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Cutaneous Leishmaniasis in a Traveler: A Case Report

Sarah Al-Obaydi MD, MPH, Nemer Dabage MD, FACP, James DeMaio MD | HCA



Introduction

Leishmaniasis, a vector-borne infection transmitted by sandflies, is endemic throughout the Mediterranean basin and the tropics. We present a case diagnosed in Florida after overseas travel.

Case presentation

A 39-year-old immunocompetent male with no past medical history presented to the outpatient infectious disease clinic with four painless skin lesions. The lesions had progressed over two months after the patient had received multiple insect bites in Maroua, Cameroon. The patient denied any fevers, chills or abdominal pain. On examination, there were four raised, 3-4 cm, red, violaceous plaques with yellow necrotic centers, two on the right arm, one on the left arm and one on the right ankle (Figure I). Workup, including CBC, metabolic panel, and HIV screen, was non-revealing. No eosinophilia was noted. Leishmania IgG antibody was mildly positive. The patient was sent for an excisional skin biopsy and histopathology results done locally were consistent with leishmaniasis. A biopsy sample sent to the CDC confirmed the diagnosis of *Leishmania tropica* by pathology and PCR. Further questioning of the patient elicited a history of travel through Syria 8 months earlier. Currently, the patient is using heat packs 3 to 4 times daily in order to clear the infection.



Figure I: Leishmania Lesions at Presentation

Discussion

This case underscores several important clinical points. First, with rapid travel, the world has become a very small place. Infections that were previously considered exotic can now present at any local clinic. Second, a careful review of a patient's travel itinerary is critical in diagnosing tropical infections. Our patient's initial history of sand fly bites during a three month stay in Cameroon led us to assume that he had acquired the infection in Maroua. Although *L. major* is highly endemic in Northern Cameroon, *L. tropica* has never been described there. Our patient's infection was likely acquired during his stay in Syria, a country where *L. tropica* is endemic. Third, species identification is critical in leishmaniasis. The risk of systemic spread and the choice of treatment depends greatly upon the exact species involved. In this case, *L. tropica* is more strongly associated with systemic disease than *L. major*. Finally, optimal treatment for leishmaniasis is poorly defined. We have elected to start with heat therapy due to its low risk of side effects. If heat therapy fails, we plan on using liposomal Amphotericin as salvage therapy. Given the lack of evidence of systemic spread in this case, we do not believe that the use of pentavalent antimonials is justified.

Recommendations

Healthcare professionals in the US need to have a basic knowledge of tropical diseases given the increase in overseas travel. Better treatment guidelines for leishmaniasis are needed to optimize patient care.

References

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