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Clinical Image

Hyperkeratotic cutaneous leishmaniasis: A rare presentation

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Case

A 45-year-old female patient presented to our clinic with the complaint of incrustation in the nose dorsum that had lasted for 2 years. The lesions started as small-diameter papules, developed over time and became scabbed. The patient had received no previous treatment and was otherwise healthy. Dermatological examination revealed yellow-coloured crusted areas on the erythematous area, with indefinite edges completely covering the nose dorsum and spreading from the vibrissae to the cheeks (Figure 1). Amastigotes/promastigotes were observed in Giemsa-stained smears taken from the lesion area (Figure 2). Reproduction of the parasite was observed in Novy-Mac Neal-Nicole (NNN) culture medium. The patient was diagnosed with cutaneous leishmaniasis

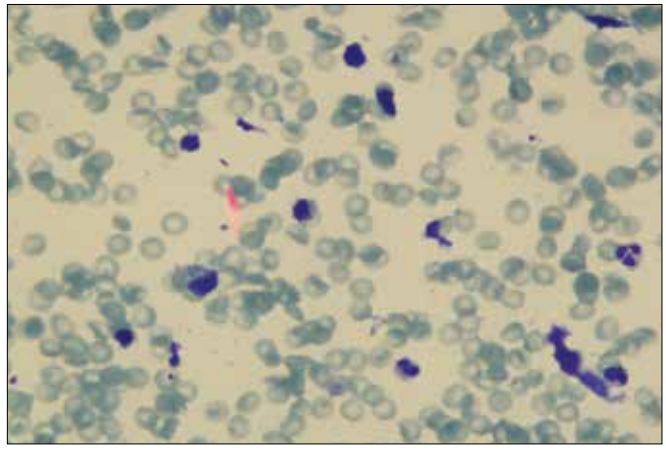

Figure 2. Amastigote forms of leishmania spp.in smear from cutaneous leishmaniasis

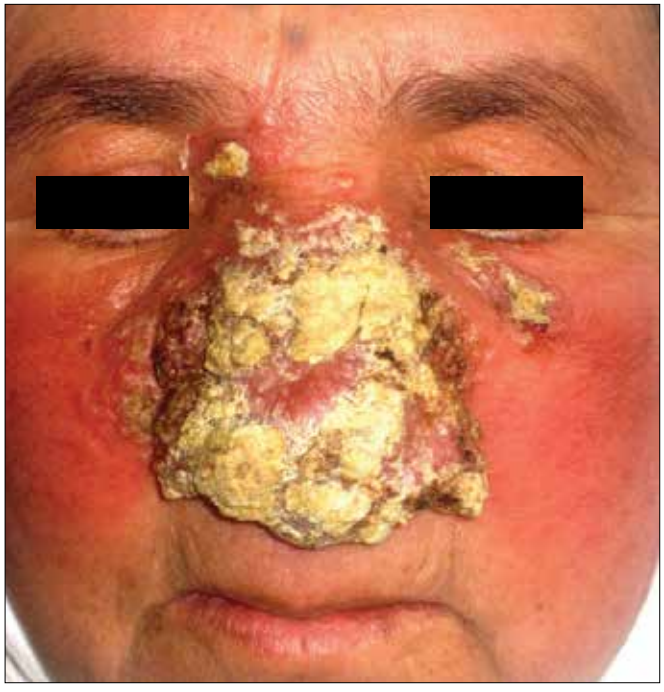

Figure 1. Clinical appearance before intralesional antimoniate (Glucantime) treatment

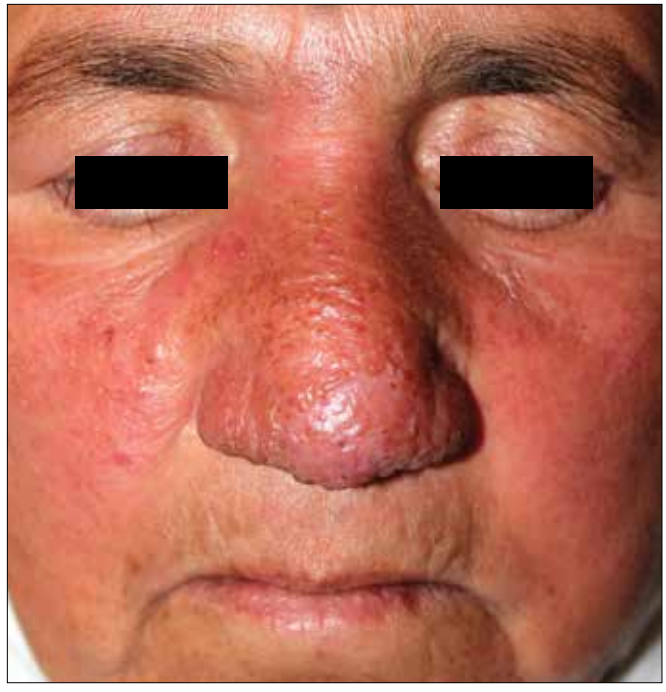

Figure 3. Clinical appearance after intralesional antimoniate (Glucantime) treatment

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(CL) according to the results of clinical and laboratory evaluations. The patient received intralesional antimoniate (Glucantime) treatment. During the course of the treatment, improvement in the hyperkeratotic plates and shrinkage of the lesion were observed (Figure 3).

Discussion

CL begins in the form of asymptomatic, erythematous papules in open areas of the body, frequently on the face, eyelids, forehead, hands, wrists and sometimes legs; it develops over approximately 4-6 months, ulcerates and reaches up to 1-2 cm in size and becomes crusted as it conjoins to the bottom. In the absence of treatment, healed lesions cause scarring. Cutaneous leishmaniasis is often seen in papular, nodular, noduloulcerative, plaque and ulcerated plaque forms. More rarely, it occurs as psoriasiform, mycetomatous, DLE-like, squamous cell carcinoma-like, erysipeloid, zosteriform, eczematous, hyperkeratotic and sporotrichoid clinical forms (1). The literature includes few studies of the hyperkeratotic form of CL. Most previous studies of leishmaniasis were based in the New World region. Northeast American tegumentary leishmaniasis was reported in the hyperkeratotic form of CL (2). Since CL is locally endemic, we suspected CL in this lesion, which had not healed for a long time. In summary, we feel that CL should be considered in order to ensure early diagnosis and rapid instigation of specific therapy.

Informed Consent: *Informed consent was obtained from patients who participated in this study.*

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