Non-Fatal Leishmaniasis in a Renal Transplant Recipient

S.		Lamas
L.		Orte
F.		Parras
J.G.	García	Laraña
R.		Matesanz
J.		Ortuño

Department of Nephrology, Hospital Ramón y Cajal, Madrid, Spain

S. Lamas, Department of Nephrology, Hospital Ramón y Cajal, Carretera de Colmenar, Km. 9,100, E-28034 Madrid (Spain)

Dear Sir,

Infection is the main cause of serious morbidity and mortality in the renal transplant recipient, as a result of immunosuppressive therapy. Among infections, proto-zoa and parasitic ones have been reported, though they are not the most prevalent [1]. Leishmaniasis and, in particular, kala-azar have been only occasionally described [2–4], and the course of these cases has been always fatal. We describe a case of kala-azar in a renal transplant recipient who experienced a good outcome after treatment.

A 23-year-old man received a renal transplant on March 1985. Four years before, diagnosis of systemic lupus erythematosus was made and the patient had been on hemodialysis treatment for six months. After transplantation he recovered good renal function – serum creatinine 1.4 mg/dl – and the postoperative course was complicated by a urinary fistula and two episodes of acute rejection which were controlled with intravenously administered 6-methylprednisolone (total dose 3.5 g). Basal immunosuppression consisted of 150 mg/day of azathioprine and prednisone which was tapered to 20 mg/day at the 3rd month. Five months after transplantation the patient developed fever, malaise, and intense fatigue. Leucopenia and splenomegaly were detected. Bone marrow examination showed invasion by Leishman-Donovan ovoid bodies evidencing visceral leishmaniasis. Indirect serology for Leishmania donovani was positive with a 1/20 titre. No recent travels could be elicited in the history, and a serological analysis of the patient's dog was negative. The patient was treated with an anti-monial compound (Glucantime 100 mg/kg/day i.m.) during two 10-day cycles. Bone marrow examination performed 1 month later showed disappearance of the parasite, the patient being dismissed in an excellent clinical condition.

Spain is one of the countries where kala-azar is still endemic [5]. The area of Madrid province is one of the most affected, and the infection is mainly prevalent among children [6]. The period of incubation is so variable that any speculation seems out of order. In the literature available to us, 1 case from Australia, 1 from Belgium, and 1 from our country suffered post-transplant kala-azar, all of them complicated with fatal infection which led to death [2–4]. The immune response during the amastigote phase has been mainly related with cell immunity, being the active phase of the illness, a situation where cellular responses are depressed [7]. Probably both the systemic illness

of our patient (systemic lupus erythematosus) and the immunosuppressive therapy were high-risk factors for developing the disease. However, early recognition and treatment, as fortunately happened in our case, may be lifesaving in these patients.

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