A 27 year old Hindu male, resident of district Barmer, Rajasthan, presented with multiple, diffuse, brownish, non umbilicated, papulonodular, non itchy, swellings of size 2 - 22 mm all over the body for last seven months. Swellings first appeared on the trunk, then on face (Fig. 1) and other part of the body and lastly on buccal mucosa and tongue (Fig. 2). He was a known People Living with HIV and AIDS (PLHA) taking ART for last one and half years with CD4 count of 224. There was no history of fever, cough, shortness of breath and weight loss. There was no hepatosplenomegaly and lymphadenopathy. Examination of other systems revealed no abnormality. Routine blood investigation including CBC, blood chemistry was also normal. Smear Biopsy of the skin lesion showed multiple amastigotes of *Leishmania tropica* intracellularly chiefly in dermal macrophages with lymphocytic infiltration (Fig. 3). With these findings the patient was diagnosed as a case of diffuse mucocutaneous leishmaniasis with HIV. He was treated with intravenous Amphotericin B for two weeks, patient started improving and the lesions started drying with crust formation. He was discharged on Fluconazole 400 mg per day for eight weeks.

Cutaneous leishmaniasis (CL) is caused by a protozoan genus Leishmania, which is transmitted by the bite of an infected female sand fly belonging to genus Phlebotomus and Lutzomyia and occasionally by nonsterile needles among intravenous drug users. Species of leishmania involved for CL includes *L. major*, *L. tropica* and *L. aethiopica* (L tropical complex). Diffuse cutaneous leishmaniasis (DCL) is a rare anergic variant of leishmanial infection with the characteristic presentation of numerous non ulcerating nodules with an abundant parasite load, lack of visceral involvement, negative reaction to the leishmanin skin test, and a chronic course with incomplete response to treatment and frequent relapses.1

There are about 1.5 million cases of CL each year, of which 90% occurs in seven countries namely Afghanistan, Algeria, Brazil, Iran, Peru, Saudi Arabia and Syria. CL often occurs in specific pockets. Though India is nonendemic for CL still indigenous cases are confined to some specific pockets in the dry northwestern half of the indo-gangetic plane including dry areas bordering Pakistan from Amritsar to Gujarat and a few cases have been reported from Delhi and Varanasi. Few sporadic CL cases not associated with HIV infection have been reported in past from Rajasthan i.e. Hanumangarh, Bikaner and Ajmer district.2 Leishmaniasis is an emerging disease in HIV-infected persons. We report this case of diffuse mucocutaneous leishmaniasis in a HIV infected patient as a new emergence of this disease in the desert district of Rajasthan. Since the lesions developed after the initiation of ART, this could be a case of DCL that developed in the context of the immune reconstitution inflammatory syndrome (IRIS) in a man of AIDS.3

Diffuse cutaneous forms have a chronic relentless course and are usually refractory to treatment. Conventional parenteral therapy for the cutaneous leishmaniasis are pentavalent antimonial compound (Sb’), Sodium stibogluconate and meglumine antimonate have been used for more than half a century. The alternative parenteral therapy includes, Pentamidine isethionate and Amphotericin –B. Oral Fluconazole, Ketoconazole, Itraconazole and Miltefosine are also useful. Since antimonial compounds were not available with us, we used Injection Amphotericin –B followed by oral Fluconazole.4 Effective treatment requires simultaneous treatment of the two infections.

**References**