

Case Report

Cutaneous Leishmaniasis in Bangladeshi Adult Male: A Case Report

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Introduction:

Leishmaniasis is a group of protozoal diseases caused by genus *Leishmania* and transmitted by the bite of female sandfly of *Phebotomus*.³ Human Leishmaniasis is usually classified as visceral, cutaneous and mucocutaneous variety.

Cutaneous Leishmaniasis is rare in Bangladesh although very few case reports are seen since last few years. It is very likely to be mistreated as cutaneous tuberculosis.¹ Cases of cutaneous leishmaniasis are usually imported to Bangladesh from other endemic countries.

Case Report:

A 46-years-old non-diabetic, hypertensive, asthmatic male had been working as supervisor of a poultry farm in Saudi Arabia for more than 15 years returned to Bangladesh with the complaints of multiple ulcerated lesions on dorsum of left middle finger and part of hand for last 2 years.

He initially noticed some papulo-nodular lesions in that finger which subsequently became ulcerated and crusted. He also gave history of low grade intermittent evening rise of temperature with no chills and rigor, anorexia, weight loss, contact with known TB patient, sensory disturbance or pigmentation over skin or bowel disturbance.

On examination, ulcers were mildly tender reddish, deep, crusted, 3-4 cm in size with no discharge (Figure-1). His

vitals were normal. There were no lymphadenopathy or organomegaly and nerve thickening.

Before treatment:

Investigation shows Hg 13 g/dl, ESR 25 mm in 1st hour, TC-WBC 11,900mm³, neutrophil 74%, lymphocyte 21%. Serum creatinine, liver function tests, chest x-ray, ECG, urine routine examination are within normal limit.

Biopsy from the skin lesions confirmed the diagnosis of cutaneous leishmaniasis evidenced by presence of intra and extracellular LD bodies. We treated the patient with oral miltefosine 100 mg daily for 3 months.

After 1 month of treatment, patient developed recurrent mid abdominal pain and watery stool. We thought this was due to miltefosine induced diarrhea /inflammatory bowel disease/ intestinal TB. Eventually we performed colonoscopy that revealed normal findings. Later, diarrhoea stopped after completion of miltefosine treatment.

Finally we diagnosed it as a case of cutaneous leishmaniasis with miltefosine induced diarrhoea. After completion of treatment patient's ulcers were completely healed (Figure-2) and diarrhoea was stopped.

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Figure 1:



Figure 2:

Discussion:

Leishmaniasis is a major world health problem. Brazil, Iran, Afghanistan, Saudi Arab suffer the highest prevalence.¹ Infection is transmitted by bite of female sand fly where incubation period ranges from few days to years.² Clinical stages pass from papule, nodule, crusting, ulceration and finally healing with scarring.^{1,2}

Diagnosis of Cutaneous Leishmaniasis can be confirmed by demonstration of amastigotes in H&E stained smears from infected skin by direct microscopy, presence of *Leishmania* granuloma in dermis, growth of promastigotes in dermis in NNN culture media and demonstration of *Leishmania* DNA by PCR. In non-endemic country like Bangladesh where it is uncommon, diagnosis missed easily.^{2,3}

Most lesions heals spontaneously, but there duration cannot be predicted in an individual case. Various treatment modalities have been used for treatment like oral miltefosine or IM/IV injection of sodium stibogluconate 20/kg/dose.³ In our case we used tab. miltefosine (50mg) orally bd for 3 months. Patient complained of diarrhoea, a common side

effect of miltefosine^{4,5} that subsided after completion of treatment with complete healing of ulcer.

Conclusion:

Although Cutaneous Leishmaniasis is rare in Bangladesh, clinicians should be aware of the disease while treating non healing ulcer of long duration especially if the patient is an immigrant from endemic areas.

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