

LETTER TO THE EDITOR

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To,
Editor-in-Chief
Journal of Bangladesh College of Physicians and Surgeons

The reported case in "A case of diffuse Cutaneous Leishmaniasis in a HIV positive patients" (April, Vol 29 No. 2, 2011, page 106-108) is a rare one. We are happy to be informed about such a case, which is also the first reported case in Bangladesh.

After going through this case report, a question has arisen in our mind. Could it be case of post kala-azar dermal leishmaniasis (PKDL)? Not only PKDL is more common in our country, but also 20% of patients with PKDL have no past history of Kala-azar or its treatment. Only on skin biopsy, LD bodies can be seen in such patients.

In those cases DAT and ICT for Kala-azar can help us to identify the subclinical infection. It is seen that DAT can be positive up to 7 years after treatment and ICT using the rK39 can be positive in patient even after 1 year of treatment.

Although paucity of LD bodies is more common in PKDL, in nodular variety, plenty of LD bodies can be seen, as demonstrated in this case.

By doing ICT and DAT, the case report could have been cleared to us by differentiating from PKDL. However, thanks to all the authors to identify this kind of emerging problem in Bangladesh.

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Author's Reply

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Editor-in-chief
Journal of Bangladesh College of Physicians & Surgeons

First of all we would like to thank Prof. M A Jalil Chowdhury, Dr Farjana Sumi and Dr Abed Hossan Khan Of BSMMU Dhaka, for making an inquiry about the published article, "A case of diffuse cutaneous Leishmaniasis" in a HIV positive patient.

Disseminated cutaneous Leishmaniasis begins with single ulcer, nodule or plaque from which satellite lesions develop and disseminate to cover the entire body. In our case, the lesion first appeared over the left cheek and gradually involved the whole of the face, extremities and genitalia. On the contrary, in PKDL there is an eruption of macular depigmented or nodular variety or skin lesions including nodule, papule, macule and patches; that are typically most prominent on the face.

Disseminated cutaneous Leishmaniasis is characterised by anergy to the organism. In our case the patient complained of fever, cough, diarrhea, anorexia and weight loss for six months & papulo-nodular lesion for only one month. So, it could be concluded that a patient acquired HIV first and then cutaneous leishmaniasis; the anergy is evident by negative Tuberculin Test.

In Disseminated cutaneous Leishmaniasis there is a super abundance of parasites in the lesion and the histology is characteristic in that Macrophages full of Amastigotes. In contrast in PKDL there is paucity of LD bodies.

As the patient expired, the tests like ICT for Kala-azar and DAT could not be done.

We again congratulate such a fascinating query and looking forward for your comments.

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