ALA-AZAR (LEISHMANIASIS)

Last issue of JAPI has covered new breakthrough in the treatment of Leishmaniasis. It is time to ponder a bit on the history of Kala-azar through philately.

In India, Kala-azar was recognized as a disease entity for a long time. Several epidemics occurred in Assam, the worst being in 1875. In that province, both malaria and ankylostomiasis were widely prevalent, and Kala-azar used to be confused with both these diseases for a long time. Rogers (1897) and Ronald Ross (1899) considered kala-azar to be a severe form of malaria.

The real cause of the disease was established when William Boog Leishman (1865-1926) in 1900 found the parasite in the necropsy material of the splenic smear, of a soldier who died in England from Dum-Dum fever contracted at Calcutta. Leishman thought it to be a degenerative stage of a trypanosome. He delayed the publication until May 1903. The same year Charles Donovan in July reported a similar organism from the splenic puncture on an Indian boy with Kala-azar in Madras independently. Leishman was forced to share his discovery with Donovan, hence the name LD bodies. In 1903 Ronald Ross suggested that the parasite should be included under the genus Leishmania. It was Rogers, who succeeded in cultivating the organism and obtained the flagellate form of the parasite.

In 1942, CS Swaminathan along with HE Shortt and Anderson reported successful transmission of Indian Kala-azar to man by the bite of Phlebotomus argentipes, showing it to be the vector of Leishmania.

The Brazilian stamp above shows beautifully the amastigote form of LD body with details along with Gaspar Oliveira Vianna (1885-1914) who first showed the destructive effect of antimony (tartar emetic) in cases of Leishmanial ulcers on the face and nasal mucosa caused by Leishmania brasiliences (South American Leishmaniasis). His preliminary announcement on this form of treatment was made in 1912. In India Rogers and Brahmachari later introduced sodium antimony tartarate, which was used most extensively. Sodium stibogluconate was introduced in 1939. Over the years pentamidine, meglumine antimoniate, amphoteracin B and its targeted delivery have all been added to the therapeutic armamentarium. We have to evaluate the promising oral miltefosine (hexadecyl phosphocholine), now introduced in the market with cautious optimism.