central venous catheter, by using radio-opaque dyes or using radio-opaque catheters, should be mandatory to prevent such complication. Secondly, axillary approach has greater risk as compared to antecubital approach, so should be avoided if possible. Thirdly, never start infusion till the placement of any invasive catheter is confirmed by a radiologist.

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Chronic granulomatous macrocheilitis due to lupoid leishmaniasis

Inflammation of lip with any cause is named as cheilitis, and may arise as a primary disorder of the vermilion zone, it may extend from the nearby skin or less often, from the oral mucosae.²

Cheilitis is usually induced by adverse environmental conditions, eczematous, infections, ultraviolet radiations and drugs. Leishmanial cheilitis has two types. Among the many acute infectious parasitic causes of macrocheilitis and are trichiniasis and leishmaniasis. Chronic inflammation is seen in Miescher's cheilitis. Herpes simplex is a common cause of infective acute cheilitis that must be ruled out. Inoculation of L tropica into the skin of lip may result in a spectrum of clinical manifestations of acute cheilitis to chronic lupoid type. The acute cheilitis may be due to acute cutaneous leishmaniasis in small self healing lesions and the chronic lupoid type may be due to self regressing lymphadenopathy to complete visceralization. The mechanisms underlying the various tissue tropisms displayed by tropica remain a mystery and we are unable to explain why infection with the leishman organisms resulted in simple adenopathy in Shiraz (a province of Iran) outbreak.¹

A 32 year old Iranian Caucasian man is referred to central clinic of dermatology in Kerman, a province of Iran, due to chronic swelling of lips from 5 years ago. He gave a history of acute cutaneous leishmaniasis in his chin from 8 years ago, that has been improved during the first 2 years. He was free of skin lesion for the next year, but after this time his lower lip had been inflammed and tumifacted gradually so that severe macrocheilitis and eclabion has appeared (Figure 1). An excision biopsy is carried out for him and the specimen of lip showed organised structures such as granulomatous cheilitis with a rare number of leishman bodies found. Five intralesional injections of long acting corticosteroid in combination with pentavalent antimony (Pentostam) (R) has been administered weekly.

Tumefaction of lower lip reduced gradually after 3 months of this therapy (Figure 2). Nodular lupoid lesions had appeared after 6 months. Twice direct smear and a culture of needle discharge of some nodules in Nicolle Novy-MacNeal (NNN) medium was positive for leptomonad parasite.

Discussion. The essential clinical feature of granulomatous cheilitis in this case is swelling of lips (more in lower lip) one year after healing of acute cutaneous leishmaniasis on his chin. Almost 8 years ago, the diagnosis had been approved by direct smear examination of mid chin lesion. In early phases of any cheilitis the clinical differential diagnosis with angioedema and Melkerson Rosenthal syndrome are considered especially in the absence of either tongue involvement or facial palsy.³ Persistent chronic swelling of the lips, especially one year after completely healing of cutaneous leishmaniasis, should lead us to leishmanial cheilitis rather than other unknown causes of chronic granulomatous cheilitis Kerman is a province of Iran and is an endemic area for Leishmania tropica. Many clinical types of cutaneous and lymphatic leishmaniasis have been seen and reported in this area.¹ Sometimes the diagnosis of chronic type can be achieved only by
seeing the leishman body organisms in the pathological specimen but when it is impossible to see the organism, it will be very difficult to distinguish the cause of chronic cheilitis. Although chronic cheilitis following South American cutaneous leishmaniasis have been seen, we can conclude that the leishmania tropica can be added to agents that can cause chronic granulomatous cheilitis. It seems that *L. tropica* infection in humans may result in a spectrum of clinical manifestations ranging from small, self-healing cutaneous lesions to chronic lupoid form, and from self-regressing lymphadenopathy to complete visceralization. Injection must be repeated weekly and continued every 4-6 months once a plateau has been reached. In this case therapy with five intralesional injection of long acting corticosteroid 10 mg and pentavalent antimony 400 mg was carried out weekly. The response was comparatively good so that the tumefaction of lower lip decreased after 5 injections nearly to normal size at first, but sparse nodular lupoid lesions have appeared above the chin and around the lips. Antimonial injections with or corticosteroid have been repeated every two months and continued once every 4-6 months to maintain the

Figure 1a - Before treatment

lesions in a plateau position.

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