Clinical Guidelines For The Management Of Cutaneous Leishmaniasis In British Military Personnel

MS Bailey, AD Green, CJ Ellis, TJ O’Dempsey, NJ Beeching, DN Lockwood, PL Chiodini, AD Bryceson

Introduction
Cutaneous leishmaniasis (CL) is an increasing problem for British military personnel due to current deployments in Belize, Iraq and Afghanistan. Recent developments in the diagnosis and treatment of CL have emphasised the importance of a species-specific approach to management (1). This is especially important in New World CL (NWCL), where there may be a risk of mucocutaneous leishmaniasis (MCL) developing.

These guidelines are primarily written for the management of military patients. They differ from civilian patients because having CL will usually prevent them from carrying out their duties and so there must be a greater emphasis on active treatment. These guidelines are not intended to replace Surgeon General’s Policy Letter (SGPL) 09/04 (2), but aim to establish clinical standards for the management of suspected CL by physicians. There are currently no plans nor any need for investigation or treatment of suspected cases to take place on overseas deployments. Any suspicious lesions in personnel deployed overseas should be discussed with an appropriate specialist (Appendix 1) and the individual affected must be evacuated for investigation and treatment if advised.

The guidelines are summarised in Figure 1, but the following text should also be read in full.

Sampling of Lesions
A rigorous approach to making a parasitological diagnosis is important because of the toxicity associated with systemic sodium stibogluconate therapy, which remains the mainstay of treatment in these guidelines. Suspicious lesions should be sampled by aspiration (without dilution), scraping (either directly from an ulcer or from skin slits) and biopsy (usually with a 4 mm punch biopsy tool). Skin biopsy is the most useful of these methods, but lesions that can not be biopsied (eg. on a finger, ear or face) should still be aspirated and scraped.

Sampling should only be performed by staff who are properly trained in these techniques, otherwise poor results and complications may occur. Additional descriptions of these sampling methods are available elsewhere (3). It is recommended that contact be made with one of the laboratories listed in Appendix 2 before any sampling is performed.

A lesion that has re-epithelialised would usually not be sampled. If a lesion is reported during or within 2 years of travel to a leishmaniasis endemic area, which does not resolve with 1-2 weeks of appropriate antibacterial therapy. Leishmaniasis endemic areas may be identified from the relevant military Medical Intelligence Assessment (MIA) or from www.who.int/leishmaniasis. Suspected cases may be discussed with the clinical staff listed in Appendix 1 and digital photographs (taken with written consent) can be extremely useful in this respect. Military patients should be notified to the relevant communicable disease control appointment by the referring medical officer at this stage (2).

Referral to a Specialist
All patients with suspected CL should be referred as soon as possible, even before they have completed their initial course of antibacterial therapy. Patients should still be referred if their lesions appear static or even if they are improving. It is not necessary for patients to see a dermatologist before being referred. If investigations are negative, then patients will be referred on to a dermatologist at their local hospital.

These guidelines are not intended to exclude any hospital specialists who are already experienced in the complexities of investigating and treating CL. However, management should involve species identification and species-specific treatment wherever possible. This will require liaison with one of the laboratories listed in Appendix 2 and hence it may be expedient to refer patients to the clinical facilities at one of these locations. Military patients must be referred to one of the specialists listed in Appendix 1 (2).
Aspiration
Aspirations are performed from the raised edge or nodular part of a lesion. A 0.5 mm diameter needle is tightly connected to an empty syringe. The needle is slowly advanced, with negative pressure applied, in a straight line (to avoid blood contamination) along the edge of an ulcer or into the centre of a solid lesion. It is withdrawn in a similar manner, taking care not to draw any air into the syringe. The needle is then disconnected, air is drawn into the syringe, the needle is re-attached and the contents are blown out rapidly onto a clean, polished and alcohol-free microscope slide. The aspirate should be gently spread on the slide using the tip of the needle to achieve best results on microscopy. This slide should be labelled to identify the patient and the sampling technique used and transported as directed by the laboratory. Aspirates may also be mixed into a tube of PCR buffer and transported as directed or else it may be possible to perform PCR tests on the material sent as a slide.

Scraping
Scrapings are performed either from the surface of an ulcer or from skin slits. Ulcer scrapings should be taken from both the edge and the centre of the lesion. Slit skin
scrapings should be taken from the raised edge or nodular part of a lesion. Either type of scraping should be smeared onto a clean, polished and alcohol-free microscope slide. This slide should be labelled to identify the patient and the sampling technique used and transported as directed by the laboratory. Scrapings may also be mixed into a tube of PCR buffer and transported as directed or else it may be possible to perform PCR tests on the material sent as a slide.

**Biopsy**

Two standard 4 mm punch biopsies from the raised edge or nodular part of a lesion should usually be performed. Blood contamination can be prevented by using local anaesthetic with adrenaline (where anatomically permitted), applying pressure haemostasis before removing the core and gently rolling the core on gauze after its removal. The first biopsy is cut lengthways into 2 equal pieces and used as follows. The freshly-cut surface of one piece is firmly pressed (not smeared) to create a series of 3-5 touch preparations on a clean, polished and alcohol-free microscope slide, which is labelled to identify the patient and the sampling technique used and transported as directed. This piece is then put into an appropriate medium (either PCR buffer, normal saline or viral culture medium containing anti-bacterial, but no antifungal additives) for PCR testing and transported as directed by the laboratory. The other piece is placed directly into a tube of culture medium and transported as directed by the laboratory. The second biopsy should be handled gently to prevent any crush artefacts, put into formalin for histological examination and transported as directed by the laboratory.

**Investigations**

It is recommended that contact be made with the nearest laboratory listed in Appendix 2 before any samples are sent and before any investigations are performed.

**Microscopy**

Slides must be prepared immediately from aspirates, scrapings or touch preparations of skin biopsies in all suspected cases of CL. These should be air-dried (and preferably fixed in methanol for 1 minute) and sent to one of the laboratories listed in Appendix 2. (Where they will be stained with Giemsa at pH 6.8 and examined for the presence of *Leishmania* amastigotes.) It may also be possible to perform PCR analysis on slide material, but a dedicated sample for this purpose will achieve better results.

**Histology**

Skin biopsy tissue is prepared and stained with either Haemotoxylin & Eosin or Giemsa. Most pathology laboratories will be able to identify *Leishmania* amastigotes so long as they are alerted to this possibility. However, it is recommended that all histology specimens are also forwarded for review to Professor Sebastian Lucas, Department of Histopathology, St Thomas's Hospital, London, SE1 7EH (email: sebastian.lucas@kcl.ac.uk / telephone: 020 7188 2954), who has confirmed that there will be no charge for this service.

**PCR Testing**

Samples that are negative on microscopy may undergo a generic / screening PCR test for parasites of the *Leishmania* genus (4,5) before they undergo any species-specific PCR tests. Unless specimens are negative on both microscopy and the generic / screening PCR test, then they should undergo further PCR tests dependant on whether OWCL or NWCL is suspected. If OWCL is suspected then a species-specific PCR test will be performed to identify *L. major*, *L. tropica*, or *L. donovani* complex species (6). If NWCL is suspected then a specific PCR test for parasites of the *L. Viannia* sub-genus (*L. braziliensis* complex) will be performed (7 or 8,9).

These tests are only available at the laboratories listed in Appendix 2 and they should be contacted for advice on what samples to send and how to transport them. PCR tests can be performed on material preserved in paraffin blocks or even from microscopy slides if no other tissue is available. This option should also be discussed with the laboratory in question.

**Culture**

Specimens for culture are placed in either semi-solid blood agar or a modified Novey-MacNeal-Nicolle (NNN) medium and incubated at an appropriate temperature. In practice it will only be possible to perform this investigation for patients seen at either the Liverpool School of Tropical Medicine (LSTM) or the Hospital for Tropical Diseases (HTTD). Although PCR speciation tests are sufficient for clinical practice, culture remains an important technique and the only way of obtaining sufficient parasites for sub-speciation tests, such as zymodeme analysis.

**Other Investigations**

Existing serology tests have no role in the diagnosis of cutaneous leishmaniasis.

**Treatment**

Recommended treatments are summarised in the table within Figure 1.

---

**“Simple” vs. “Complex” Lesions**

“Complex” lesions are defined as those that:

- are > 4-3 in number
- are > 40 mm in their maximum diameter
are associated with lymphatic or lymph node involvement
• could lead to cosmetic problems eg. on the face, ear or neck
• could lead to functional problems eg. on the hand or over a joint
• have not responded adequately to treatment as a “simple” lesion

Observation
Suspected or confirmed OWCL lesions that are improving may be simply observed, especially if they are due to L. major. OWCL due to L. tropica or L. donovani complex species is likely to be more prolonged and to need treatment. NWCL lesions that are improving may only be observed if the cause is proven to be non-Viannia (L. mexicana complex) parasites. NWCL lesions due to L. Viannia sub-genus (L. braziliensis complex) parasites or confirmed NWCL lesions for which a species cannot be identified must always receive systemic therapy because of the risk of MCL developing in the future. Suspected NWCL lesions that are improving and remain negative for all Leishmania investigations should be observed, but patients must be warned of the ~5% risk of MCL developing in the future and advised to seek medical attention for any oro-nasal symptoms or genital ulceration.

Physical Treatments
Cryotherapy, thermotherapy or curettage may be used for “simple” OWCL lesions and “simple” non-Viannia NWCL lesions (ie. “simple” CL lesions that do not have the potential to become MCL). However, lack of equipment and expertise plus concerns over altered pigmentation, secondary infection, dissemination of parasites, slower healing and larger scars mean that alternative treatments are usually preferred. More recent versions of certain physical treatments do offer some hope for the future (10).

Intra-Lesional (IL) Sodium Stibogluconate (SSG)
This is a more established treatment for “simple” CL lesions that do not have the potential to become MCL. Correct technique is essential and this is well described elsewhere (1). However, some patients are unable to tolerate the transient pain of infiltration and it will be less effective for atypical infections with unexpected systemic features (11). The advantages of IL SSG are that it does not require hospital admission, monitoring investigations or restriction of exercise. However, sometimes complete healing may be quicker and relapse/recurrence may be less likely with IV SSG. Hence an individual assessment for each patient is necessary and these matters will be studied further.

Intra-Venous (IV) Sodium Stibogluconate (SSG)
There is now a consensus that 20 mg/kg (with no upper limit) for 20 days should be the standard dose of IV SSG for NWCL (12) despite the associated toxicity (13). The situation for OWCL is less clear, but there is some evidence that 20 mg/kg (with no upper limit) for 10 days may be sufficient according to recent and ongoing trials in the USA (14). OWCL lesions that are not clearly responding at 10 days should be treated for 20 days in total. An observational study of the efficacy and toxicity resulting from these regimens will be performed.

IV SSG may be given via a series of butterfly needles or intravenous cannulae, which should be changed frequently to avoid phlebitis. It may also be given via a peripherally-inserted central catheter (PICC) line, but this is associated with a relatively high complication rate (15). IV SSG should be diluted in 5% glucose and administered over 30 minutes. Filtration, cardiac monitoring and keeping the infusion in the dark are not necessary. Patients receiving IV SSG do not need to be admitted, but should be advised to avoid exercise and alcohol for the duration of their treatment and for 1 week afterwards.

Adverse effects with IV SSG at 20 mg/kg (with no upper limit) are common (13) and patients should undergo twice weekly monitoring investigations, including a full blood count (FBC), urea & electrolytes (U&E), liver function tests (LFT), serum amylase and electrocardiographs (ECG). It is recommended that treatment be interrupted if:
• FBC changes become significantly abnormal
• U&E changes become significantly abnormal
• liver transaminases exceed 15 times the upper limit of normal (ULN)
• serum amylase exceeds 4 times the ULN or if other features of pancreatitis develop
• ECG changes become significantly abnormal (eg. QTc prolongation > 500 milliseconds)

In practice the most common reason for interrupting treatment is musculoskeletal symptoms, which may be severe (especially in older patients), but often settle with non-steroidal anti-inflammatory drugs (NSAIDs). Treatment can usually be recommenced once the abnormality in question has begun to return to normal.

Military patients treated with IV SSG for 20 days should be given sick leave and advised to avoid exercise and alcohol for 1 week after treatment. They may also require a few weeks of gradually increasing exercise to regain full fitness.
Other Treatments

Topical paramomycin remains a much-debated treatment for CL and there are concerns that lesions may initially get worse on this therapy.

Oral fluconazole has been shown to be effective against L. major lesions (16), but our experience has been that lesions may continue to enlarge after treatment has begun. Some studies have shown that oral ketoconazole may also be of benefit in certain forms of CL (17), but further research is required to confirm this.

Oral miltefosine has been used with mixed results in NWCL (18). It performed well against L. V. panamensis in Colombia, but poorly against L. V. braziliensis and L. mexicana in Guatemala – which is more comparable to the situation in Belize. Preliminary results from its use against L. tropica in Afghanistan are disappointing.

Intramuscular pentamidine is now used for CL amongst French military personnel working in French Guyana (19). However, it has been less successful against different Leishmania species in other South American countries (20). In addition the risk of diabetes mellitus and other adverse effects may outweigh its possible benefits.

Intravenous amphotericin is effective against CL, but it is not known which of the various preparations (standard, colloidal or liposomal) produces the best results.

Secondary Infections

Bacterial secondary infections may exacerbate and prolong CL lesions and should be treated with either co-amoxiclav or clindamycin. Patients with lesions that are not fully healed should avoid physical activities that could lead to disruption or secondary infection of their lesions.

Follow-Up Arrangements

Patients must be reviewed 6 weeks after the commencement of treatment and monthly thereafter until their lesions have fully healed. A final review 6 months after treatment is also recommended and patients should be warned of the possibility of recurrence for up to 2 years.

Audit & Research

All confirmed cases of CL (including those with only a clinical diagnosis) should have data recorded as per Appendix 3. Wherever possible these forms should be completed electronically and emailed to Major Mark Bailey RAMC (mark.bailey@ramc.org). This will enable an audit and observational study to be performed on the approach to management recommended in these guidelines. Further studies may follow in due course.

Conclusion

CL is a rare, but increasing problem in British military personnel. Its management requires specialist expertise that is not widely available. These guidelines are not intended to exclude hospital specialists who are already experienced in managing CL. However, a standard approach to management is needed in order to optimise patient care, consolidate current knowledge and learn from future cases. The treatments recommended may seem “conservative” compared to some research findings, but they represent a foundation on which to build in the future. Suspected CL in military personnel must be managed in accordance with these guidelines by one of the specialists listed in Appendix 1.

References


**Appendix 1.**
Specialists to whom military patients with suspected CL may be referred.

Dr. Chris Ellis  
Consultant Physician  
The Infectious Diseases Unit  
Birmingham Heartlands Hospital  
Bordesley Green East  
Birmingham  
B9 5SS  
Phone: 0121 424 0357  
Fax: 0121 424 1309  
Email: christopher.ellis@heartsol.wmids.nhs.uk

Dr. Tim O'Dempsey  
Consultant Physician  
Liverpool School of Tropical Medicine  
Pembroke Place  
Liverpool  
L3 5QA  
Phone: 0151 705 3109  
Fax: 0151 705 3365  
Email: tjod@liv.ac.uk

Dr. Diana Lockwood  
Consultant Physician  
Hospital for Tropical Diseases  
Mortimer Market  
Capper Street  
London  
WC1E 6AU  
Phone: 020 7387 9300 ext. 5414  
Fax: 020 7383 0041  
Email: peter.chiodini@uclh.org  
julie.watson@uclh.org

**Appendix 2.**
Diagnostic laboratories specialising in leishmaniasis.

Dr. Wendi Bailey  
The Diagnostic Laboratory  
Liverpool School of Tropical Medicine  
Pembroke Place  
Liverpool  
L3 5QA  
Phone: 0151 705 3290  
Fax: 0151 705 3365  
Email: jwbailey@liv.ac.uk

Prof. Peter Chiodini / Ms. Julie Watson  
Department of Clinical Parasitology  
Hospital for Tropical Diseases  
Mortimer Market  
Capper Street  
London  
WC1E 6AU  
Phone: 020 7387 9300 ext. 5414  
Fax: 020 7383 0041  
Email: peter.chiodini@uclh.org  
julie.watson@uclh.org
### Appendix 3
Data Collection from Military Cutaneous Leishmaniasis Cases

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Number</td>
<td>Military Rank</td>
</tr>
<tr>
<td>Age</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Height</td>
<td>Weight</td>
</tr>
<tr>
<td>Regiment</td>
<td>Company/Squadron</td>
</tr>
<tr>
<td>Platoon/Troop</td>
<td>Job Description</td>
</tr>
<tr>
<td>Countries Visited (in last 2 years)</td>
<td>Areas &amp; Terrains</td>
</tr>
<tr>
<td>Date of arrival in country where CL originated</td>
<td></td>
</tr>
<tr>
<td>Date of initial sandfly bite (if recalled)</td>
<td></td>
</tr>
<tr>
<td>Date when lesions first noticed</td>
<td></td>
</tr>
<tr>
<td>Date when seen by specialist</td>
<td></td>
</tr>
<tr>
<td>Number of skin lesions</td>
<td></td>
</tr>
<tr>
<td>Sites of skin lesions (describe)</td>
<td></td>
</tr>
<tr>
<td>Sizes of skin lesions (maximum diameters)</td>
<td></td>
</tr>
<tr>
<td>Lesions = worsening / static / improving / healed</td>
<td></td>
</tr>
<tr>
<td>Secondary infection (organism if known)</td>
<td></td>
</tr>
<tr>
<td>Lymph node / lymphatic involvement (describe)</td>
<td></td>
</tr>
<tr>
<td>Aspirate impression smear result</td>
<td></td>
</tr>
<tr>
<td>Aspirate PCR results</td>
<td></td>
</tr>
<tr>
<td>Scraping impression smear result</td>
<td></td>
</tr>
<tr>
<td>Scraping PCR results</td>
<td></td>
</tr>
<tr>
<td>Biopsy impression smear result</td>
<td></td>
</tr>
<tr>
<td>Biopsy PCR results</td>
<td></td>
</tr>
<tr>
<td>Biopsy tissue culture result</td>
<td></td>
</tr>
<tr>
<td>Biopsy histology result (granulomata/amastigotes)</td>
<td></td>
</tr>
<tr>
<td>Photographs of lesions available</td>
<td></td>
</tr>
<tr>
<td>Case notified with F Med 85 (as per SGPL 09/04)</td>
<td></td>
</tr>
<tr>
<td>Treatment received + dose + duration / frequency</td>
<td></td>
</tr>
<tr>
<td>Date when treatment started</td>
<td></td>
</tr>
<tr>
<td>Adverse effects due to treatment</td>
<td></td>
</tr>
<tr>
<td>Treatment interruption + reason + date + duration</td>
<td></td>
</tr>
<tr>
<td>Maximum FBC abnormalities + date</td>
<td></td>
</tr>
<tr>
<td>Maximum U&amp;E abnormalities + date</td>
<td></td>
</tr>
<tr>
<td>Maximum LFT abnormalities + date</td>
<td></td>
</tr>
<tr>
<td>Maximum amylase abnormality + date</td>
<td></td>
</tr>
<tr>
<td>Maximum ECG abnormalities + date</td>
<td></td>
</tr>
<tr>
<td>Date when treatment completed</td>
<td></td>
</tr>
<tr>
<td>Prevention used in location where CL originated:</td>
<td>Never (&lt;10%)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Fully clothed from dusk to dawn?</td>
<td></td>
</tr>
<tr>
<td>Sleeves rolled down from dusk to dawn?</td>
<td></td>
</tr>
<tr>
<td>Hat worn at dusk and dawn?</td>
<td></td>
</tr>
<tr>
<td>Clothing dipped in “peripel” every 6 weeks?</td>
<td></td>
</tr>
<tr>
<td>Issued insect repellent applied every 8-12 hours?</td>
<td></td>
</tr>
<tr>
<td>Non-issued insect repellent used instead?</td>
<td></td>
</tr>
<tr>
<td>Slept under bednet?</td>
<td></td>
</tr>
<tr>
<td>Bednet dipped in “peripel” in last 6 months?</td>
<td></td>
</tr>
<tr>
<td>Knockdown insecticide spray for inside bednet?</td>
<td></td>
</tr>
<tr>
<td>Swingfog / environmental spraying used daily?</td>
<td></td>
</tr>
</tbody>
</table>

Additional information:

Progress at 6/52 after treatment started

Progress at 10/52 after treatment started

Progress at 14/52 after treatment started

Progress at 18/52 after treatment started

Progress at 22/52 after treatment started

Progress at 26/52 after treatment started

(Progress at 10/52 after treatment started)

(Progress at 14/52 after treatment started)

(Progress at 18/52 after treatment started)

(Progress at 22/52 after treatment started)

(Progress at 26/52 after treatment started)
Clinical Guidelines For The Management Of Cutaneous Leishmaniasis In British Military Personnel

MS Bailey, AD Green, CJ Ellis, TJ O'Dempsey, NJ Beeching, DN Lockwood, PL Chionini and AD Bryceson

*J R Army Med Corps* 2005 151: 73-80
doi: 10.1136/jramc-151-02-03

Updated information and services can be found at:
http://jramc.bmj.com/content/151/2/73.citation

**Email alerting service**

These include:
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/