Cutaneous Leishmaniasis in the Chest and Abdomen: Unusual Clinical Presentation

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Abstract: Infections with Leishmania spp. have been placed very high amidst the 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 had diffuse 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 twelve months history of several skin lesions on the chest and in his abdomen for a year. The man lives in al-Mekhwa region in Southern areaof Saudi Arabia. It started by him noticing the first skin lesion down the left side of his chest and began to escalate in size with some itching. Later, several lesions began to surface in the abdomen and just about umbilical area within the period of one month interval stuck between the appearance of each one (2). On examination, it displayed well-defined hyperkeratotic infiltrated violaceous sign in the leftward upper chest with several trivial scaly spots dispersed 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) donated large 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.

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III. Discussion

Special Program for Research and Training in Tropical Diseases of the World Health Organization (WHO), has described Leishmaniasis as one of its topmost five targeted diseases (2). An estimation of 1.5 million new cases is reported yearly. Additionally, there are over 350 million persons living in areas of active parasite transmissionism. Leishmania species have the capacity to lead to a widespread spectrum of cutaneous lesions in patients with HIV-positive: localized cutaneous, mucosal, muco-cutaneous, diffuse cutaneous, or post-kala-azar leishmaniasis (2). Parasite species and host cell mediated immunity (CMI) response mostly determine the Medical variations of leishmaniasis (cutaneous, mucosal, and visceral) and clinical rank (subclinical, self-healing, spread, death) essentially determined by. Quite a lot of opinions submit that distribution of lesions is more a product of host immunogenic status (antigenic specific immunosuppression - IL-10 more than INF-Y) than by the virulence of the involved species. Some new publications have stated fresh or uncommon medical variations of CL with or without HIV infection. Leishmania braziliensis, Leishmania amazonensis, and Leishmania aethiopica are the species, 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 DCL as 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 with diffuse 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 treatment choices for cutaneous leishmaniasis comprise (A) cryo-therapy, (B) permeation of sodium stibogluconate, (C) oral rifampicin, itraconazole, allopurinol and ketoconazole (4) topical paromomycin preparations as well as topical antifungal clotrimazole have a duty to be effective and operational (2).

IV. Conclusion

(DCL) is an exceptional sort 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 to become diffuse to involve wide-ranging parts of skin, leading to a state generally 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 to be promising with tremendous outcomes.

References

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