A US Soldier Who Returned from Iraq with Nonhealing Sores
(See pages 1008–9 for Photo Quiz)

Figure 1. Indurated lesions on the patient’s neck showing central scales that characterize cutaneous leishmaniasis caused by Leishmania major.

Diagnosis: Cutaneous leishmaniasis caused by Leishmania major.

Giemsa staining of a sample of tissue from the base of one of the lesions on the patient’s neck (figure 1) revealed intracellular amastigotes with peripheral nuclei and rod-shaped kinetoplasts. The result of a PCR assay specific for L. major was positive. A culture of the tissue sample also grew Leishmania, which was identified by isoenzyme typing as L. major. The patient received 20 doses of sodium stibogluconate (Pentostam; GlaxoSmithKline), and there was significant improvement in the lesions by the end of therapy and resolution of the infection by 2 months after the end of therapy.

Cutaneous leishmaniasis is the most common form of leishmaniasis. Infection is characterized by one or more sores or nodules on the skin, which are often described as being volcano-like in appearance, with raised edges and a central crater. The sores are usually painless (unless they are secondarily infected with bacteria) and may be associated with swelling of the lymph nodes that are proximal to the lesions [1]. Old World leishmaniasis (i.e., infection with L. major, Leishmania tropica, or Leishmania infantum) is endemic in many parts of Iraq [2]. The majority of cases among US soldiers returning from Iraq have occurred along the Iraq-Syria border (near Tall Afar) and the Iraq-Iran border (near Balad Ruz or Kanaquin) [3]. Leishmaniasis is transmitted by the bite of an infected sand fly. Most sores appear within a few weeks of the sandfly bite but can appear months later. Diagnosis can be made by microscopy (figure 2), PCR assay [4], and/or culture. The majority of cutaneous leishmaniasis lesions will heal without treatment in 2–12 months and usually leave a depressed scar. Treatment options available in the United States include oral fluconazole (for L. major) [5], intravenous amphotericin B, and intravenous sodium stibogluconate [6–8]. This patient received 20 concurrent daily doses of 20 mg/kg of sodium stibogluconate, and all lesions healed completely.

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References


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