IOSR Journal of Pharmacy and Biological Sciences (IOSR-JPBS)
e-ISSN:2278-3008, p-ISSN:2319-7676. Volume 12, Issue 3 Ver. IV (May – June 2017), PP 76-77
www.iosrjournals.org

Cutaneous Leishmaniasis in the Chest and Abdomen: Unusual Clinical Presentation

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Abstract: *Infections with Leishmania spp. have been placed very high amidstthe commonest travel-related dermatoses. The research was carried out with the aim to determine the effectiveness of rifampicin and topical clotrimazole in the treatment of patients who havediffuse cutaneous leishmaniasis with uncommon demonstration.*

Keywords: *diffuse cutaneous Leishmaniasis, oral rifampicin, topical clotrimazole.*

I. Introduction

Leishmania of the skin has different clinical presentations. There is the possibility to view carefully, the immune status of the patients and diverse disease exhibitions; however, it is liable to the country where the infection is acquired. At least, an estimation of ninety percent of cases has been reported as cutaneous Leishmaniasis. The use of biopsy material with histology, parasite culture, and PCR aids to make the diagnosis. Therapeutic choices range from local therapies to systemic ones, especially with the single lesion cases in patients with more severe forms (1).

II. Case report

A man of 60 years of age has twelvemonths history of severalskin lesions on the chest and in his abdomen for a year. The man lives in al-Mekhwahregion in Sothern areaof Saudi Arabia. It started by him noticing the first skinlesion down the left side of his chestandbegan to escalate in size with someitching.Later,several lesionsbegan to surface in the abdomen andjust aboutumbilical area withinthe period of one month interval stuck between theappearance of each one(2). onexamination, it displayedwell-defined hyperkeratotic infiltrated violaceoussign in the leftward upper chest with several trivial scalyspotsdispersed in the chest and abdomen. (Fig.1A&B).

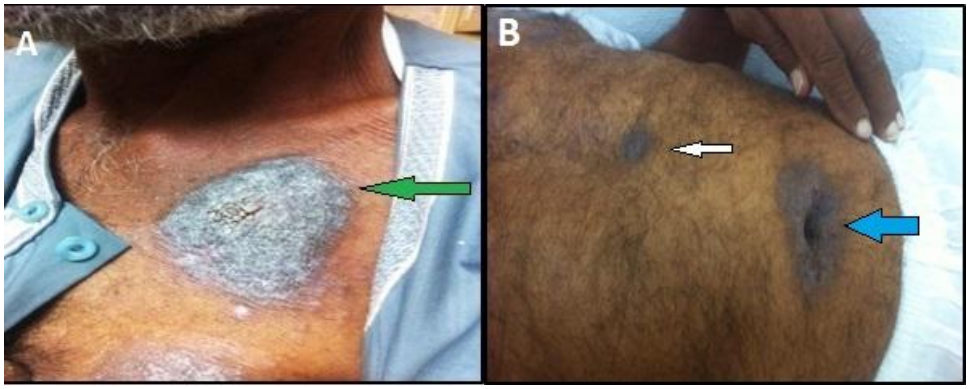

Fig. 1: well-defined hyperkeratotic infiltrated violaceous plaque (Green arrow) in the left upper chest (**A**), whilst the (**B**) showed the well-defined hyperkeratotic infiltrated violaceous plaque (white arrow) and (blue arrow) donatedlarge plaque in the umbilicus.

The Histopathological Examination revealed Manifold leishmania Donovan bodies in leishmann stain. (Fig.2A). Manifold leishmania Donovan bodies in giemsa stain. (Fig.2B). The patient was placed on oral rifampicin 600 mg PO and topical clotrimazole cream BID for one month each with clearance of all lesions with residual hyperpigmentation.

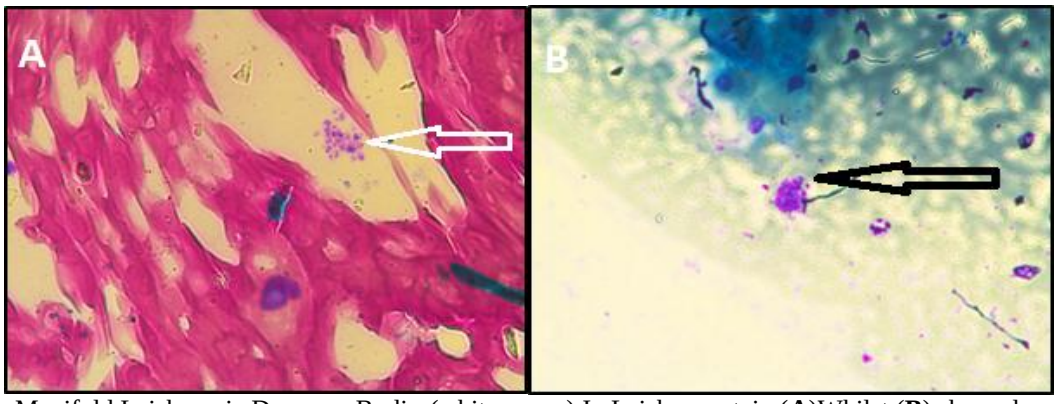

Fig 2: Manifold Leishmania Donovan Bodies(white arrow) In Leishman stain (**A**)Whilst (**B**) showedmanifold Leishmania Donovan Bodies(black arrow) In Giemsa Stain

III. Discussion

Special Program for Research and Training in Tropical Diseases of the World Health Organization (WHO), has described Leishmaniasis as one of itstopmost five targeted diseases(2). An estimation of 1.5 million new cases isreported yearly. Additionally, there are over 350 million persons living in areas of activeparasite transmissionism. Leishmania species have the capacity to lead to a widespread spectrum of cutaneouslesions in patients with HIV-positive: localized cutaneous,mucosal, muco-cutaneous, diffuse cutaneous, or postkala-azar leishmaniasis(2). Parasite species and host cell mediated immunity (CMI) response mostly determine the Medicalvariations of leishmaniasis)cutaneous, mucosal, and visceral) and clinical rank (subclinical, self-healing, spread, death) essentiallydetermined by. Quite a lot ofopinionssubmitthat distribution of lesions is more a product of hostimmunogenic status (antigenic specific immunosuppression- IL-10 more than INF-Y) than by the virulence of the involved species.Some new publications have statedfresh or uncommonmedicalvariations of CL with or without HIV infection. Leishmania braziliensis, Leishmania amazonesis, and Leishmania aethiopica are thespecies, which are involved in diffuse CL. Moreover, Leishmania donovani has been described in post-kala azar dermal leishmaniasis (PKDL) in relation with HIV(1). Large numbers (>10) of lesions like papules, nodules, or ulcers often characterized DCLas well as good response to classic treatment. In addition, there was the active form, which was often characterized by DCL secondary to the underlying shortfall in cellular resistance specific for certain species of leishmaniasis(4).The histopathological discoveries in dermatological lesions in patients withdiffuse CL and HIV co-infected are inconstant and may be determined by patients' immune position. An enormous and even colossal amount of amastigotes histiocytes could be noticed in dermal and subcutaneous tissue in most cases. Leishmania local treatmentchoices for cutaneous leishmaniasis comprise (A) cryo-therapy, (B) permeation of sodium stibogluconate, (C) oral rifampicin,Iitraconazole, allopurinol andketoconazole (4) topical paromomycin preparationsas well as topical antifungal clotrimazole have a duty to be effective and operational(2) .

IV. Conclusion

(DCL) is anexceptionalsort of Leishmania infection that has been discovered in patients infected with L. aethiopica and L. Mexicana amazonensis.2 inpatients who are immune-suppressed, lesions of CL are likely tobecome diffuse to involve wide-rangingparts of skin, leading to a stategenerally regarded as DCL. Subsequently, DCL should be kept on mind for the reason that it is simply missed. Treatment with rifampicin and clotrimazole topical has proven tobe promising with tremendousoutcomes.

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