004
	Negative for all PCRs on blood $(n=37)$	11/11 (100%)	8/8 (100%)	>0.9999	0/4 (0%)	0/14 (0%)	0/18 (0%)	<0.0001
PCR on skin	TBR positive $(n=37)$	0/11 (0%)	6/8 (75%)	0.0010	1/4 (25%)	13/14 (93%)	14/18 (78%)	<0.0001
	TgsGP positive (n=37)	0/11 (0%)	0/8 (0%)	>0.9999	0/4 (0%)	0/14 (0%)	0/18 (0%)	>0.9999
	Negative for all PCRs on skin (n=37)	11/11 (100%)	2/8 (25%)	0.0010	3/4 (75%)	1/14 (7%)	4/18 (22%)	<0.0001
Histology	Dermal touchpreps (n=22, 3 reads)	ND	2/6 (33%)		1/3 (33%)	12/13 (92%)	13/16 (81%)	
	HE section $(n=36, 1 \text{ read})$	0/11 (0%)	6/8 (75%)	0.0010	4/4 (100%)	8/13 (62%)	12/17 (71%)	0.0003
	Giemsa section (n=37, 2 reads)	0/11 (0%)	4/8 (50%)	0.0181	0/4 (0%)	14/14 (100%)	14/18 (78%)	<0.0001
	IHC Hsp70 $(n=31, 1 \text{ read})$	0/11 (0%)	1/4 (25%)	0.2667	1/4 (25%)	11/12 (92%)	12/16 (75%)	0.0002
	IHC ISG65 $(n=37, 3 \text{ reads})$	0/11 (0%)	8/8 (100%)	<0.0001	4/4 (100%)	14/14 (100%)	18/18 (100%)	<0.0001
	Negative for all reads $(n=37)$	11/11 (100%)	0/8 (0%)	<0.0001	0/4 (0%)	0/17 (0%)	0/18 (0%)	<0.0001

# Table 4. Clinical, serological, molecular and histological follow-up analyses at 6 and 20 months after enrolment.

Total values correspond to the numbers of subjects for which a value was available (n/total). For each group of subjects, p values were obtained by comparing one by one the parameters recorded at 6 months and 20 months after treatment/enrolment to those obtained at enrolment, using two- sided Fisher's exact tests at 5% confidence. LN: lymph nodes; CATT: card agglutination test for trypanosomiasis; VAT: variable antigen type; PCR: TBR polymerase chain reaction; Hsp70: heat shock protein 70; ISG65: invariant surface glycoprotein 65; ND: not determined.

			Seronocitive				Confir	med		
Parameters			amendanc			Stage 1			Stage 2	
		Enrollment	6 months	20 months	Enrollment	6 months	20 months	Enrollment	6 months	20 months
		n/total (%)	n/total (%) <i>p values</i>	n/total (%) <i>p values</i>	n/total (%)	n/total (%) $p$ values	n/total (%) <i>p values</i>	n/total (%)	n/total (%) $p$ values	n/total (%) <i>p values</i>
Clinics	Asthenia	3/5 (60%)	1/5 (20%) 0.5238	2/4 (50%) > 0.9999	4/4 (100%)	0/4 (0%) <b>0.0286</b>	2/3 (67%) 0.4286	13/13 (100%)	3/13 (23%) 0.0001	3/9 (33%) 0.0011
	Swollen LN	4/5 (80%)	1/4 (25%) 0.2063	3/4 (75%) >0.9999	4/4 (100%)	2/3 (67%) 0.4286	2/3 (67%) 0.4286	12/13 (92%)	2/11 (18%) 0.0005	3/9 (33%) 0.0066
	Any dermatological symptoms	4/5 (80%)	1/5 (20%) 0.2063	1/4 (25%) 0.2063	4/4 (100%)	1/4 (25%) 0.1429	0/3 (0%) 0.0286	12/13 (92%)	5/13 (38%) 0.0112	3/9 (33%) 0.0066
	Fever	1/5 (20%)	1/5 (20%) > 0.9999	0/4 (0%) > 0.9999	2/4 (50%)	0/4 (0%) 0.4286	0/3 (0%) 0.4286	9/13 (69%)	0/13 (0%) 0.0005	1/9 (11%) 0.0115
	Headache	5/5 (100%)	2/5 (40%) 0.1667	3/4 (75%) 0.4444	3/4 (75%)	0/4 (0%) 0.1429	0/3 (0%) 0.1429	12/13 (92%)	2/13 (15%) 0.0002	4/9 (44%) 0.0231
	Pruritus	1/5 (20%)	0/5 (0%) > 0.9999	1/4 (25%) > 0.9999	0/4 (0%)	0/4 (0%) > 0.9999	0/3 (0%) > 0.9999	10/13 (77%)	3/13 (23%) 0.0169	2/9 (22%) 0.0274
	Weight loss	2/5 (40%)	2/5 (40%) >0.9999	0/4 (0%) 0.4444	2/4 (50%)	1/4 (25%) >0.9999	0/3 (0%) 0.4286	5/9 (56%)	0/13 (0%) 0.0048	0/9 (0%) 0.0294
	Dermatitis	4/5 (80%)	1/5 (20%) 0.2063	1/4 (25%) 0.2063	4/4 (100%)	1/4 (25%) 0.1429	0/3 (0%) 0.0286	10/13 (77%)	5/13 (38%) 0.1107	3/9 (33%) 0.0789
	Eating disorders	1/5 (20%)	1/5 (20%) > 0.9999	1/4 (25%) > 0.9999	0/4 (0%)	0/4 (0%) > 0.9999	0/3 (0%) > 0.9999	6/13 (46%)	0/13 (0%) 0.0149	1/9 (11%) 0.1649
	Sexual dysfunctions	1/5 (20%)	3/5 (60%) 0.5238	0/4 (0%) > 0.9999	0/4 (0%)	0/4 (0%) > 0.9999	0/3 (0%) > 0.9999	5/13 (38%)	5/13 (38%) >0.9999	1/9 (11%) 0.3330
	Circadian rhythm disruptions	1/5 (20%)	1/5 (20%) > 0.9999	0/4 (0%) > 0.9999	0/4 (0%)	0/4 (0%) > 0.9999	0/3 (0%) > 0.9999	4/13 (31%)	1/13 (8%) 0.3217	1/9 (11%) 0.3602
	Behaviour changes	0/4 (0%)	1/5 (20%) > 0.9999	$0/4 \ (0\%) \ > 0.9999$	0/4 (0%)	0/4 (0%) > 0.9999	$0/3 \ (0\%) > 0.9999$	2/12 (17%)	0/13 (0%) 0.2200	0/9 (0%) 0.4857
Diagnosis	CATTwb	5/5 (100%)	4/5 (80%) >0.9999	3/4 (75%) 0.4444	4/4 (100%)	4/4 (100%) >0.9999	2/3 (67%) 0.4286	13/13 (100%)	10/13 (77%) 0.2200	4/9 (44%) 0.0048
	CATTp	5/5 (100%)	1/5 (20%) 0.0476	2/4 (50%) 0.1667	4/4 (100%)	0/4 (0%) 0.0286	1/3 (33%) 0.1429	13/13 (100%)	3/13 (23%) 0.0001	0/9 (0%) <0.0001
	Parasitology	0/5 (0%)	0/5 (0%) > 0.9999	0/4 (0%) > 0.9999	4/4 (100%)	0/4 (0%) 0.0286	0/3 (0%) <b>0.0286</b>	13/13 (100%)	0/13 (0%) <0.0001	0/9 (0%) <0.0001
Trypanolysis	LiTat 1.3 positive	1/5 (20%)	1/5 (20%) > 0.9999	0/4 (0%) > 0.9999	4/4 (100%)	4/4 (100%) >0.9999	3/3 (100%) >0.9999	13/13 (100%)	10/11 (91%) 0.2200	5/9 (56%) 0.0172
	LiTat 1.5 positive	1/5 (20%)	1/5 (20%) > 0.9999	0/4 (0%) > 0.9999	4/4 (100%)	4/4 (100%) >0.9999	2/3 (67%) 0.4286	11/13 (85%)	8/11 (73%) 0.6299	5/9 (56%) 0.1778
	LiTat 1.6 positive	1/5 (20%)	1/5 (20%) > 0.9999	0/4 (0%) > 0.9999	4/4 (100%)	4/4 (100%) >0.9999	0/3 (0%) <b>0.0286</b>	11/13 (85%)	6/11 (54%) 0.1819	0/9 (0%) 0.0002
	Positive for all VATs	1/5 (20%)	1/5 (20%) > 0.9999	0/4 (0%) > 0.9999	4/4 (100%)	4/4 (100%) >0.9999	0/3 (0%) <b>0.0286</b>	11/13 (85%)	6/11 (54%) 0.1819	0/9 (0%) 0.0002
	Negative for all VATs	4/5 (80%)	4/5 (80%) >0.9999	4/4 (100%) > 0.9999	0/4 (0%)	0/4 (0%) > 0.9999	$0/3 \ (0\%) \ >0.9999$	0/13 (0%)	1/11 (9%) 0.4583	3/9 (33%) 0.0545
TBR PCR	Blood	0/5 (0%)	0/5 (0%) >0.9999	$0/4 \ (0\%) \ > 0.9999$	4/4 (100%)	0/4 (0%) <b>0.0286</b>	0/3 (0%) 0.0286	13/13 (100%)	0/13 (0%) <0.0001	0/9 (0%) <0.000
	Skin	3/5 (60%)	0/5 (0%) 0.1667	0/4 (0%) 0.1667	1/4 (25%)	0/4 (0%) >0.9999	$0/3 \ (0\%) > 0.9999$	12/13 (92%)	0/13 (0%) <0.0001	0/9 (0%) <0.0001
Histology	Dermal touchpreps	1/3 (33%)	0/2 (0%) >0.9999	ND	1/3 (33%)	1/4 (25%) >0.9999	ND	11/12 (92%)	2/13 (15%) 0.0002	ND
	IHC Hsp 70	1/4 (25%)	ND	0/4 (0%) > 0.9999	1/4 (25%)	ND	$0/3 \ (0\%) \ >0.9999$	11/12 (92%)	ND	0%) <0.00 (0%) <0.000
	IHC ISG65	5/5 (100%)	1/5 (20%) 0.0476	0/4 (0%) 0.0079	4/4 (100%)	0/4 (0%) 0.0286	0/3 (0%) 0.0286	13/13 (100%)	5/13 (38%) 0.0016	0%) <0.00 (0%) <0.000
	Negative for all reads	0/5 (0%)	2/5 (40%) 0.4444	4/4 (100%) 0.0079	0/4 (0%)	2/4 (50%) 0.4286	2/3 (67%) 0.1429	0/13 (0%)	1/13 (8%) >0.9999	9/9 (100%) <0.0001