UNUSUAL CLINICAL VARIANT OF CUTANEOUS LEISHMANIASIS: ERYSPIELOID LEISHMANIASIS

ABSTRACT

Although cutaneous leishmaniasis was an important health problem in the Southeast Anatolian region of Turkey before the 1950s, it was effectively controlled by successful health policies thereafter. Classical clinical presentation of cutaneous leishmaniasis is the painless erythematous papules or nodules developed in the areas of infected sandfly bite which are ulcerated and healed gradually with a scar formation. Cutaneous leishmaniasis can be presented in its atypical forms as well, such as zosteriform, sporotrichoid, psoriasiform, chancreiform, paronychial cutaneous leishmaniasis. In this case report, we present a 67 years old women with eryspieloid cutaneous leishmaniasis, a rare atypical form of cutaneous leishmaniasis, who was successfully treated. Cutaneous leishmaniasis is an increasing health problem in Middle Eastern countries and countries receiving refugees nowadays. Regional and international health organizations should be aware of this problem and support the fight against this disease accordingly.

Key Words: Aged; Cutaneous leishmaniasis; Erysipeloid leishmaniasis.

OLGU SUNUMU

KUTANÖZ LEİSHMANİAŞİSİN NADİR VARYANTI: ERİZİPELOİD LEİSHMANİAŞİS

Öz


Anahtar Sözcükler: Yaşlı; Kutanöz leishmaniasis; Erysipeloid leishmaniasis.
INTRODUCTION

Cutaneous leishmaniasis (CL) is a protozoal infection caused by intracellularly located Leishmania species that are transmitted through Phlebotomus genus vectors (1). Although CL was an important health problem in the Southeast Anatolia region of Turkey before the 1950s, it was effectively controlled by successful health policies thereafter (1). However, due to the recent increase in the Middle Eastern refugee population in Turkey, CL cases have remarkably increased and a great variability of atypical forms of the disease have also begun to frequently appear, which may cause some difficulties in diagnosis and treatment. Here we describe the case of a 67-year-old woman with erysipeloid CL, a rare atypical form of CL, who was successfully treated.

CASE REPORT

A 67-year-old female was admitted to our clinic with enlarging areas of redness on her face. The patient’s history revealed the development of a painless papule 0.5–1 cm in diameter on the nose 2 years previously, which began to extend to her cheeks and forehead. On clinical examination, erysipeloid-like erythematous, edematous plaques with superficial ulcerations and crusts were observed on the midline of the face, including the dorsum of the nose, cheeks, lower forehead, and the philtrum (Figure 1). She was otherwise healthy. Laboratory examinations, including the complete blood count, blood and urine biochemistry, and chest radiography showed normal results. Microscopical examination of Giemsa-stained smears prepared from the lesion revealed intracellular and extracellular amastigote forms of the Leishmania protozoa, confirming the diagnosis of cutaneous leishmaniasis (CL). Since it was a clinically atypical erysipeloid CL and the lesion was located on the face, meglumine antimoniate 15 mg/kg/day was administered intramuscularly, and the treatment was continued for 15 days without any side effects. At the end of the treatment, she recovered completely (Figure 2).

DISCUSSION

The classical clinical presentation of CL is characterized by the development of painless erythematous papules or nodules in the areas of infected sandfly bites that have ulcerated and healed gradually with the formation of a scar. However, CL can also present in its atypical forms, such as zosteriform, sporotrichoid, psoriasiform, chancriform, paronychial, and erysipeloid CL (2-4). Erysipeloid CL is a rare type of CL that was first reported in Iran in 1994 (5). The frequency of erysipeloid CL and other atypical forms of CL are not exactly known due to a lack of reports related to this subject. However, the studies that have analyzed the frequencies of atypical CL and erysipeloid CL are shown in Table 1.

The causes for the formation of atypical erysipeloid CL instead of classical CL are not known, although the patient’s immune status may be responsible. Erysipeloid and other atypical forms of CL may appear in patients with defective im-
mune systems, such as a previous patient of ours who has diabetes mellitus (8). Secondly, erysipeloid CL has been reported to commonly appear in middle aged and elderly females like our patient (5). This may indicate a possible role of some hormonal factors in the development of this subgroup (9). Thirdly, as was seen in our patient, mid-face involvement seems to be common in erysipeloid CL (9,10). Increased fragility of the skin in this area may facilitate the spread of the parasite in this location (5). Finally, erysipeloid CL may be associated with a new leishmania species (3).

Based on this case, we want to indicate two important points: first, the diagnosis of atypical CLs including erysipeloid CL can be difficult and this may cause a delay in treatment. To prevent late diagnosis, we recommend giving special attention to patients with atypical lesions, traveling from endemic regions. Additionally, in patients with chronic lesions, lesions ≥5 cm, lesions on the face, fingers or toes, or in cases of immunosuppression, we emphasize the necessity of systemic treatment.

Cutaneous leishmaniasis is an increasing health problem in Middle Eastern countries and countries currently receiving refugees. Regional and international health organizations should be aware of this problem and support the fight against this disease accordingly.

**REFERENCES**


**Table 1— Frequencies of Atypical CL and Erysipeloid CL**

<table>
<thead>
<tr>
<th>Studies</th>
<th>Total Number of Patients</th>
<th>Frequency and (Number) of Atypical CL</th>
<th>Frequency and (Number) of Erysipeloid CL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gurel et al. (6)</td>
<td>2120</td>
<td>1.9% (20)</td>
<td>–</td>
</tr>
<tr>
<td>Bari et al. (3)</td>
<td>718</td>
<td>5.7% (41)</td>
<td>–</td>
</tr>
<tr>
<td>Momeni et al. (5)</td>
<td>1250</td>
<td>–</td>
<td>1.36% (17)</td>
</tr>
<tr>
<td>Bongiorno et al. (4)</td>
<td>50</td>
<td>40.0% (20)</td>
<td>34.0% (17)</td>
</tr>
<tr>
<td>Raja et al. (7)</td>
<td>1709</td>
<td>2.1% (37)</td>
<td>0.05% (1)</td>
</tr>
</tbody>
</table>