

Recurrent Cutaneous Leishmaniasis Mimicking Rosacea

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Cutaneous leishmaniasis of humans is endemic in the Middle East and is recognised in several regions of the Kingdom of Saudi Arabia. The disease is seasonal, probably because of the insect vector, and affects all age groups of both sexes.

Leishmania tropica transmitted by the sandfly *Phlebotomus sergenti* causes Oriental Sore and *Leishmania recidivans* in the population of the high plateau of Asir in southwest Saudi Arabia.⁽¹⁾ The zoonotic *Leishmania major*, transmitted by *Phlebotomus papatasi*, has reservoirs of infection in rodents and small desert mammals and causes oriental sore and oronasal leishmaniasis in the populations of the semi-arid areas of the Eastern Province, in the environs of the capital city Riyadh, and in oases and areas of irrigated agriculture.

The lesions are nodulo-ulcerative, papular, plaque and impetiginised. The face is the most frequent site of involvement followed by the upper and lower extremities. Cutaneous lesions on these exposed areas of the body may take days or months to develop but once healed there is generally a solid long-lasting immunity. However recurrent lesions (*L. recidivans*) can occur and are more likely following infection with *L. tropica*.

Case History

In August 1993 a 71 year-old male Saudi national from the South West Highlands presented with a history of non-insulin-dependent Diabetes mellitus

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for the previous three years and complaining of a burning and stinging sensation of the face over a similar period.

He showed a papulo-modular lesion, symmetrical erythema with crusts on his cheeks and rhinophyma. [Fig.1] The clinical picture and histological examination suggested a diagnosis of rosacea but treatment with oral tetracycline for one month produced no improvement.

A second biopsy from the facial lesions showed the presence of amastigotes and treatment with sodium stibogluconate (Pentostam; wellcome) was started immediately. The facial lesions cleared after twelve days of intralesional and intramuscular injections, 500 mgm daily.

One year later the patient relapsed with papules and ulceration of cheeks, nose, upper lip and nasal mucosa and he was admitted to hospital for treatment with sodium stibogluconate 500 mgm intramuscular daily for one month and intralesional injections once every ten days during the same period combined with oral 100 mg itraconazole capsule once daily.

The facial lesions resolved and the medication was well tolerated by the patient with no observable side effects. Laboratory values for tests of haematology and liver and kidney function taken at the beginning and end of treatment remained within the accepted normal ranges.

The patient was discharged with a further two weeks oral treatment of itraconazole capsules 100 mgm daily. The response was good and no relapse has been observed over a period of two years. [Fig.2]

Comment

Our patient had chronic cutaneous leishmaniasis with recurrence on the face and nose and partially on the nasal mucosa. This type of leishmaniasis has a low prevalence and, known as erysipeloid type, is more common in elderly females.⁽²⁾ The local culture permits only exposure of face, hands and feet of female, a habit that affects distributions of lesions.



Figure 1: Facial cutaneous leishmaniasis mimicking Rosacea



Figure 2: Complete regression of the erythema, papulo-nodular lesions and rhinophyma.

Patients usually respond fully to treatment, the lesions healing without scars.

Based on the single case reported above, it appears that the regime of sodium stibogluconate and itraconazole is an effective treatment which could be repeated in similar cases of leishmaniasis recidivans.

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