Concerns About Topical Treatment for New World Cutaneous Leishmaniasis

To the Editor—The treatment for New World cutaneous leishmaniasis (NWCL) is controversial, and the optimal therapy for every case has not yet been defined. An important issue is whether to use local or systemic treatment. The potential benefits of local therapies are a reduction in systemic toxicity and cost (important in low-income countries). Local therapies could be associated with a higher risk of mucosal involvement; however, this risk has not been clearly established [1–3].

It is especially relevant to define the treatment options for NWCL caused by *Leishmania braziliensis* because of its potential risk for mucosal involvement. A recently published study has defined the risk of mucosal dissemination in *L. braziliensis* NWCL in the Andean countries to be 7.1%, with the highest rates in Bolivia where there is an associated risk of 16% to 37% [3]. Clinical trials are necessary to assess efficacy and the risks involved in using topical treatment for *L. braziliensis* NWCL.

The recent article by Soto et al [4] has great value as it is the first clinical trial to evaluate the efficacy of intralesional pentavalent antimony in *L. braziliensis* NWCL. However, there are a few concerns that should be mentioned. There are ethical issues regarding the inclusion of a placebo control group in patients with identified
such a control group implies not treating infected patients despite the known natural history of *L. braziliensis* NWCL in this geographical area of South America. Moreover, an explanation of the management of the placebo control patients after the 6-month follow-up and of those patients for whom local therapy failed would have been of interest.

Patients were followed for only 6 months. Mucosal leishmaniasis can develop many years after the initial episode of NWCL, so a longer period of time would be needed to conclude the appropriate management for these cases.

Finally, these results, together with those reported by Oliveira-Neto et al [5], could be misinterpreted, leading to the widespread use of intralesional antimony for *L. braziliensis* NWCL, assuming there will be a 70% to 80% cure rate. In fact, this approach is suggested by the authors in the discussion for those cases with single lesions.

Clinical trials that compare local and systemic treatments for *L. braziliensis* NWCL and with a long follow-up period are necessary. In this way all patients would be treated and the risk for mucosal metastases over time following local therapy could be estimated.

### Notes

**Financial support.** Support was provided by I+D+I 2008-2011, ISCIII -Subdirección General de Redes y Centros de Investigación Cooperativa, expediente RD12/0018/0019.

**Potential conflicts of interest.** All authors: No reported conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

---

**Begoña Monge-Maillo, José Antonio Pérez-Molina, Francesca F. Norman, and Rogelio López-Vélez**

Tropical Medicine and Clinical Parasitology, Infectious Diseases Department, Ramón y Cajal Hospital, Instituto Ramón y Cajal de Investigación Sanitaria, Madrid, Spain

### References


Correspondence: Rogelio López-Vélez, MD, DTM&H, PhD, Tropical Medicine and Clinical Parasitology, Infectious Diseases Department, Ramón y Cajal Hospital, Carretera de Colmenar, Km 9. 28034 Madrid, Spain (rogelio.lopezvellez@salud.madrid.org).

**Clinical Infectious Diseases** 2013;57(10):1502–3

© The Author 2013. Published by Oxford University Press on behalf of the Infectious Diseases Society of America. All rights reserved. For Permissions, please e-mail: journals.permissions@oup.com.

DOI: 10.1093/cid/cit523