A differential to consider in a case of non-healing skin lesion

Aruna Goturu, Neemisha Jain

DESCRIPTION

We report a case of a 5-year-old Asian boy with an 8-month history of non-healing lesions on the left side of cheek (figure 1).

It started as a non-tender red papule which increased to a pea-sized nodule over a period of few weeks. The lesion persisted for over 6 months and was oozing pus intermittently. At the same time two other erythematous papules appeared under the chin.

He had travelled to Pakistan a year before the lesions appeared. His family members did not have tuberculosis.

A punch biopsy of the lesion revealed a non-caseating granuloma (figure 2). Stain and cultures for bacteria, acid-fast bacilli and fungi were negative. The Mantoux test was negative and the chest radiograph was normal. His renal, liver function, C reactive protein and erythrocyte sedimentation rate were normal. Serum immunoglobulins and lymphocyte subsets were normal.

Leishmania donovani DNA complex was detected on PCR and confirmed a diagnosis of cutaneous Leishmaniasis. Ultrasound of the neck and abdomen did not show any lymphadenopathy or hepatosplenomegaly. He responded well to oral fluconazole (10 mg/kg) treatment for 2 months.

Cutaneous leishmaniasis is a parasitic skin infection caused by Leishmania species, which is transmitted by sandfly bites. Papules are the most common clinical presentation in the initial stages. They can also present as plaques, nodule or ulcers. Face is the most common affected area. Microscopy and culture have low sensitivity in the diagnosis of leishmaniasis. However, a molecular diagnosis by PCR is highly sensitive and specific for detecting the DNA of the Leishmania species.

Learning points

▸ Cutaneous leishmaniasis should be considered in the differential diagnosis of non-healing skin lesions when the biopsy shows granulomatous inflammation with negative stains and culture for tuberculosis.

▸ In such cases, Leishmania PCR is a very sensitive and specific molecular diagnostic test in the absence of confirmatory histological diagnosis.

Acknowledgements  The authors would like to thank Dr Hilary Birch, Consultant Pathologist, East Surrey Hospital for providing the histopathology specimen picture.

Contributors  AG wrote the manuscript and NJ revised the manuscript.

Competing interests  None.

Patient consent  Obtained.

Provenance and peer review  Not commissioned; externally peer reviewed.

REFERENCES

