

Sir,
Eyelid leishmaniasis masquerading as chalazia
Leishmaniasis is a parasitic infection caused by the haemoflagellate protozoan of the genus *Leishmania*. This parasite causes cutaneous and visceral infection. The cutaneous form of leishmaniasis usually affects exposed parts of the body, but rarely the eyelids,¹ and can simulate adnexal tumours.² Here, we describe an unusual case of bilateral localized leishmaniasis of the eyelids masquerading as chalazia.

Case report

A 2-year-old girl presented with a 4-week history of bilateral upper eyelid redness, swelling and mucoid discharge. She had been treated elsewhere as having impetigo and chalazia. External examination revealed erythematous bilateral upper eyelid swelling with overlying yellow crusting lesions (Figure 1). The remainder of her comprehensive eye exam was normal. An excisional biopsy of each lesion was performed. Haematoxylin–eosin and Giemsa staining revealed granulomatous inflammation and macrophage-filled amastigotes, thus confirming the diagnosis of leishmaniasis (Figure 2). The patient was treated



Figure 1 Erythematous bilateral upper lid swelling with overlying yellow crusting lesion.

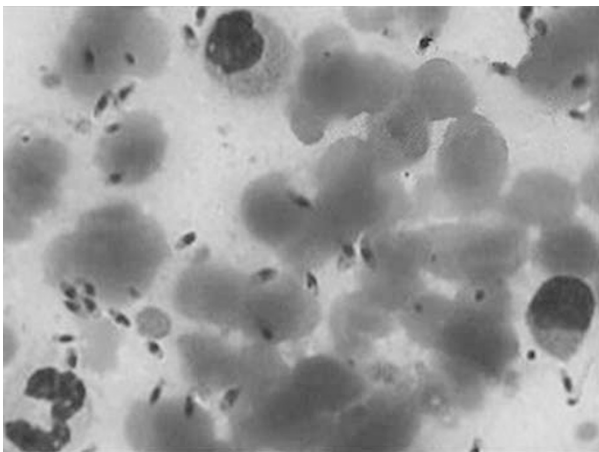


Figure 2 Histopathology showing granulomatous infiltrate and numerous intra- as well as extracellular Leishman bodies (H&E, × 400).

systemically with meglumine antimoniate glucantime. All lesions resolved after 3 weeks of therapy, leaving a minimal nonmarginal scar on each eyelid.

Comment

Leishmaniasis is found in parts of about 88 countries. Approximately 350 million people live in these areas. Most of the affected countries are in the tropics and subtropics. The settings in which leishmaniasis is found range from rain forests in Central and South America to deserts in west Asia. Epidemics frequently occur when a nonimmune population intrudes into a natural enzootic cycle.³

After a bite from an infected sand fly (*Phlebotomus*), an infiltration of plasma cells, lymphocytes, and macrophages produces a localized cutaneous nodule and ulcer with surrounding inflammation. The parasites are sparse in the mature lesion, residing mainly along the lesion's margins. Healing occurs within a few months, with lasting immunity.

The diagnosis of the leishmaniasis is by the detection of amastigotes microscopically or by *in vitro* cultures. Recently, PCR amplification of parasite genes has also been used diagnostically.⁴

Although the infection is self-limited in most immunocompetent patients, curative treatment of leishmanial diseases involves systemic or local use of pentavalent antimony compounds and aromatic diamidines. Systemic monotherapy with IFN- γ may also be effective in complicated cases.⁵

In summary, we present an unusual case of bilateral eyelid leishmaniasis masquerading as chalazia. Ophthalmologists should include cutaneous leishmaniasis in the differential diagnosis of patients suffering from chronic granulomatous lid lesions in areas where this parasite is endemic.

References

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