THE SRI LANKA JOURNAL OF DERMATOLOGY

The official publication of the Sri Lanka College of Dermatologists

Volume 9, 2005

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Editorial

Cutaneous leishmaniasis in Sri Lanka

Sri Lanka Journal of Dermatology, 2005, 9, 1-2

Over the past 2 decades cutaneous leishmaniasis has become a significant problem in Sri Lanka.

Initially it was seen among workers returning from the Middle East[1]. The first patient with locally acquired leishmaniasis was reported in 1992[2]. Subsequently more than 700 patinets have been confirmed as having cutaneous leishmaniasis[3] (Siriwardena HVYD, Wijesundera M de S. Personal communication). Most of them were personnel from armed forces, employed in North Central and Northern provinces. Presently the disease is encountered in all the provinces, affecting all categories of population.

Slowly evolving asymptomatic papules or nodules, with or without surface ulceration, located in an exposed area is the usual clinical presentation. Atypical presentations were noted in few[4]. Two patients with mucosal involvement were reported in 2005[5]. Visceral involvement was not noted in any of the patients.

Presently, facilities to investigate leishmaniasis are limited to the main teaching centers of the country. Departments of parasitology in Colombo and Peradeniya have rendered a valuable service by organizing the diagnostic services. These need to be introduced to the other teaching, provincial, base and district hospitals of the country, in order to improve case detection. In institutions with basic laboratory facilities, smears could be easily done. Smear positivity rate in Sri Lankan patients is 85%.

Histologically, cutaneous leishmaniasis can mimic other entities such as cutaneous tuberculosis and leprosy. The histopathological spectrum of cutaneous leishmaniasis needs to be studied in detail. Histological evidence of parasite was found in 50%.

About 21 species of leishmania are known to produce leishmania syndromes[6]. Isoenzyme analysis, which identifies the exact species of leishmania parasite is not available in Sri Lanka. Causative species of

cutaneous leishmaniasis in Sri Lanka has been identified as Leishmania Donovani MON 37[7].

Cutaneous leishmaniasis is known to heal spontaneously most of the time. Treatment has to be non toxic, producing a cosmetic appearance superior to that of natural healing. Once the diagnosis was confirmed, all Sri Lankan patients were treated actively, considering the viscerotropic potential of the causative species.

Cryotherapy is an inexpensive mode of therapy, which was used in majority of our patients. It is available in the major hospitals of the country. Patients need 2-4 sessions of treatment, in a hospital clinic. This and the tendency to cause depigmentation limit its use.

Sodium stibogluconate is an expensive drug, available only in the main teaching hospitals. Next to Cryotherapy, intralesional sodium stibogluconate is the most widely used treatment. To achieve cure 2-4 intralesional injections were necessary. Intramuscular sodium stibogluconate, used in few patients with special indications was well tolerated, despite many adverse effects described.

Availability of these treatment modalities is restricted to main hospitals of the country. Most of the patients have to travel long distances to obtain treatment. This has made the regular follow up and assessment of the response to treatment difficult. Easily administrable therapies such as paromomycin ointment and miltefosine tablets are not available in Sri Lanka. Such treatment modalities will be of advantage in treating uncomplicated lesions, especially in those who live in distant areas.

Dermatologists have to play a pioneering role in creating awareness about leishmaniasis among general public. In addition it is important to educate primary care physicians including non-allopathic practioners regarding this disease.

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