Correspondence

Smouldering focus of kala-azar in Assam

Sir,

Kala-azar, transmitted by sandflies was endemic in Assam until 1950, with three major epidemics between 1875 and 19501,2. Intensive insecticide spraying as part of National Malaria Eradication Programme eliminated the disease from Assam by mid 1950s, except for isolated case reports upto 19853. We recently diagnosed kala-azar in an adult male aged 43 years from Guwahati city, Assam, who was misdiagnosed as haemolytic anaemia. He presented with fever and epistaxis since last 10 months. On examination, he had pallor, splenomegaly (15 cm below left costal margin) and hepatomegaly (3 cm below right costal margin). Laboratory investigations revealed pancytopenia (haemoglobin 6.4 g/dl, total leucocyte count 1600/mm³, platelets 1,00,000/mm³), hypergammaglobulinaemia (total serum proteins 11.7 g/dl, albumin 2.9 g/dl and globulins 8.8 g/dl) and normal liver and renal function tests. A bone marrow aspiration done to rule out malignancy, showed 1-10 amastigotes of Leishmania on Giemsa staining. ELISA for Leishmania antibodies (Ridascreen, Dolivstr, Germany), aldehyde test and immunochromatographic test for rK39 antibodies (Kala-azar Detect, InBios international, USA) were also found to be positive. He was administered sodium stibogluconate at a dose of 20 mg/kg for 28 days and made a complete recovery. This could be the first documented indigenous case of kala-azar from Assam after 20 years. The source of infection could only be hypothesized. The patient had never travelled out of Assam and had never received blood transfusion. Animal reservoir could be excluded based on epidemiological grounds4. Therefore, infected sandfly could have transmitted the infection from carriers or cases of post kala-azar dermal leishmaniasis (PKDL), locally present or from endemic areas through migrant workers5,6.

This new case of kala-azar from Assam may imply a smouldering focus of this disease in the region. Though the majority of population in the state would be susceptible to kala-azar, an outbreak may not be impending because a large vector population is needed to maintain transmission cycle, the build up of which is difficult as seen in Assam1,7. Isolation and residual spraying can be implemented to contain focal outbreaks in such isolated pockets of the disease in our country1,8. Physicians should be sensitized to the occurrence of indigenous and isolated cases of kala-azar having characteristic clinical and laboratory profiles including a positive rK-39 antibody test.

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