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Abstract

Schistosomiasis, a neglected tropical disease, is a major cause of chronic morbidity and disability, and premature death. The hepatosplenic form of schistosomiasis is characterized by hepatosplenomegaly, liver fibrosis, portal hypertension and oesophageal varices, whose rupture may cause bleeding and death. We review currently available abdominal imaging modalities and describe their basic principles, strengths, weaknesses, and usefulness in the assessment of hepatosplenic schistosomiasis. Advanced imaging methods are presented that could be of interest for hepatosplenic schistosomiasis evaluation by yielding morphological, functional and molecular parameters of disease progression. We also provide a comprehensive view of preclinical imaging studies and current research objectives such as parasite visualisation in hosts, follow-up of host-immune response, and development of non-invasive quantitative methods for liver fibrosis assessment.

Hepatosplenic schistosomiasis

Schistosomiasis, a waterborne helminthic disease is a major cause of chronic morbidity and premature death in Africa, South America, South East Asia, and Middle East, whereas imported cases have recently been on the rise in Europe. *Schistosoma mansoni* and *Schistosoma japonicum* are the main causative agents of hepatosplenic schistosomiasis (HSS). Schistosome eggs eliminated with mammalian excreta hatch in water and release miracidia that infect specific intermediate host snails. The gastropods shed on cercariae that can penetrate the skin of the human host. These larvae transform into schistosomulae, migrate to the venous circulation, and differentiate into sexually mature worms [1, 2]. The eggs laid in the mesenteric vessels (*S. mansoni, S. japonicum*) migrate to the gastrointestinal tract and the liver. The host immune response leads to egg encapsulation within layers of immune cells embedded in extracellular matrix (ECM). Granuloma formation is a cause of chronic inflammation and fibrosis (Box 1) [1]. The diseases caused by *S. mansoni* and *S. japonicum* are divided in two stages, the acute and chronic phases. The acute syndrome generally occurs in the first infection, in the first months after exposure. In the chronic phase, two main clinical forms of schistosomiasis may occur, the hepatointestinal or the hepatosplenic disease [3].

The hepatosplenic complication occurs in less than 10% of patients, 5–20 years after infection [4, 5], owing to chronic granulomatous inflammation in the liver, leading to severe fibrosis of the portal system (Figure 1, Key Figure). Hepatomegaly is often an early sign of granulomatous inflammation [1, 6]. Fibrosis in HSS occurs with little hepatocellular damage unlike cirrhosis (Box 1) [5, 7]. The major complication of liver fibrosis is portal hypertension (PH) (Box 1), which causes splenomegaly and esophageal, gastric, splenorenal, pancreaticoduodenal and periumbilical varice formation. Esophageal varice bleeding is potentially fatal [1, 2, 5, 8]. Other complications include anemia, thrombocytopenia, nephritic glomerulopathy, and pulmonary arterial hypertension with right heart failure [1, 2, 5, 8]. Liver dysfunction may occur in cases

of comorbidities (hepatitis, steatosis) (Box 1) [5] and in advanced-stage disease. HSS is associated with a higher incidence of hepatocellular carcinoma [2]. The diagnosis of parasite infection is generally based on fecal egg count (Kato-Katz technique) and requires sexually mature worms. Rectal mucosa biopsy for egg detection is performed when infection is suspected despite negative Kato-Katz tests. The diagnosis of HSS relies on clinical examination, liver biopsy and medical imaging. Changes in size and consistency of the liver and the spleen can be detected at palpation and percussion. Biopsy, the standard diagnostic technique is highly invasive and tissue sampling often inadequate to cover fibrosis heterogeneity. **Ultrasonography** (USG, see Glossary) is currently the most widely used technique to detect organomegaly and altered texture due to fibrosis [9, 10].

Overview of imaging modalities and applications to HSS

Imaging allows the assessment of HSS morbidity by diagnosing and staging fibrosis, evaluating vascular complications, guiding surgical interventions, and monitoring response to treatment. Improving fibrosis diagnosis and staging, especially early and mild forms, with non-invasive and quantitative methods is a major challenge in liver imaging, regardless of the cause of fibrosis. Preclinical imaging studies are essential to better characterize specific morphologic and functional changes linked to granulomatous inflammation. They are also required for the development and validation of imaging methods with improved sensitivity to early fibrosis, and for the identification of robust biomarkers translatable to the clinical setting.

This review provides an update on HSS imaging, covering clinical and research applications. After a methodological overview of abdominal imaging modalities, we discuss their utility in the diagnosis and follow-up of HSS. We describe multimodal approaches combining imaging techniques with **elastography** and the results obtained so far on HSS. We discuss the potential of advanced methods evaluated in the research setting that could take up the challenge of non-

invasive quantitative assessment of fibrosis severity and vascular dysfunction. We also provide the first synthesis of preclinical imaging studies and present the main lines of research including parasite visualization in hosts, follow-up of host-immune response, and development of non-invasive quantitative methods for HSS assessment.

Ultrasonography (USG)

USG is the first-line medical imaging examination for the non-invasive exploration of gastrointestinal and hepatic diseases (Table 1). Real-time imaging of parenchymal texture, vascular anatomy and haemodynamics allows fast clinical interpretation as well as guidance of interventional procedures and monitoring response to therapy.

Due to its portability and cost-effectiveness, USG is also the most-widely used radiologic method to diagnose HSS (Table 2). Although HSS caused by *S. mansoni and S. japonicum* share common features, differences in fibrotic lesions have been described such as the "mosaics" formed by echogenic septa [11-14] in *S. japonicum* infection. The need for fibrosis scales specific for HSS and standardized USG methods for schistosomiasis exploration led to consensus guidelines. The landmark Niamey classification specific for the mansonian disease includes scores for liver parenchymal patterns, periportal fibrosis and PH [15]. Granulomatous inflammation is described as pattern B or "starry sky" (Figure 1) because of diffuse echogenic spots. Fibrosis along portal sub-branches is described in pattern C as "rings" and "pipestems" depending on the viewing angle, and as "bull's eye" on cross-sections with an anechogenic portal vein surrounded by echogenic fibrous tissue. Fibrosis can also be localized around the portal vein bifurcation as "ruff" (pattern D). USG permits to measure fibrosis thickness of second order branches, of the gallbladder as well as ruff thickness. In advanced forms, patches form around the hepatic portal vessels for pattern E and extend to the liver periphery as "Bird's claw" for pattern F. Combinations of patterns are possible (e.g. iDb, Dc, Ec). PH is evaluated by measuring portal vein diameter, second order branch dilation, splenic vein diameter and by

detecting varices. Volumetric assessment of the liver is possible with newer USG systems. Spleen enlargement and texture (homogenous or granular) can be evaluated. Ascites, masses such as cancers (pattern Z) or haemangioma can be detected. The differential diagnosis between cirrhosis and schistosomiasis is complicated by the presence of intraparenchymal fat (*e.g.* alcoholic and non-alcoholic steatosis) resulting in hyperechogenicity of the parenchyma. In this case, pattern Y is assigned. Systemic varices and portal vein thrombosis can be detected by analysing blood flow using Doppler ultrasound.

Computed tomography (CT)

CT is widely used to explore diffuse or focal digestive diseases (Table 1). There are few CT studies on liver fibrosis [16]. Analysis of texture features from CT images enables staging of fibrosis throughout the liver, but is less accurate in case of heterogeneous fibrosis and considered inferior to ultrasound transient elastography (TE, FibroScan®) [17]. PH can be diagnosed by portal vein and mesenteric vein dilation, varices and organomegaly detectable with a single rapid scan. Repeated scanning during injection of mainly tri-iodinated benzene ring-containing contrast agents (**CA**) allows identification of arterial, venous and perfusion phases with the potential to detect perfusion changes occurring during fibrosis, but delivers higher radiation dose. Increased parenchymal CA retention is observed in advanced fibrotic tissue.

Unexpected hepatic and pancreatic lesions have been described in the acute phase of *S. mansoni* infection together with hepatomegaly and splenomegaly [18] (Table 2). In mansonian HSS, the main features of the fibrotic liver are round low-density periportal zones enhancing after CA administration, and linear bands in longitudinal sections of portal veins [19]. In HSS caused by *S. japonicum,* capsular and septal calcifications result in a "turtle back" appearance of the liver. Fibrous septa are enhanced after CA injection [11-13, 20-22].

126

127 ***Magnetic resonance imaging (MRI)***

128 Anatomy, microstructure, vasculature, perfusion, and metabolism can be assessed with
129 magnetic resonance methods (Table 1). In the portal venous phase and the delayed venous
130 phase, unspecific extracellular gadolinium chelates enhance fibrous hepatic tissue, and improve
131 texture analysis [23]. Clinically approved hepatocyte-specific CAs such as Gadoxetate
132 Disodium (Gd-EOB-DTPA) employed for diagnosing and staging HCC are used to assess the
133 residual liver tissue function in liver fibrosis [24].

134 MRI would provide more precise information than USG regarding periportal fibrosis,
135 gallbladder fibrosis, and alterations of the abdominal venous system in HSS (Table 2) [4, 25].
136 Besides the detection of morphological anomalies suggestive of liver fibrosis and PH on
137 anatomical images (splenomegaly, large portal vein diameter, varices, ascites…) [4, 14],
138 granulomatous inflammation and liver fibrosis can be detected on CA-enhanced MRI, and
139 various methods can be used to assess subtle changes in liver microstructure [26]
140 (Supplementary file).

141

142 ***Scintigraphy, single-photon emission computed tomography (SPECT), positron emission***
143 ***tomography (PET)***

144 Although the main applications of nuclear medicine techniques are in oncology (Table 1),
145 scintigraphy can be used to stage PH and portosystemic shunts in chronic liver diseases [27],
146 whereas ^{18}F-fluorocholine radiotracer seems promising for the grading of liver fibrosis [28].
147 Differentiation between cirrhotic and non-cirrhotic PH is possible with ^{99m}Tc-labelled sulphur
148 colloid particles but specific fibrosis patterns pathognomonic for schistosomiasis are not
149 discernible. Scintigraphy has been used in the post-operative follow-up of patients who
150 underwent splenectomy followed by auto-implantation of spleen tissue [29, 30]. A case report

described hypermetabolic pancreatic lesions with **deoxy-2-(^{18}F)fluoro-D-glucose** in HSS [31]. Interestingly, hepatic angioscintigraphy with ^{99m}Tc-labelled sulphur colloid particles revealed increased hepatic perfusion index in patients with HSS, which was correlated with splenomegaly and oesophageal varices [32]. This finding would reflect an increased perfusion through the hepatic artery (Table 2).

Endoscopy and laparoscopy

Endoscopy can be used for diagnosis, biopsy, follow-up, and therapeutic purposes (*e.g.* laparoscopic surgery, image-guided embolization or ligation of varices) (Table 1).

HSS can be explored by endoscopy (Table 2) [33]. The cost and risk of infection linked to the invasiveness of the technique are limitations to its use in resource-limited countries. Endoscopy permits to view and treat collaterals, to identify ascites, PH, whereas hepatomegaly, splenomegaly and granulomatous inflammation in liver can be detected with laparoscopy. Endoscopy is the gold-standard technique to guide ligation or sclerotherapy treatment of oesophageal varices. In HSS with PH, endoscopic sclerotherapy for esophageal varices was shown to be more efficient for secondary prophylaxis of upper gastrointestinal bleeding when preceded by splenectomy and esophagogastric devascularisation [34].

Which imaging modality for which HSS stage?

The acute stage is characterized by a syndrome with severe clinical manifestations including hepatomegaly, splenomegaly and lymphadenopathy. The enlargement of the liver, the spleen and abdominal lymph nodes can be visualized with USG [35]. When other sites of lesions are suspected during this stage (e.g. central nervous system, lungs or intestines…), other imaging modalities more appropriate for the exploration of these organs should be utilized (CT, MRI or endoscopy). Regarding the chronic phase, physical examination and laboratory findings may

not always permit to classify patients, especially if the time of infection is unknown. Moreover, there are frequent overlaps of the pathological signs of the acute and chronic stages, and of moderate and severe HSS (Table 2). Fibrosis and PH are common features of both moderate and severe HSS, but PH predominates in severe HSS and is associated with congestive splenomegaly and a high risk of variceal bleeding. Fibrosis grade is regarded as a predictive value for PH and esophageal varices. USG, the first line imaging modality, permits the detection of splenomegaly, fibrosis, and hemodynamic changes. Although USG can be used for fibrosis grading, it is not sensitive to mild disease, and often underestimates fibrosis in comparison to liver biopsy [14], and is sensitive to inflammation [35]. If available, conventional CT or MRI methods can be used to map fibrosis spatial distribution [5, 36]. As for USG, the results may be affected by inflammation in early disease stages. Fibrogenesis and inflammation are generally concomitant processes and such indirect parameters are not sufficiently specific. (Supplementary file). Additional investigation can be performed with SWI to detect iron deposits in inflammatory processes. When using CT or MRI, additional hemodynamic parameters can be collected with DCE or ASL. All these methods are available on clinical MRI scanners.

Emerging methods for human schistosomiasis assessment?

Evaluation of liver fibrosis

Elastography - Elastography has become the most widely used method to detect liver fibrosis and cirrhosis consecutive to steatosis or viral hepatitis [37]. Elastography cannot be regarded as an emerging method, but so far only few studies have reported its use in HSS.

In sonographic elastography, tissue excitation is either induced by acoustic radiation force impulse (ARFI) or using a mechanical vibrating device for TE. Pulse-echo acquisitions are performed to measure the velocity of the shear-wave, which informs about the elastic properties of the tissue. Few studies have explored HSS using sonographic elastography (Table 3) and only one used the ARFI method (Table 3). In patients with hepatitis C virus co-infection discrepancies between liver biopsy and ultrasonographic TE findings were identified [38, 39], probably due to fibrosis heterogeneity. In the absence of comorbidities, liver stiffness measurement (LSM) was higher in HSS patients than in controls and cirrhotic patients [40, 41]. One single study evaluating both liver and spleen stiffness reported a correlation between spleen stiffness and some USG signs of PH (portal vein diameter, area, and congestion index, splenic artery resistance index, splenic vein diameter and spleen diameter) [41]. In *S. japonicum* HSS, LSM was not correlated to USG findings [42]. These studies suggest that liver LSM could be a marker of HSS fibrosis. Moreover, spleen stiffness could assist in selecting patients for endoscopy. Indeed, it would be superior to liver stiffness in predicting esophageal varices [43]. However, ultrasound TE has several limitations, including a lack of reproducibility/reliability in case of steatosis, light fibrosis, obesity or ascites. Moreover, liver stiffness is affected by inflammation, iron overload, blood flow, and venous congestion [37, 44, 45].

Mechanically generated shear waves propagating through the liver can also be detected using motion-sensitive MRI techniques [37] implemented on standard MRI systems. Magnetic resonance elastography (MRE)-derived stiffness correlates with fibrosis stage in patients [46]. MRE appears more accurate and reliable than USG elastography to stage fibrosis [45, 47-50] and allows better coverage of fibrosis heterogeneity [37], moreover it is reliable in case of ascites. However, confounding comorbidities such as iron overload can limit the reliability of MRE.

225 *Advanced MRI methods* - MRI methods sensitive to Brownian water motion in tissues are used
226 to probe tissue microstructure. Diffusion-weighted imaging (based on Gaussian distribution of
227 water diffusion) with apparent diffusion coefficient (ADC) mapping, diffusion kurtosis imaging
228 (based on non-gaussian distribution of water diffusion) have been successfully applied to stage
229 moderate to advanced fibrosis in pre-cirrhotic liver with equal performance [51, 52]. Intravoxel
230 incoherent motion (IVIM) analysis which separately assesses parenchymal diffusion and
231 microvascular perfusion changes could be potentially more sensitive to pathophysiological
232 alterations during early fibrosis [53].
233 Double contrast-enhanced MRI using gadolinium-based CAs and SPIOs with or without texture
234 analysis has been used to differentiate early liver fibrosis from advanced disease with excellent
235 results [23, 54, 55]. Collagen fiber deposition in the space of Disse leads to an increase of the
236 extracellular space quantifiable as the distribution volume fraction of nonspecific CA in the
237 parenchymal (equilibrium) phase by MRI (or CT) [56-59]. Preclinical studies have shown that
238 the liver accumulation of collagen targeted CAs correlates with histological fibrosis scores [60].
239 Non-contrast enhanced relaxometric studies quantifying the longitudinal (T_1), transverse (T_2*)
240 and combined ($T_1\rho$) magnetic relaxation time constants, which provide information on tissue
241 microstructure and macromolecule content, have shown a good correlation of these parameters
242 with liver fibrosis, without being specific for it [61-64]. (Supplementary file).
243 *Phosphorus magnetic resonance spectroscopy (^{31}P-MRS)* - **MRS** is a non-invasive method for
244 monitoring cellular metabolism that can be performed during an MRI exploration. Spectra are
245 often acquired from a unique **voxel** (single voxel spectroscopy, SVS). MRS imaging (MRSI)
246 permits the simultaneous acquisition of multiple spectra in contiguous voxels and the
247 generation of metabolic maps providing spatial distribution of metabolite signals. ^{31}P-MRS
248 allows assessment of bioenergetics and phospholipid metabolism intermediates mainly
249 phosphomonoesters (PME) and phosphodiesters (PDE) (Box 1). An alteration of phospholipid

metabolism in cirrhosis has been identified using SVS and MRSI techniques [65, 66]. Fibrosis was associated with a decrease in PDE and the PME/(PME+PDE) ratio could separate mild from advanced fibrosis [65]. In another study, the PME/PDE ratio was strongly correlated with advanced fibrosis [66]. (Supplementary file).

Assessment of vascular damage

Detection of varices with non-invasive capsule endoscopy - Capsule endoscopy involving transit of an ingestible wireless camera along the digestive tract can be performed to visualise the entire small bowel when simultaneous therapeutic intervention or tissue sampling is not required. Capsule endoscopy has been successfully used in a pilot study to detect oesophageal varices in HSS and enabled the identification of small bowel lesions in PH together with edema, erosions and scarred mucosa [67, 68]. Although clinically significant esophageal and rectal varices are typically visible endoscopically, ectopic varices may require cross sectional or multiplanar portal venous phase CT or MRI for diagnosis.

Assessment of liver perfusion - Besides the non-invasive delineation of hepatic vascular anatomy by CT and MRI angio- and portography, several methods can be used for the assessment of hemodynamic changes in liver pathologies, including cirrhotic or non-cirrhotic PH. Among them, **dynamic contrast-enhanced** (DCE) CT, MRI or USG, relying on CA injection and liver-specific tracer kinetic modelling, allows quantitative assessment of liver perfusion and separation of arterial and portal-venous phases [69, 70]. DCE MRI studies showed that reduced portal perfusion was quantitatively related to fibrosis stage [71]. Hemodynamic parameters obtained from DCE imaging, such as increased mean transit time [72] and arterial blood flow [73], have the potential to detect perfusion changes occurring early during fibrosis. Non-invasive and quantitative tissue perfusion measurement can also be performed **with arterial spin labelling** (ASL) techniques without exogenous CA. These

techniques developed for the heart, kidney and brain have been successfully applied to the liver. A significant reduction in liver and spleen perfusion could be measured in cirrhosis [74, 75]. Although ASL has not yet been implemented in the clinical abdominal MRI routine, it represents an alternative to standard DCE methods, when repeated measures are required or when CA injection is contraindicated.

Quantitative MRI providing blood velocity in all directions and over the entire cardiac cycle, now feasible within tenth of minutes, can depict altered flow patterns in the abdominal vasculature, revealing PH and its consequences such as portocaval anastomoses less accessible by USG, Doppler US or endoscopy.

MRI detection of splenic siderotic nodules - **Diffusion MRI** with ADC mapping of the spleen [41] and magnetic susceptibility-weighted imaging (SWI) [76, 77] have been successfully used to evaluate splenic signs of PH including splenic siderotic nodules (Gamna-Gandy bodies) (Box 1) with higher sensitivity than anatomical MRI. Although these nodules are a frequent sign (> 65%) of PH in HSS [78, 79], SWI which is sensitive to iron deposits, has not yet been applied in HSS. SWI as well as quantitative susceptibility mapping (QSM) is also sensitive to calcifications, which are frequent in *S. japonicum* infection, and to hemorrhages. SWI has shown high accuracy for the grading of mild and advanced liver fibrosis [77, 80].

Pre-clinical imaging studies of schistosomiasis

Animal models

Models of schistosomiasis have been developed in different animal species providing the opportunity to study host immune response to schistosome infection, granulomatous inflammation, fibrogenesis, and to evaluate new therapies or vaccine candidates. Although they do not recapitulate all the features of the human disease, they remain clinically relevant as they develop liver fibrosis [81] and PH [82]. The characterization of experimental HSS with imaging

methods is essential for the selection of appropriate models in pharmacological studies. Preclinical studies aim at developing methods allowing direct visualisation and quantification of the parasites within host tissues, monitoring of host immune response to schistosome, detection, staging and quantification of liver fibrosis, and identification of markers for assessing anti-parasitic or anti-fibrotic drug efficacy (Table 4).

Imaging parasites within host tissues

In vivo visualisation of schistosomes at different developmental stages could help monitor parasite burden, detect ectopic localization and assess the schistosomicidal efficacy of new chemotherapies. Using **fluorescence molecular tomography** (FMT) [83] and microPET in mice, adult worms of different species (S. *mansoni, S. japonicum* and *S. haematobium* the agent of urogenital schistosomiasis) were directly visualized [84] and the anti-helminthic efficacy of several drugs could be monitored. FMT was used alone or in combination with microPET and MRI [85]. MicroPET studies showed that (^{18}F)FDG was taken up by *S. mansoni* worms in mice (Table 4).

Confocal laser scanning microscopy combined with a lens system integrated in a rigid endoscope was tested for the visualisation of eggs within the gut mucosa of mice infected with *S. mansoni* [86]. Detection and differentiation between viable and dead eggs was achieved in real time during endoscopy. Although performed on euthanized animals, this technique is a potential substitute for invasive tissue sampling when stool specimens are negative in early infection or due to treatment. The technique was applied shortly after to detect eggs in the bladder mucosa of a *S. haematobium* infected patient [87]. Fluorescent CA targeting eggs could possibly increase sensitivity of the endoscopic approach.

Monitoring host immune response

Bioluminescence imaging (BLI), a method allowing direct visualisation of gene expression through chemically-induced light emission [88, 89] was used to follow up eosinophilia and eosinopoiesis in mice infected with *S. mansoni* and expressing a luciferase reporter driven by an eosinophil peroxidase promoter [90]. In another study, the dynamics of collagen deposition in *S. japonicum* infection were monitored in mice expressing luciferase under a collagen promotor [91]. Newly formed collagen was assessed in mice with and without praziquantel treatment after granuloma formation.

Characterization of HSS and identification of imaging markers of fibrosis

HSS has been investigated with SPECT/CT, MRI, and USG (Table 4). USG studies in *S. japonicum* infected mice, rabbits and pigs identified common features with the human disease including hepatomegaly, advanced liver fibrosis, and enlarged portal vein diameter. A longitudinal study of the mouse model provided further description of HSS including portal and splenic vein diameter, spleen and liver morphometry, liver fibrosis patterns, and intestinal wall thickening [92]. These studies confirmed the relevance of experimental models of *S. japonicum* infection in pathophysiological and pharmacological studies.

HSS in *S. mansoni* infection was investigated in experimental models (mice) and semi-captive chimpanzees. As for *S. japonicum* infection, the imaging studies demonstrated the relevance of these models to the characterization of HSS. A longitudinal study performed on *S. mansoni* infected mice using microSPECT/CT and a new radiotracer labeled with ^{188}Re (^{188}Re-OCTAM) binding to hepatocyte asialoglycoprotein receptors (Box 1) permitted to detect hepatic necrosis and fibrosis [93]. The first MRI study of *S. mansoni* infected mice [94] used anatomical MRI and identified a patchy liver pattern assigned to fibrosis at histology. A longitudinal MRI study of this model [95] revealed anatomical signs of PH (liver, spleen and portal vein enlargement) and contrast-enhancement of fibrotic liver lesions. Furthermore, this study proposed that

quantitative mapping of the transverse T_2 relaxation time constant could be used to non-invasively assess fibrosis [95].

Concluding remarks

Assessment of HSS morbidity and treatment monitoring would benefit from non-invasive imaging methods allowing reliable fibrosis staging and estimation of vascular dysfunction (see outstanding questions). Quantitative methods, which have been successfully evaluated on human fibrotic and cirrhotic liver (USG elastography, MRE, ^{31}P-MRS, ASL, perfusion PET …) or in experimental schistosomiasis (T_2 mapping) have a potential for clinical/human schistosomiasis assessment provided the equipment is available. Advanced acquisition and post-processing methods under development aiming at identifying markers sensitive to early pathological mechanisms (inflammation, perfusion changes) and early fibrosis stages (*e.g.* IVIM, combined arterial and portal venous input DCE, double-contrast enhanced MRI) still require validation in schistosomiasis models. Moreover, the precise relationship between imaging markers (*e.g.* relaxation time constants or ADC) and pathophysiological changes accompanying chronic hepatic inflammation (iron accumulation and edema) as well as the possible contributions of confounding factors such as comorbidities (steatosis, hepatitis) need to be established. Non-invasive markers of hepatic fibrosis are increasingly needed in pharmacological studies prompting the development of advanced and standardized quantitative methods with translational potential in clinics.

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HIGHLIGHTS

- Liver fibrosis and portal hypertension in HSS may lead to variceal bleeding.
- Fibrogenesis in HSS differs from fibrogenesis of other etiology and requires specific and sensitive markers covering fibrosis heterogeneity. Currently no imaging markers are specific for HSS.
- USG is the leading imaging modality for HSS diagnosis, but other diagnostic imaging techniques can quantify liver fibrosis.
- Quantitative markers of HSS (collagen, iron and calcium deposition, microvascular density and flow) became accessible by medical imaging modalities.
- Semiquantitative and quantitative imaging markers for the assessment of vascular and hemodynamic alterations constitute valuable markers for staging, prognosis and treatment response.
- Preclinical imaging studies of HSS contribute to the development of clinically transferable markers sensitive to granulomatous inflammation and mild fibrosis.

GLOSSARY

Arterial spin labelling (ASL): Quantitative microvascular perfusion MRI technique relying on magnetically labeled arterial blood water molecules as endogenous tracer.

Bioluminescence imaging (BLI): whole-animal imaging method requiring the introduction of a bioluminescent reporter gene (*e.g.* firefly luciferase gene) fused to a gene of interest. When the luciferase substrate is injected to the animals, its oxidation results into detectable light emission.

626 **Contrast agents (CA):** mostly intravenously injected small molecules, which have the capacity
627 to enhance tissue contrast by modifying signal intensity upon accumulation. MRI CAs:
628 paramagnetic agents modifying the relaxation of neighbouring water protons. CT CAs contain
629 atoms with high atomic number increasing local photoelectric absorption. USG CAs: gas-
630 containing microbubbles.
631 **Deoxy-2-(^{18}F)fluoro-D-glucose:** a non-metabolizable glucose derivative used as radiotracer to
632 assess glucose uptake in activated cells with PET imaging.
633 **Diffusion MRI:** unique imaging modality capable of probing tissue microstructure by
634 measuring the water diffusivity which is hindered by biological barriers (*e.g.* cell membranes).
635 **Dynamic contrast enhancement (DCE):** following intravenous injection of a CA bolus,
636 different phases of signal changes occur that are analysed using a pharmacokinetic model. The
637 main phases are the arterial, portal venous and parenchymal phase in chronological order
638 providing information about microvascular hemodynamics and CA distribution volume.
639 **Elastography:** method allowing the quantification of tissue stiffness (resistance to
640 deformation) following the propagation of a mechanical strain or shear wave.
641 **Fluorescence molecular tomography (FMT):** whole-animal imaging method requiring the
642 injection of a fluorescent dye and irradiation with an excitation laser to generate light emission.
643 **Intravoxel incoherent motion (IVIM):** a mathematical model distinguishing two
644 contributions to the total tissue diffusivity in diffusion MRI: the microvascular
645 (pseudodiffusivity D* weighted by the perfusion fraction f_{IVIM}) and the extravascular diffusivity
646 D.
647 **Magnetic resonance spectroscopy (MRS):** a spectroscopic modality allowing to identify and
648 to quantify biochemical molecules by analysing the resonance frequency of electromagnetic
649 waves emitted by atomic nuclei with magnetic properties such as ^{1}H and ^{31}P.

Quantitative susceptibility mapping (QSM): a parametric map of the tissue magnetic susceptibility generated by the presence of para- and diamagnetic compounds and obtained by deconvolution of the magnetic field distributions in T_2* weighted MRI

Relaxometry: measurement of magnetic relaxation time constants describing the return to equilibrium of excited nuclei (longitudinal T_1, (true) transverse T_2, (observed) transverse T_2*, mixed $T_1\rho$. Magnetic relaxation is affected by molecule mobility and environment.

Voxel: volume element equivalent to a three-dimensional pixel.

Box 1. Liver fibrosis and portal hypertension in hepatosplenic schistosomiasis

Liver fibrogenesis is a wound-healing process activated by an inflammatory trigger and perpetuated by chronic inflammation. In schistosomiasis, a moderate Th1 response occurs, followed by a shift to a strong Th2 response elicited by egg antigens. The eggs become surrounded by immune cells. IL13 stimulates hepatic stellate cells (HSCs), the major ECM-producing cells, serving as vitamin A reservoirs and modulating vascular resistance and sinusoidal blood flow. Sinusoids are fenestrated vessels receiving blood from terminal hepatic arterioles and portal venules and delivering oxygen and nutrients to hepatocytes. Quiescent HSCs located in the space of Disse separating sinusoidal endothelial cells from adjacent hepatocytes and containing connective tissue trans-differentiate into phenotype-like myofibroblasts with increased contractile properties. They lose their vitamin A-containing lipid droplets and secrete fibrous collagens, fibronectin and proteoglycans, together with matrix metalloproteinases (MMPs) degrading ECM and tissue inhibitors of metalloproteinases (TIMPs) regulating their proteolytic activity. The imbalance between ECM synthesis and degradation progressively leads to replacement of liver tissue by a fibrous scar (fibrosis), resulting in increased liver stiffness and distorted vascular architecture. Fibrosis is potentially reversible, even in advanced stages. The therapeutic strategies explored to reverse fibrosis

target either the inhibition of fibrogenetic mechanisms or fibrolysis but clinical validation is needed [96]. Grading scales for fibrosis based on histology (*e.g.* METAVIR score) or serum markers exist but are not specific for schistosomiasis. Cirrhosis is the end-stage of liver fibrosis and is characterized by regenerative nodule formation, distorted hepatic vasculature, portal hypertension and liver dysfunction.

Portal hypertension is the main complication of liver fibrosis and is defined by an elevation of the hepatic venous pressure gradient (HVPG) above 5 mmHg. A value of 10 mmHg is indicative of clinically patent PH with a high risk of developing varices [97]. In HSS, periportal fibrosis and granulomatous thrombophlebitis lead to progressive presinusoidal blood flow obstruction (terminal portal venules level) and increased hepatic resistance causing PH. PH is complicated by congestive splenomegaly, formation of Gamna-Gandy bodies containing iron and calcium inclusions, varices, destruction of the main portal vein branches despite the development of portosystemic collateral blood flow that may partly decompress the portal system and at end-stage by life-threatening variceal bleeding. Gastrointestinal bleeding is often the first clinical sign of PH. The management of PH may be pharmacological with the prophylactic administration of β-blocker propanolol, or surgical with portacaval shunt, varice devascularization and splenectomy, distal splenorenal shunt, or with endoscopic sclerotherapy or ligation.

OUTSTANDING QUESTIONS

- Some patients progress to severe HSS, while patients with strong immunologic modulation capacity develop less severe (intestinal or hepatointestinal) variants of the chronic disease. Can imaging examinations of hepatic manifestations of acute schistosomiasis have prognostic potential?

- How reliable is the non-invasive imaging assessment of fibrosis at early stages of the disease?
- Can we disentangle confounding factors to quantitative fibrosis markers (*e.g.* comorbidities, inflammation, iron overload)?
- Is a detailed classification equivalent to the Niamey USG classification (made for *S. mansoni* infection) needed for *S. japonicum* HSS?
- Should the Niamey USG classification be refined to include novel measurable markers by more advanced USG equipment *(e.g.* hemodynamics, vascular morphology, microbubble contrast enhancement, DCE)?
- Will the establishment of new guidelines and standardized protocols for imaging modalities other than USG be of diagnostic and prognostic utility?
- What is the (multiparametric) imaging protocol best suited for reliable diagnosis and staging of HSS patients?
- Will the ASL technique and the newly-developed DCE-USG technique allow the assessment of hemodynamic alterations in HSS?

Table 1. General features of clinical abdominal imaging modalities

	USG	**CT**	**MRI**	**Scintigraphy+ SPECT**	**PET**	**Endoscopy/Laparoscopy**
Portability	Yes	No	No	No	No	Portable equipment used in surgical setting
Cost of equipment	≈ 30k $	≈ 1M $	>1M $	γ-camera ≈ 0.5M $	PET+CT≈ 2M $	< 25k $
Invasiveness	No*	No*	No*	Yes	Yes	Yes, anesthesia required
Scanning/exam time	Real-time imaging / 5 - 20 min	30 s / 10 min**	5 / 30 min**	30 min / 4 h	20 min/ radionuclide injected 1 h before	Real-time imaging/ 1-2 h for preparation
Basic principle / type of radiation-tissue interaction	Propagation of pulses of ultra-high frequency (1 to 20 MHz) acoustic waves. US reflection at tissue interfaces with differing impedances and their diffusion in tissue parenchyma provide	External irradiating tomographic method using X-ray photon transmission to obtain image contrast based on the attenuation	Absorption and reemission of radiofrequency electromagnetic waves by nuclear magnetic resonance of tissue hydrogen when placed in a strong external magnetic field. Image contrast is obtained by magnetic relaxation, local susceptibility differences and	Internal irradiating method involving the injection of labelled biomolecules (radiotracers) and based on the detection of the emitted γ-ray photons after distribution.	Internal irradiating method involving the injection of labelled biomolecules (radiotracers) and based on the detection of γ-ray photons emitted in the annihilation	Introduction of flexible or rigid tubes into internal hollow organs or cavities conducting visible light *via* optic fibres for endoluminal images of epithelium.

	morphological information in brightness (B) mode. The Doppler frequency shift of the wave reflected by blood cells provides hemodynamic information.	coefficients of the tissues.	water motion due to flow, diffusion or tissue deformation.		process between positrons from the radiotracer with electrons from tissue.	
Principal imaging applications	Anatomical imaging (tissue interfaces, echogenicity, texture) Functional imaging Image-guided intervention	Anatomical imaging Perfusion imaging Image-guided intervention	Multiparametric anatomical imaging Functional/physiological imaging Metabolic imaging Image-guided intervention	Functional / physiological imaging Metabolic imaging Image-guided intervention	Functional / physiological imaging Metabolic imaging Image-guided intervention	Anatomical imaging of tissue surfaces Image-guided intervention
Use of contrast agents (CA) or radiotracers (RT)	CEUS with injection of microbubbles as reticuloendothelial or blood pool CA for the characterization of focal liver lesions, vascular	CA: mainly non-specific iodine - containing agents	CA: non-specific extracellular gadolinium chelates for perfusion imaging and parenchymal contrast enhancement, hepatocyte-specific gadolinium and	RT: ^{99m}Tc labelled molecules most widely used	RT: ^{18}F, ^{15}O, ^{13}N, ^{11}C labelled molecules (ie: ^{18}F 2-Deoxy Glucose)	Topically or systemically administered targeted fluorescent CA for molecular endoscop

	imaging and therapy monitoring		manganese chelates taken up by functioning hepatocytes only, superparamagnetic iron oxide (SPIO) particles targeting Kupffer cells			
Spatial resolution (range)	0.3 to 1.5 mm depending on US frequency	0.3 to 1 mm depending on X-ray tube dimensions and detector size	0.5 to 3 mm depending on acquisition time, magnetic field strength and gradient coils	5 to 12 mm depending on collimator and detector system	4 to 10 mm depending on detector size	< 0.1 mm depending on camera matrix
Penetration depth	1 to 30 cm depending on US frequency, US probe can be inserted into gastrointestinal tract	Limitless	Limitless	Limitless	Limitless	Superficial
Soft tissue contrast	Good	Medium	Excellent	NA	NA	Visual contrast
Vascular imaging -Anatomy of vessels (AV)	AV: 2D, angiography, venography. HD: blood flow, blood volume, velocity,	AV: 2D and 3D angiography, venography. HD: blood flow, blood volume, velocity,	AV: 2D and 3D, angiography, venography. HD: blood flow, blood volume, velocity, perfusion. CA injection not necessary	HD : blood flow	HD: blood flow	AV: limited to superficial mucosal vessels, improved with narrow band imaging (higher relative intensity of blue light)

-Hemodynamics (HD)	using Color encoded Doppler, Power Doppler (B-flow) or CEUS	arterial, venous and perfusion phases, using CA injection				
Organ volumetry	Multiplanar 2D imaging, volumetric analysis with 3D option	Axial 2D and 3D imaging	Multiplanar 2D and 3D imaging	2D and 3D imaging	3D but requires CT or MRI for anatomical location	Size estimation from organ surface view (images, videos)
Fibrosis assessment	Organ surface morphology, parenchymal echogenicity, elastometry or elastography	Morphology, texture analysis	Morphology, texture analysis, hepatocyte specificCA, **relaxometry**, diffusion MRI, elastography, ^{31}P-MRS	^{99m}Tc-labelled sulphur colloid particles	^{18}F fluorocholine	Organ surface morphology
Detection of splenic siderotic nodules	Hyperechogenic parenchymal foci, acoustic shadowing if calcified	Attenuation dependent on calcification, hypodense on contrast enhanced CT	Hypointense lesion on T_1w MRI, T_2w MRI, SWI, even after CA administration	No	No	No
Theranostic applications	Use of high intensity focussed ultrasounds (HiFu) for abdominal cancer treatment	(Preclinical research)	(Preclinical research)	Yttrium for liver cancers	(Preclinical and clinical research)	Theranostic capsule endoscopy (research) Fluorescence imaging endoscopy with nanoparticles (research)

Limitations	Operator dependent, qualitative signal yielding only relative echogenicity, few images are usually saved, limited field of view, decreasing image quality and spatial resolution with depth, acoustic shadowing by gas, gallstones and bone	Allergic risk to Iodine-based CA observed in up to 0.7%, repeated exposure to ionising radiations not recommended,	Long scan times, sensitivity to motion, absolute contraindications exist, precautions regarding radiofrequency energy absorption are required, possible interference with vital medical electronic devices, CA with rare adverse reactions (<0.01%) but contraindicated in patients with renal insufficiency	Main applications in oncology, Co-registration with CT or MRI often necessary for better anatomical localization of radiotracers, cumulative exposure to internal (radiotracers) and external (CT) ionizing radiation	Few scanners available, main application in oncology Co-registration with CT or MRI often necessary for better anatomical localization, cumulative exposure to internal (radiotracers) and external (CT) ionizing radiation	Qualitative images limited to surface of the organ or cavity Sedation or anesthesia required, surgical team needed, infectious risk

* non-invasive technique in the absence of contrast agent injection; ** depending on protocols; CEUS = contrast enhanced ultrasound; NA= not applicable; T_1w = T_1-weighted MRI; T_2w = T_2-weighted MRI, US = ultrasound.

Table 2. Assessment of human HSS morbidity with abdominal imaging modalities

Imaging findings in hepatosplenic schistosomiasis	Disease stage	USG	CT	MRI	Scintigraphy / SPECT	PET	Endoscopy
Schistosome visualisation	Acute stage Chronic stage	In combination with endoscopy	No	No	No	No	No
Granulomatous inflammation	Chronic stage	Yes Echogenic structure	With and without CA	Anatomical MRI	Yes	^{18}FDG	Yes (laparoscopy)
Liver fibrosis (Symmers pipestem fibrosis)	Chronic stage	Yes, standard patterns, measurement of portal vein, gall bladder and fibrosis of second order branches	Measurement of portal vein, gall bladder and fibrosis of portal vein branches	Measurement of portal vein, gall bladder and fibrosis of portal vein branches	No	No	In advanced stage fibrosis visible at the liver surface by laparoscopy
Portal hypertension	Chronic stage	Portal vein diameter, blood flow and velocity Doppler USG	Portal phase after CA injection, detection of vessel dilation	Anatomical MRI	hepatic angioscintigraphy with 99mTc-labelled sulphur colloid particles	No	Yes, qualitative (laparoscopy)

Hepatomegaly	Acute stage Chronic stage	Qualitative evaluation and organ axis measurements, no volumetric analysis without 3D option	Yes, volumetric analysis	Yes, volumetric analysis	Qualitative	No	Yes, qualitative (laparoscopy)
Splenomegaly	Acute stage Chronic stage (severe HSS)	Qualitative evaluation and organ main axis measurement, no volumetric analysis without 3D option	Yes, volumetric analysis	Yes, volumetric analysis	Yes, volumetric analysis	No	Yes, qualitative (laparoscopy)
Gall bladder abnormalities	Chronic stage	Yes, wall thickness measurement	Yes, wall thickening and inflammation visible	Yes, wall thickening and inflammation visible	No	No	Yes, if reaching the gall bladder surface
Esophageal varices	Chronic stage (severe HSS)	Yes with special probe	Yes, venography	Yes, venography	No	No	Yes, gold standard
Visceral collaterals	Chronic stage (severe HSS)	USG angiography, Doppler USG	Angiography with CA	Angiography	No	No	Yes, qualitative (laparoscopy)
Splenic siderotic nodules	Chronic stage	Hyperechogenic parenchymal foci, acoustic shadowing if calcified	Attenuation dependent on calcification, hypodense on contrast enhanced CT	Hypointense lesion on T_1-w MRI, T_2-w MRI, SWI, even after CA administration	No	No	No
Ascites	Chronic stage (severe HSS)	Anechoic fluid	Hypodense with respect to liver parenchyma	Anatomical MRI	No	No	Yes, qualitative (laparoscopy)

CT= computed tomography; MRI= magnetic resonance imaging; PET= positron emission tomography; SPECT= Single-photon emission computed tomography; T_1w= T_1-weighted MRI; T_2w= T_2-weighted MRI; USG = Ultrasonography.

Table 3. Assessment of liver fibrosis in HSS with elastography[1]

References	Comorbidities	Parasite strain	Population characteristics	Elastographic method	Additional Imaging modalitie(s)	Main findings	Limitations
[40]	None	*S. mansoni*	-358 Brazilian patients, among them 86 with mild periportal fibrosis (Niamey C pattern) and 272 with advanced periportal fibrosis (Niamey D, E, F patterns)	Point shear wave elastography, ARFI	USG with a 6C1 MHz transducer for USG and elastography	Differentiation between mild and advanced periportal fibrosis	USG and elastography performed by the same sonographer
[42]	None	*S. japonicum*	-106 Chinese patients with advanced schistosomiasis and no current infection, among them 80 patients without comorbidities (blood tests with biochemical assessment of liver function and fibrosis, percutaneous liver biopsy) -Conclusive results obtained on 73 patients (METAVIR score: 3 F0, 11 F1, 22 F2, 24 F3, 13 F4)	Transient elastography, FibroScan	USG classification into 5 grades, Doppler USG, histology	-No correlation between LSM and USG grading but good correlation with histology -LSM superior to blood serum analysis for detection of fibrosis and cirrhosis and predictive of fibrosis in patients	No USG-based classification of liver fibrosis (Niamey patterns)

						with advanced schistosomiasis japonica	
[41]	None	*S. mansoni*	-77 Brazilian patients: 30 with hepatosplenic schistosomiasis (24% Niamey B pattern, 28% Niamey C pattern, 48% Niamey D pattern), 30 patients with HCV cirrhosis and 17 controls	Transient elastography, FibroScan	USG with Doppler-fluxometry, ultrasound color Doppler	- Increased LSM values in patients with schistosomiasis compared to controls -Increased spleen stiffness, comparable to that of cirrhotics _increased spleen stiffness correlated with portal hypertension	- Absence of severe fibrosis (*e.g.* patterns E or F) - differentiation of schistosomiasis patients from cirrhotic patients by LSM could be biased
[39]	HCV	Unknown, *S. mansoni* most likely	-352 Egyptian patients with chronic HCV hepatitis (no decompensated cirrhosis, no HCC): 122 controls, 122 with positive antischistosomal antibodies and without periportal tract thickening,	Transient elastography, FibroScan	USG	-No difference in liver stiffness among groups -Best correlation between METAVIR score and LSM in	No USG-based classification of liver fibrosis (Niamey patterns)

			108 with positive antischistosomal antibodies and periportal tract thickening -Liver biopsies and METAVIR scores available			patients with HCV only -Only higher antischistosomal antibody titres reduce the correlation between METAVIR score and LSM	
[98]	HCV	Unknown, *S. mansoni* most likely	-312 Egyptian patients with HCV genotype 4, among them 36 with positive schistosomiasis serology, and 4 with hepatic schistosomiasis lesions detected on liver biopsy	Transient elastography, FibroScan	No	No influence of positive schistosomiasis serology on elastography results	Very small number of patients with schistosomiasis lesions
[38]	HCV	Unknown, *S. mansoni* most likely	-231 Egyptian patients with chronic HCV, among them 67 patients presenting positive schistosomal serology -Liver biopsies and METAVIR scores: 31 F0-F1, 13 F2, 14 F3 and 9 F4	Transient elastography, FibroScan	No	Positive schistosomal serology impairs correlation between FibroScan results and METAVIR score (more obvious in F2 and F3 stages)	No USG-based classification of liver fibrosis (Niamey patterns)

*Transient elastography and Point shear wave elastography are strictly speaking no imaging modalities since LSM is performed in a point at a particular depth. Transient elastography uses a one-dimensional USG signal for guidance, while Point shear wave elastography relies on 2D USG for determining the measurement point. ARFI = acoustic radiation force imaging; HCV = Hepatitis C virus; HCC = hepatocellular carcinoma; LSM= Liver Stiffness Measurement; USG = Ultrasonography.

Table 4. Preclinical imaging studies of schistosomiasis

References	Imaging modalities and methods	Animal model and groups	Parasite, number of cercariae and mode of infection	Observation period	Assessment of pathogenic features	Main findings	Potential applications
[91]	BLI, endogenous expression of luciferase under a collagen promotor	Male and female B6.Coll 1A-luc+ mice (C57BL6/J background) SjC mice (n=12), SjP mice (n=14) SjC mice treated with PZQ (n=10), SjP mice treated with PZQ (n=10) Control group (n=5)	*S. japonicum (SjC,* Chinese origin, 35 cercariae) and *SjP* (Philippines origin, 14 cercariae)	From week 4 to 10 post infection for SjC mice, and from week 4 to 11 post infection for SjP	-Collagen deposition with BLI and comparison with histology	-Dynamic assessment of collagen deposition before and after PZQ treatment	-Assessment of antifibrotic drug effects in infected mice
[92]	USG, classic (18–4 MHz human probe) and high-resolution (50 MHz probe, resolution 30 μm)	5-week old infected BALB/C female mice (n=22) and controls (number unknown)	*S. japonicum* (Yamanashi strain), 25 cercariae (n=12) and 10 cercariae (n=10), percutaneous route	Up to 13 weeks (n=12) and one year (n=10) post infection	-Morphometry of spleen and liver, signs of PH, intestinal wall thickening,	-Visualisation of live worms in portal vein -Real-time evaluation of schistosomiasis impact on digestive organs	-Studies of new anti-parasitic drugs on worms, longitudinal preclinical studies (therapy, molecular

					echogenic patterns of liver fibrosis		mechanisms of disease, transfer to the clinical setting)
[95]	MRI @11.75T, 2D anatomical MRI with and without Gd-DOTA injection Relaxometric studies (T_2 mapping, T_2* mapping) comparison with histology	6-week old CBA/J female mice, infested mice (n=12) and controls (n=12)	*S. mansoni,* 30 *cercariae,* percutaneous route	2, 6 and 10 weeks post infection	-Liver and spleen volumetry, and PH assessment with anatomical MRI -Fibrosis assessment with relaxometry and histology	-Detection of indirect signs of PH -Quantification of splenomegaly and hepatomegaly -Identification of T_2 relaxation time as a marker for liver fibrosis	-Longitudinal studies of antifibrotic drug effects, mechanistic studies on genes or immune molecules involved in fibrogenesis -Transfer to the clinical setting
[93]	MicroSPECT/CT with injection of 188Re-OCTAM	6 to 8-week old BALB/C male mice, divided in 3 groups of infected mice and one control group (n=7-10 per group)	*S. mansoni* (Puerto Rican strain), 100 cercariae, percutaneous route	Imaging at 1, 4, 24 and 48h post injection of 188Re-OCTAM, 9, 12 and 18 weeks post infection	-Liver inflammation, necrosis and fibrosis	-Identification of various levels of remnant liver function in different stages of the disease	-Longitudinal studies of antifibrotic drug effects, mechanistic studies on genes or immune molecules involved in fibrogenesis

[85]	micoPET using ^{18}FDG + FMT with near-infrared imaging agent MRI @7T for T_2-weighted images with contrast agent, comparison with histology	6-week old female nude mice (nu/nu) Infected mice (n=35) and controls (n=4), 6 mice treated with PZQ	*S. mansoni*, number of cercariae unknown, percutaneous route	5-6 weeks post infection	-Localization and quantification of schistosome worms	-^{18}FDG fixed by *S mansoni* worms -In vivo quantification of the worm burden with ^{18}FDG PET	-Studies of new anti-parasitic drug effects on worms -*In vivo* parasite detection in humans
[84]	FMT with near-infrared imaging agent	6 to 8-week old female BALB/c mice (exact number unknown)	*S. mansoni* (Puerto Rican strain), 100 or 50 cercariae per mouse, *S. hematobium*, 25 cercariae per mouse and *S. Japonicum*, 25 cercariae per mouse, percutaneous route	5 weeks (*S. Mansoni*), 8 weeks (*S. Hematobium*) and 6 weeks (*S. Japonicum*) post infection	-Localization and quantification of schistosome worms	-New method to detect, quantify and localize worms	-Studies of new anti-parasitic drug effects on worms
[90]	BLI, genetically encoded luciferase (luc) reporter driven by an eosinophil peroxidase (EPX) promoter, intraperitoneal injection of luciferase substrate luciferin	EPX334-luc or EPX339-luc mice and EPX-luc hemizygous mice as controls (age and exact number unknown)	*S. mansoni*, 50 cercariae, subcutaneous route	Over 12-week period post infection	-Eosinophilia and eosinopoiesis	-Detection and quantification of eosinophilia and eosinopoiesis in schistosomiasis -First *in vivo* description of	-Study of molecules modulating eosinophilia and eosinopoiesis in schistosomiasis

						eosinopoietic response to schistosomes	
[94]	MRI @9.4T, anatomical T_1, T_2, T_2*-weighted MRI, no contrast agent	10 to 20-week old BALB/C infected mice and controls (exact number unknown)	*S. mansoni*, 150 cercariae, subcutaneous route	Followed for 13 weeks post infection	-Assessment of liver disease and involvement of intrahepatic bile ducts	-Patchy pattern in the liver related to fibrosis after 6 weeks of infection	-Anatomical MRI for the assessment of liver disease in preclinical studies
[99]	USG with a system for human imaging (multifrequent convex array probe of 3.5/4.3/5.0 MHz)	12-week old female and castrated male pigs (Danish landrace x Duroc and or Hampshire crossbreeds) Infected pigs (n=9) and uninfected controls (n=10)	*S. japonicum,* 1000 cercariae of Chinese origin. Route of injection not documented.	Imaged 12 weeks after infection	-Assessment of HSS disease, comparison of USG findings with histology	-Enlarged liver Diffuse parenchymal alterations -Echogenic portal thickening -Enlarged portal vein diameter	-Validation of the swine model of schistosomiasis as a good model of human HSS
[100]	Portable USG	8 semi-captive chimpanzees (Uganda), infected by *S. mansoni,* under PZQ treatment but still excreting schistosome eggs	*S. mansoni* (naturally infected animals)	USG included in the annual health assessment of infected animals	-Assessment of intestinal disease and progression toward HSS. -Parasitological assessment (urine and stools)	-Detection of a spectrum of fibrosis stages including mild disease, pipestem fibrosis and occluding fibrosis.	-Detection of fibrosis patterns identical to those described in humans (Niamey protocol)

					-DNA schistosome barcoding	-DNA schistosome diversity	Probable zoonosis (chimpanzees, humans, snails)
[101]	USG (B mode)	24 male New-Zealand rabbits infected with *S. japonicum* used for the assessment of the anti-fibrotic effects of Chinese traditional medicine -6 animals received PZQ -6 animals received *Radix astragali and Salvia miltiorrhiza* -6 animals received *Radix astragali and Angelica sinensis* -6 animals received *Radix astragali, Salvia miltiorrhiza, Angelica sinensis* and PZQ	*S. japonicum,* 100 cercariae, percutaneous route	-Treatment started 18 weeks post infection, -Weekly USG from week 13 until week 28	-Assessment of HSS in liver (liver diameter, PV inner diameter, echogenic septa forming mosaics, echogenic spots) -Assessment of serum markers of fibrosis and liver function -Comparison of the effects of traditional Chinese medicines to PZQ on liver fibrosis	Validation of the rabbit model of HSS obtained with *S. japonica* Beneficial effects of traditional Chinese medicines on liver fibrosis	Assessment of antifibrotic drug effects in a good model of the human disease resulting from *S. japonicum* infection

Abbreviations: BLI = bioluminescent imaging; CT= computed tomography; EPX= eosinophil peroxidase promoter; FMT= Fluorescence molecular tomography; LSM= Liver Stiffness Measurement; luc= luciferase; MRI= magnetic resonance imaging; PET= positron emission tomography; PH = portal hypertension; PV= portal vein; PZQ= praziquantel; SPECT= Single-photon emission computed tomography; USG = Ultrasonography.

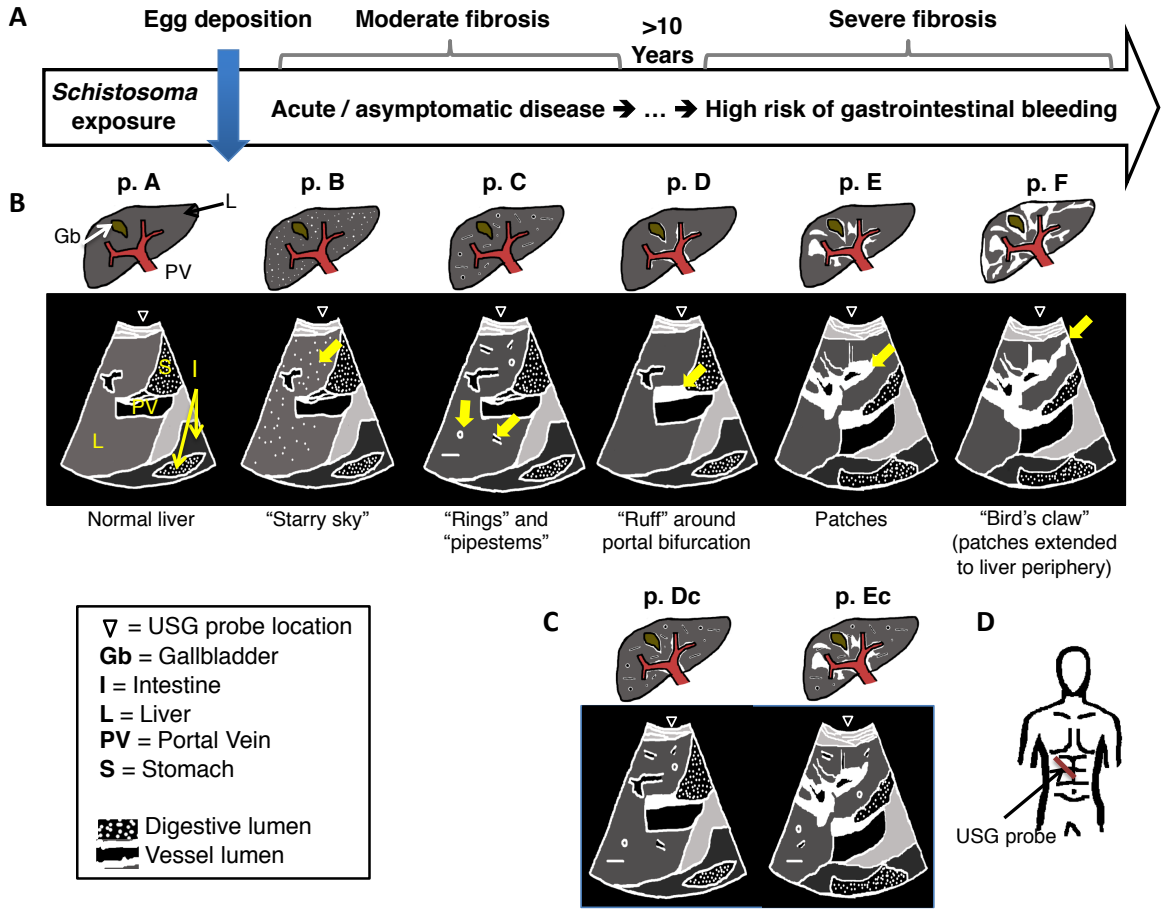

Figure 1, Key Figure. Schematic representations of typical USG images in HSS and corresponding patterns based on Niamey classification. A. Temporal progression of HSS. **B.** Illustration of the different stages of HSS with Niamey classifications patterns (top row) and corresponding schematic representations of USG images (bottom row). The right oblique ultrasound probe orientation allows visualisation of the hepatic hilar area with the portal vein (PV) and surrounding vessels. This view allows detection of periportal fibrosis (pattern D to Ec) and measurement of PV diameter as well as evaluation of hypertension (dashed line in D, E and F patterns). Pattern B (p. B) also named "Starry sky" corresponds to echogenic spots in liver parenchyma caused by inflammation and fibrosis around granuloma. Pattern C (p. C) shows echogenic signals around portal branches and represents a moderate stage of fibrosis. Acute or/and asymptomatic phases are assigned to B and C patterns. Large fibrosis areas in

parenchyma, described as “patches”, are associated with E pattern. Fibrosis extension to the liver periphery from patches was described as “Bird’s claw” and assigned to F pattern. **C.** Dc and EC are examples of combined patterns. **D.** Right echographic oblique view presented in **B**.