

COMMENT: DISTINGUISHING POST-KALA-AZAR DERMAL LEISHMANIASIS FROM LEPROSY: EXPERIENCE IN THE SUDAN

Sir,

I write with reference to the above article *Lepr Rev*, 1993; **64**, 53, on methods to distinguish lepromatous leprosy (LL) from post-kala-azar dermal leishmaniasis (PKDL).

Between 11 January and 14 April 1993 I worked in the Dharbhanga District of Bihar. The work was called 'cleaning of records operation'. We came across many cases of PKDL. In the beginning some were mistaken for lepromatous leprosy because we had no previous experience of PKDL. However, it is easy to distinguish PKDL from lepromatous leprosy for the following important reasons:

- 1 non-involvement of nerves;
- 2 non-involvement of mucosa of the upper nose and throat;
- 3 non-involvement of eye and testes in PKDL; and
- 4 skin-smear negativity.

The lesions also dramatically improve after starting treatment with sodium slibanate. (I have seen a patient who improved after only 1 week's treatment. The skin lesions in PKDL can be macules, maculopapular, and nodular lesions.)

Eyebrows are not lost, ears may not be involved—no prominence of the great auricular nerve will be present.

These patients had suffered from Kalazar for between 1 and 5 years and had not received a complete course of treatment. L.D. bodies could not be demonstrated in skin smears or from a blood sample. Formaldehyde tests of urine were also negative. However, a splenic biopsy of parasitic forms can confirm diagnosis under field conditions. A course of sodium slibanate as a therapeutic test rapidly clears the lesions.

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