Visceral Leishmaniasis in an English Girl

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(for R P K Coe MD FRCP and P D Roberts MD)
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Miss S W, aged 17

History: The patient presented in July 1968 with a 5-week history of lethargy and night sweats associated with a swinging fever of 99–102°F (37–39°C). She had lost 14 lb (6.3 kg) in weight.

She had stayed for six weeks in Ceylon from July to September 1967. During this time she was bitten by insects and her legs became swollen. She had flown to Colombo via Rome, Cairo and Bahrain and returned via Bombay and Teheran. No stop was for longer than 50 minutes.

On examination: Pale but looking relatively well. Spleen palpable 3 cm below costal margin, liver impalpable.

Investigations: Hb 11.4 g/100 ml. WBC 3100/mm^3 (neutros. 41%, eosinos. 1%, lymphos. 52%, monos. 6%). Platelets 75 000/mm^3. ESR 65 mm in first hour (Westergren). Chest X-ray normal. Formolgel test positive. Serum proteins: total 7.39 g/100 ml – albumin 3.29, globulin 4.10 g/100 ml. Electrophoresis: increased α_1, β_2 split. Bone marrow: Leishman-Donovan bodies, reduced granulocyte precursors, iron distribution compatible with depressed erythropoiesis.

Treatment and further management: Ten doses of sodium stibogluconate (Pentostam) 0.6 mg daily were given by i.v. injection. No side-effects were observed. Her fever subsided after 48 hours and she became completely apyrexial from the tenth day of treatment. The hæmoglobin rose to 12.2 g/100 ml with a reticulocytosis of 15.8% and platelets increased to 132 000/mm^3. She was discharged from hospital and was requested to keep a temperature chart. Two months after therapy she again became feverish and the pancytopenia recurred. A 25-day course of sodium stibogluconate was given and the pyrexia settled to normal by the thirteenth day. She has had no further recurrence and remains well.

Comment

Our particular interest was in where the patient had contracted the disease. Kala azar has not been reported in the native population of Ceylon who have never left the island. We knew that our patient had been bitten in Ceylon and felt it unlikely that she had been bitten during her short transit stops en route. However, the fact that she relapsed after the initial 10-day course of sodium stibogluconate suggests that she had acquired the Mediterranean or Sudanese strain which tends to be more resistant to therapy and requires longer treatment.

Sir Robert Drew said that it was just possible that this patient had acquired her infection in Ceylon but it was perhaps more likely that she had been bitten by infected sandflies at airports when her plane landed in the Middle East on her way to and from Ceylon.

Rheumatoid Laryngitis

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Mr G W, aged 66

History: 1953: right-sided 'pleurisy'. 1958: onset of pain in both shoulders, worse on exercise. 1959: thyrotoxicosis; no sign of arthropathy or chest disease. Treated with radioiodine. Following chest pain in September 1965 he was investigated at Harefield Hospital for paralysed left diaphragm; no cause was found.

March 1966: He presented to the Rheumatology Department with a six-month history of swelling and pain in the right knee and right ankle and pain in the chest. There was a four-month history of painful swollen hands, relieved by prednisolone 10 mg daily. He was receiving treatment with thyroxine 0.2 mg daily following the onset of hypothyroidism. Treatment with aspirin and reduction of prednisolone produced a good response but he has required intermittent low doses of prednisolone since.

Since 1965 he has suffered attacks of shortness of breath with production of small quantities of mucoid sputum about once yearly but between attacks has no respiratory symptoms.

July 1972: He complained of hoarseness, present for two months, not relieved by antibiotics. He was referred for laryngoscopy when a benign polyp was removed from the right vocal cord. Postoperative progress was satisfactory.

Present condition: He remains working as a self-employed builder and decorator. There is moderate pain and swelling of hands and feet but other joints are asymptomatic at the moment. Respiratory function tests show forced expiratory volume in one second/vital capacity 1.55/1.65 and peak flow 300 litres/min, compatible with the clinical diagnosis of subacute fibrosing alveolitis

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