Introduction: Cutaneous Leishmaniasis is a parasitic infection encountered in our daily dermatologic practice. Its most common clinical presentation is the “classical” ulcer which starts as a nodule over exposed area of the body after a sand-fly bite, becomes an ulcer with indurated raised margins and sharply incised central crater and then usually heals over a period of months.

In recent times the number of reports of new and rare variants of Cutaneous Leishmaniasis has been increasing which eludes the diagnosis even in endemic area. We report here a rare and unusual form and localization of Cutaneous Leishmaniasis which was misdiagnosed and treated as Sarcoïdosis by dermatologists in an endemic country. To our knowledge, this is the first reported case in Morocco.

Case Report

The case is of a 53 year-old man. In the months preceding the symptoms, he had no past medical history, nor antecedent of trauma or travel. He was referred to our tertiary center for a large, painless erythematous plaque in his abdomen. It had evolved from an initial small plaque noticed 08 months before, which gradually spread. The patient consulted a private dermatologist who performed a skin biopsy revealing granuloma in the histopathologic examination and the patient was treated as sarcoïdosis by topical and oral corticosteroids with no improvement. On examination we found an apyretic patient with large erythematous indurated slightly squamous plaque of 20cm at his left hypochondrium (Fig. 1). The diascopy of the lesion did not reveal the lupoidic pattern, and the erythematous color was mitigated. The dermoscopy showed diffuse glomerular vessels (Fig. 2). Our differential diagnosis were mycosis fungoide, Sarcoïdosis, leishmaniasis, erysipelas and morphea. The patient’s skin smear was positive for Leishmania. The histopathologic examination of the lesion showed an epithelioid geant -cell granuloma with Leishmania’s bodies in the cytoplasm of histiocytes (Fig. 3). The diagnosis of Erysipeloide Leishmania was retained and the patient was treated by oral Clarithromycine 500mg twice a day for 10 days each month during 3 months with topical Aureomycine; The evolution was good (Fig. 4).
Cutaneous Leishmaniasis (CL) is a parasitic vector-borne disease that is well known in the world. WHO stated that Leishmaniasis is endemic in 88 countries with 1.5 to 2 million new cases each year (WHO 1984, 1990). In Morocco, Leishmaniasis represents a serious health problem. It recognises three epidemiological entities: CL to Leishmania Tropica in the western chain of the Atlas Mountains, represented by a sporadic form with some endemic flare up, CL to Leishmania major in the south and southeast of the Atlas with endemo-epidemic evolution and finally the visceral Leishmaniasis to Leishmania infantum in the Rif and pre-rif area as sporadic form.

Curaneous Leishmaniasis has a spectrum of clinical presentations ranging from a single lesion to disseminated form. In the course of its typical presentation, CL starts as a small erythematous papule, which gradually enlarges to 1-2 cm in diameter in about 6 months and then ulcerates. These ulcers are painless with a necrotic base and indurated margins and are frequently covered by a firmly adherent crust. Approximately 85% of skin’s lesions are located on the exposed body sites. Recently there has been an increase in the number of reports for new and rare variants of CL [1,2]. Our case supports this finding. Our patient originated from a region that is known to experience a high prevalence of Leishmaniasis. On the eco-epidemiological level this region corresponds with a sporadic cluster of visceral Leishmaniasis to Leishmania infantum and not with Curaneous Leishmaniasis. Clinically he presented with a slightly squamous, erythematous, indurated plaque of 20 cm in diameter at his left hypochondrium. In the literature, this form corresponds with the erysipeloide form of leishmaniasis which is a very rare and unusual presentation of CL.

Discussion

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There are various treatment options for CL such as pentavalent antimony compounds, cryotherapy, topical paromomycin, local heat, surgical excision, electrodissection, CO2 laser, Clarithromycin and antifungal [8-10].

In our observation, given the extension of the lesion and the age of the patient, we opted for the oral Clarithromycin with topical Aureomycin.

**Conclusion**

Given the importance and the complexity of the clinical features of CL, it is worth reporting rare and unusual clinical forms and localizations of this disease in order to familiarize and sensitize physicians, in particular dermatologists, with different clinical presentations to avoid inappropriate diagnosis and management.

**REFERENCES**