Chronic zoster-form: a rare variant of cutaneous leishmaniasis

Jamshid Ayatollahi[a], Ali F. Bafghi[b] and Seyed H. Shahcheraghi[a]

Cutaneous leishmaniasis may present with unusual clinical variants such as erysipeloid, sporotrichoid, whitlow, paronychia and impetigo form. The chronic zoster-form variant has rarely been reported. We report a male patient with zoster-form cutaneous leishmaniasis on the back of his neck in Yazd province in central Iran. To our knowledge, this is the first reported case of chronic zoster-form cutaneous leishmaniasis from our city, and the second case in Iran. Once diagnosed, it responded well to conventional treatment.

Reviews in Medical Microbiology 2015, **26**:114–115

Keywords: cutaneous leishmaniasis, Iran, zoster-form

Introduction

The term leishmaniasis collectively refers to various clinical syndromes caused by obligate intracellular protozoa of the genus *Leishmania* [1]. Leishmaniasis is endemic in diverse environmental settings in Iran, which range from deserts to rain forests and from rural to peri-urban areas [2]. It typically is a vector-borne zoonosis, with dogs and rodents as common reservoir hosts and humans as incidental hosts. Cutaneous leishmaniasis is an important public health problem in Iran [3–5]. Most cutaneous leishmaniasis evolves from papular to nodular to raised, with a central depression surrounded by a raised indurated border [4,5]. We present a patient with a very rare case of cutaneous leishmaniasis. The patient was from the Yazd province, which is in central Iran.

Case report

A 35-year-old man was referred to the infectious disease clinic with a large erythematous plaque, 10 cm × 20 cm in size, studded with small nodules, pseudovesicles, and papules on the back of the neck for 4 months (Fig. 1). He was a farmer. The patient denied history of allergic disorders, trauma, drug intake, atopic disorders, fever, weight loss, or constitutional abnormalities. The patient and his family had no history of similar illness in the past. He had been treated with many antibiotics, including cephalexin, cloxacillin, penicillin, and acyclovir.

The patient's complete blood count, HIV serology, erythrocyte sedimentation rate, and C-reactive protein were normal. Routine biochemical tests, urine analysis, chest radiography, and intradermal purified protein derivative skin test were normal. Culture of the biopsy specimen and Gram smear prepared from the lesion were negative for bacteria, fungi, and mycobacteria, whereas Leishman bodies belonging to the genus *Leishmania* were observed in the skin smear (Fig. 2).

The patient was given meglumine antimoniate at a dose of 20 mg/kg body weight intramuscularly daily for

[a]Infectious and Tropical Diseases Research Center, and [b]Department of Medical Parasitology & Mycology, Shahid Sadoughi University of Medical Sciences, Yazd, Iran.

Correspondence to Seyed H. Shahcheraghi, Infectious and Tropical Diseases Research Center, Shahid Sadoughi University of Medical Sciences, Yazd, Iran.

Tel: +98 913 2531389; e-mail: shahcheraghih@gmail.com

Received: 11 November 2014; revised: 30 November 2014; accepted: 30 November 2014

DOI:10.1097/MRM.0000000000000031

ISSN 0954-139X

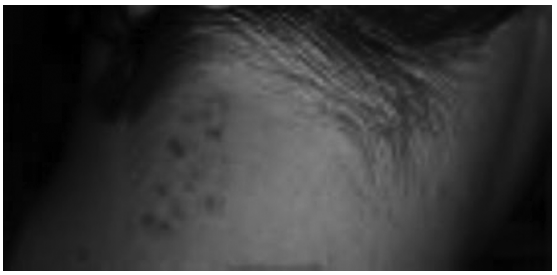

Fig. 1. Zoster-form of cutaneous leishmaniasis on the back of the neck.

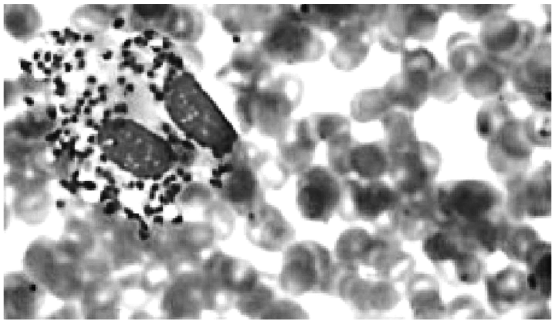

Fig. 2. Leishman bodies.

20 days [6]. After 3 months, almost all the lesions had cleared.

Discussion

Cutaneous leishmaniasis is a disease with several clinical features [6]. Clinically, the manifestations of cutaneous leishmaniasis vary from a single nodule or papule, which heals within a few months, to chronic forms that remain for several years [7]. Many of these lesions are typical and present no diagnostic difficulties [8,9]. However, a zoster-form variant is rare, and the reasons for such an unusual clinical variant are not clear, and to our knowledge have only been reported as an unusual clinical variant of cutaneous leishmaniasis [4,10].

Conclusion

In an endemic area such as Iran, it is necessary for the physician to be aware that any atypical lesion, especially chronic form, should be investigated for cutaneous leishmaniasis.

Acknowledgements

The authors would like to thank the Infectious and Tropical Diseases Research Center of Yazd Shahid Sadoughi University of Medical Sciences, because of cooperation in performing the study.

Conflicts of interest

We declare that we have no conflict of interest.

References

1. Karami M, Doudi M, Setorki M. **Assessing epidemiology of cutaneous leishmaniasis in Isfahan, Iran.** *J Vector Borne Dis* 2013; **50**:30–37.
2. Nasiri S, Robati RM, Marefat A, Saeedi M, Sarrafi-rad N. **Bilateral cutaneous leishmaniasis presenting as eczema-like eruptions on the hands.** *Indian J Dermatol Venereol Leprol* 2010; **76**:307.
3. Yaghoobi R, Maraghi S, Bagherani N. **Cutaneous leishmaniasis with unusual presentation.** *Iranian J Parasitol* 2009; **4**: 67–69.
4. Omidian M, Mapar MA. **Chronic zoster-form cutaneous leishmaniasis.** *Indian J Dermatol Venereol Leprol* 2006; **72**:41–42.
5. Ayatollahi J. **Sporotrichoid cutaneous leishmaniasis in central Iran.** *IJMS* 2006; **31**:173–175.
6. Ayatollahi J, Modares Mosadegh M, Halvani A. **Effect of glucantime on blood factors in patients with cutaneous leishmaniasis.** *Iranian J Ped Hematol Oncol* 2011; **1**:57–61.
7. Farahmand M, Nahrevanian H, Shirazi HA, Naeimi S, Farzanehnejad Z. **An overview of a diagnostic and epidemiologic reappraisal of cutaneous leishmaniasis in Iran.** *Braz J Infect Dis* 2011; **15**:17–21.
8. Iftikhar N, Bari I, Ejaz A. **Rare variants of cutaneous leishmaniasis: Whitlow, paronychia, and sporotrichoid.** *Int J Dermatol* 2003; **42**:807–809.
9. Ramot Y, Nanova K, Alper-Pinus R, Zlotogorski A. **Zosteriform cutaneous leishmaniasis diagnosed with the help of dermoscopy.** *Dermatol Pract Concept* 2014; **4**:55–57.
10. Kafaie P, Akaberi AA, Amini S, Noorbala MT, Moghimi M. **Multidermatomal zosteriform lupoid cutaneous leishmaniasis: a case report.** *J Pak Asso Dermatol* 2010; **20**:243–245.