

Mastocytosis-like Cutaneous Leishmaniasis: Unusual Presentation of Cutaneous Leishmaniasis

To the Editor. - A 6-month-old male infant patient presented to our outpatient clinic due to red swellings in his abdomen, forehead and chin. Following the complaint that started in the form of a small swelling in the abdomen 2 months ago, similar swellings occurred beneath the chin and behind the right ear. The patient's medical history showed that the patient did not have people with similar complaints around him and he did not have any other known diseases. The dermatological examination showed brown-reddish plaques at varying diameters with prominent delineations and in a neat layout on the front part of the abdomen, behind the left ear, on the forehead and beneath the chin (**Figure 1**). The systemic examination result was normal.

Our patient's routine laboratory examinations showed normal results for the whole blood analysis, full urinalysis, hepatic and renal function tests. The results of gram stain, ARB stain, acid fast stain and PPD tests conducted were negative. Novy-Mac Neal-Nicole (NNN) medium and Sabouraud's dextrose agar cultivation as well as tuberculosis culture tests were performed. Pulmonary x-ray and abdomen ultrasonography were normal. Amastigotes were observed on the Giemsa stain of the smear preparation collected from the lesion.

Preliminary diagnoses for deep fungal infections, cutaneous tuberculosis, cutaneous leishmaniasis (CL), sarcoidosis, mastocytosis, Langerhans cell histosis and xantomias as well as skin biopsy were conducted on a sample collected from the periphery of the ulcerated lesion on the left forearm of the patient. Amastigotes were observed on the microscopic examination of the biopsy material (**Figures 2 and 3**).

As a result of clinical and laboratory assessments, CL diagnosis was made and intralésionary antimonial (Glucantime) treatment was initiated. Post-treatment, brown postinflammatory hyperpigmentation recovered.

Leishmaniasis is a parasitic disease and a public health problem, which is caused by protozoa of the genus *Leishmania*. It is estimated that leishmaniasis affects approximately 12 million people in 88 countries [1]. Şanlıurfa Province, in southeastern Anatolia, Turkey, is highly endemic for CL and has drawn considerable attention. In Turkey, CL agents are *Leishmania tropica* and *Leishmania infantum* [2].

CL emerges on the exposed parts of the body such as face and hands in the form of asymptomatic, erythematous papulae, it becomes ulcerated after reaching the sizes of 1-2 cm by growing in 4-6 months on average and a crust that is securely attached to the bottom develops on it over time. In the absence of treatment, healed lesions cause scarring [2].



Figure 1. Brown-reddish plaques

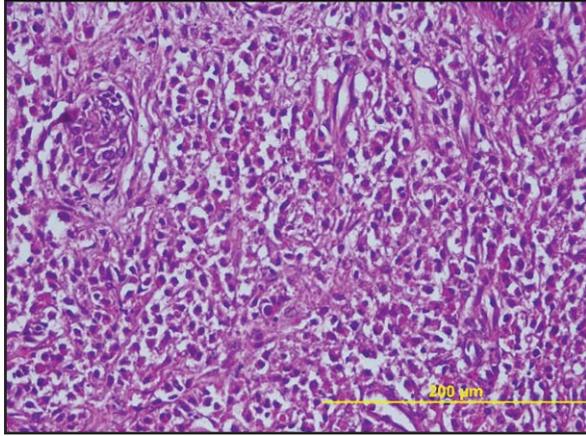


Figure 2. Amastigotes seen with microscopic examination of the biopsy material

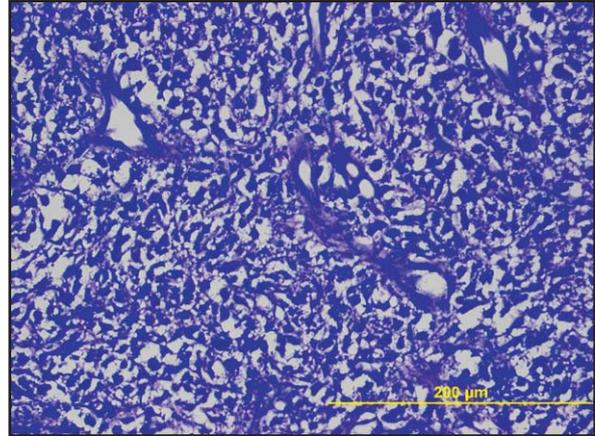


Figure 3. Amastigotes seen with microscopic examination of the biopsy material

CL often appears in the forms of papulae, nodules, nodulo-ulcerative plaques and ulcerative plaques [2]. In addition to these classical clinical types, CL may also present in atypical forms such as psoriasiform, mycetomatous, DLE-like, squamous cell carcinoma-like, erysipeloid, zosteriform, eczematous, sporotrichoid, hiperkeratotic forms [3].

As seen in our case, we may also encounter other atypical forms of CL that mimic cutaneous mastocytosis differently from what has been reported in the literature.

As a result, CL may mimic many forms of dermatosis and cause misleading results in diagnosis, which may lead to unnecessary treatments due to the morphological variety as was the case with our patient.

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