Fatal infection by two genera of free-living amoebae, *Acanthamoeba* and *Naegleria*, is well documented, with numerous human cases recorded. The first cases were published as early as 1965 in Australia (Fowler & Carter, 1965), and since then from all over the world (Ma et al., 1990). *Acanthamoeba* causes granulomatous amoebic encephalitis (GAE), almost invariably in the immunocompromised (Khan, 2006), but this amoeba more commonly causes amoebic keratitis (AK), a sight-threatening eye infection associated with corneal trauma and/or contact-lens use (Niederkorn et al., 1999). A single species of *Naegleria*, *Naegleria fowleri*, also produces an encephalitis in humans, and this is known as primary amoebic meningoencephalitis (PAM). PAM is almost always fatal (Barnett et al., 1996). More recently, a third genus of amoeba, *Balamuthia*, has been discovered to cause a fatal encephalitis in humans (Visvesvara et al., 1990). This encephalitis is known as *Balamuthia* amoebic encephalitis (BAE). At present there is a single species in this novel genus, *Balamuthia mandrillaris*, and all isolates from animals and humans have been ascribed to this single species. There are worrying features of BAE that are emerging, even compared to GAE and PAM. BAE is restricted to bodies of warm freshwater, such as swimming pools and lakes, and so can be avoided after its use (Niederkorn et al., 1999), allowing amoebae to crawl out, feeding on the bacteria as they do so.

Like GAE, BAE has often been reported to occur subsequent to a skin lesion (Deetz et al., 2003; Deol et al., 2000), in particular the face (Pritzker et al., 2004; Seas & Bravo, 2006; Valverde et al., 2006). *B. mandrillaris* amoebae spread from this primary lesion through the blood and then penetrate the blood–brain barrier to gain access to the brain. *Naegleria fowleri*, on the other hand, is thought to gain access to the brain in a relatively direct manner. This amoeba finds its way onto the nasal mucosa during swimming in warm water, digests its way up through the olfactory nerve and into the brain (Cabanes et al., 2001). This may be why the course of infection due to *N. fowleri* is so rapid. Both GAE and BAE share the features of haematogenous spread from an often chronic primary lesion, and this may explain the long time-course of the infection relative to PAM. The existence of this phase of infection prior to access to the brain may also offer a target for intervention. There are several possible reasons why so many pathogens and facultative pathogens end up in the brain. *Acanthamoeba*, *Naegleria* and *Balamuthia* are all obligate aerobes and the brain is well oxygenated. The brain also excludes antibodies and other components of the immune system. A simpler explanation is that when these organisms do penetrate the brain, their presence becomes very obvious.

A large Californian study looking at causes of encephalitis found at least 13 939 cases of acute encephalitis diagnosed between 1990 and 1999 (Trevejo, 2004). Amongst these cases, 0.1 % were attributed to *Naegleria*, 0.63 % to other protozoans, and 34.7 % were from unspecified causes. The California Encephalitis Project (CEP) (Glaser et al., 2003; Schuster et al., 2006), covering a similar time span, 1998–2000, identified three fatal cases from the 334 patients who met the criteria for CEP and whose encephalitis had been caused by *Balamuthia* (Schuster et al., 2004). No cases of encephalitis caused by either *Acanthamoeba* or *Naegleria* were seen within the CEP population, but immunocompromised patients were excluded from the study (Schuster et al., 2006), which would account for the lack of *Acanthamoeba* cases. Prima facie, these data would suggest that in the state of California in the 1990s, *Balamuthia* and *Naegleria* each accounted for approximately 0.1 % of total encephalitis cases in the otherwise healthy population!

From the limited data currently available we can conclude that BAE occurs in healthy people of any age (perhaps with emphasis on the very young and old), with a bias toward males, and a reported bias toward Hispanic people. The Hispanic bias (Schuster et al., 2004) is difficult to understand, since *B. mandrillaris* infects such a broad range of mammals in addition...
to humans, but it has been reported that Hispanic peoples are less able to make antibodies against certain *Acanthamoeba* species (Chappell *et al.*, 2001). Another possibility is that Hispanics in Southern California are more likely than other groups to be exposed to infected soils during agricultural activities (Schuster *et al.*, 2004).

Temperature seems to be an important factor in the occurrence of BAE, as the disease seems to be more common in warmer regions, such as Southern California and South America (Seas & Bravo, 2006). Isolates of *Balamuthia* can grow at 37°C *in vitro*, so perhaps this amoeba can only survive in warm soils? Certainly the ability to grow at 37°C is a prerequisite for human pathogenicity.

The immunization of mice by *Acanthamoeba* has been demonstrated to have a protective effect (Rowan-Kelly & Ferrante, 1984), and the role of antibodies in GAE is generally accepted (Cursons *et al.*, 1980; Ferrante, 1991). Many individuals have detectable antibody titres against *B. mandrillaris* (Schuster *et al.*, 2006), and while these levels are not as high as those of individuals infected with the amoeba, this may indicate prior exposure to *B. mandrillaris* or a cross-reactivity with other organisms. However, antibodies specific for *B. mandrillaris* are known not to recognize *Acanthamoeba* and vice versa (Huang *et al.*, 1999; Schuster *et al.*, 2006), and so, unfortunately, harmless exposure to the related *Acanthamoeba* does not naturally immunize against *B. mandrillaris*. The fact that some patients have an elevated titre of antibodies to *B. mandrillaris* and yet still succumb to the infection demonstrates that the situation is complex.

In this issue of the journal, Matin *et al.* (2007) shed new light on this antibody paradox. These authors show that normal human serum has antibodies that recognize *B. mandrillaris*. These normal sera inhibit the growth of *B. mandrillaris* in culture and have a demonstrable amoebicidal activity. These findings are in accordance with recent reports that many non-infected individuals possess antibodies against *B. mandrillaris* (Schuster *et al.*, 2001). The serum also inhibits the ability of the amoeba to bind to human brain microvascular endothelial cells, which form the blood–brain barrier. These observations are consistent with the suspected course of a typical BAE progression. The infection begins with a skin lesion, during which the amoeba penetrates the body. The amoeba presumably grows at a rate that is limited by the antibodies in the serum. This serum not only holds the amoeba population in check but possibly prevents amoebae from binding to the endothelia of the blood–brain barrier, and may neutralize toxins such as the proteases (Matin *et al.*, 2006b) that are presumed to take part in the destruction of the cells. The chronic phase of the infection is likely to be at the stage where the blood–brain barrier is intact, but as soon as the amoeba breaks through into the brain, the amoebae, being free of antibody, are able to multiply and to destroy the brain rapidly. Matin *et al.* (2007) also show that there is a remarkable consistency in the subgroup of about 10 amoebal proteins recognized by these human sera. Further work is necessary to determine if these may be usefully targeted for immune therapy, such as inhibiting the proteases that break down the blood–brain barrier, or by direct amoebicidal activity.

Despite these advances, we remain fundamentally ignorant about this organism and the disease that it causes. Several questions remain unanswered.

Is this amoeba really free-living? It has been isolated from soil on two occasions, so does this mean that it is to be found in virtually all soils, like its cousin and presumed food source *Acanthamoeba*? Is there a necessary third party?

How many people are at risk? Are Hispanic peoples actually more prone to this disease and, if so, why?

Is there a geographical limit to the distribution, or is *B. mandrillaris*, like *Acanthamoeba*, practically ubiquitous?

Are there other members of the *Balamuthia* genus and, if so, what threat do they represent?

The estimated frequency data from the various Californian studies (and others) are likely to be an underestimate (Schuster *et al.*, 2006), and so it is important that amoebae, especially *Balamuthia* and *Naegleria*, should be considered as possible causes of encephalitis when confronted with patients displaying general encephalitis symptoms. Further work, such as that described in this issue (Matin *et al.*, 2007), is crucial to the understanding of *B. mandrillaris* pathology if therapies are to be developed. It is also crucial that further advances are made in the detection of amoebal encephalitis cases (Qvarnstrom *et al.*, 2006).

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