ZOO NOTIC AND
PARASITIC DISEASES

PROCEEDINGS OF THE THIRD
INTERNATIONAL AND PAN-ARAB SEMINAR
HELD IN AMMAN, JORDAN,
17–20 OCTOBER, 1989
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ZOONOTIC AND PARASITIC DISEASES

Proceedings of the Third International and Pan-Arab Seminar
held in Amman, Jordan, 17-20 October 1989

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Cutaneous Leishmaniasis in Syria is an endemic disease. It had existed for hundreds of years and was known with its famous name "Aleppo boil". The old Arab physicians had described similar lesions that would stay a year or more before healing. The British physicians were perhaps first in describing Aleppo boil specifically: Pocock in 1745, Russel brothers in their book "The Natural History of Aleppo" in 1756. It was after 1920 when French and Syrian physicians had conducted studies on "bouton d'Orient". Among the French were Denaeux, Trabaut and Chevalier, and among the Syrian were El-Knani, Koussa and Tarakji.

Geographical Distribution

The geographical distribution of C.L. in Syria was sharply limited to the endemic foci in the North and North-eastern regions of the country. It was after the middle of this century when C.L. in Syria has taken a completely new dimensions. New outbreaks have been encountered in most provinces in the last three decades. A new endemic area in the South (north-east of Damascus) has been detected.

Distribution of C.L. in Syria before 1960 (see Map I): The main endemic areas were: the city of Aleppo, its vicinities, the Euphrates valley and plains of the Euphrates tributaries: El-Balikh and El-Khaboor. Other endemic foci did exist in Idleb and Latakia provinces. Cases of cutaneous leishmaniasis were encountered with the greatest frequency in Aleppo, Deir-azzor, Raqqah and Idlib. No endemic area was existed in Damascus as it has wrongly mentioned in a famous text book.

The New Outbreaks of C.L. in Syria after 1960 (see Map II): New outbreaks of C.L. have been detected after 1960 in most provinces in Syria. Some outbreaks have occurred in a previously endemic areas: as the outbreak of the new city Al-Thourah - previous name Al-Tabkah - on the Euphrate's Dam. Most new inhabitants developed C.L. Other outbreaks have been encountered in Latakia province (rural areas of Gebleh), in Tartus province (Dreikeesh), in Hama nad Idlib.

The outbreak of C.L. in the South of Syria (see Map III): Prior to 1960 no endemic foci were detected in the South (Provinces of Damascus, Der'a and Seweda). However, numerous cases of C.L. were reported yearly and most of these cases were imported from the
endemic areas (mainly in the cotton season) or from abroad. I have recorded numerous cases of C.L. imported from Saudi Arabia in workers after return to their villages in the Kalamoon (north east of Damascus). A new endemic foci in the South is the town of Dumeyr, 40 km east of Damascus city. Other endemic areas are: Nebk, Dier-Attiyeh, Gregeer and Yabrud. Cases of C.L. have been reported in the vicinities of Damascus: Yarmook, Sitt-Zenab, Duma, ... some of these cases were imported from Iraq, Iran and Afghanistan. No proven case of C.L. had occurred in the old city of Damascus.

Factors may be contributed to the new outbreaks of C.L. in Syria

Possible factors that had played a role in the new outbreaks of C.L. in Syria include:

- Pre-existence of animal reservoir and vectors in some rural areas (as in Dumeyr).
- The development of new human settlements and housing in the endemic areas, as the Euphrates Dam and the new city of Al Thorah.
- The development of camps and bases in a previously desert areas.
- The construction of new highways all over the country.
- The large number of C.L. cases imported to a suitable area.
- The poor sanitary facilities in some endemic areas create conditions for spreading the disease.

Remarks and Conclusion

Clinical Remarks: An important clinical feature noted at the onset of the outbreaks is: several members of a family, of different ages, represent all with cutaneous lesions, at the same time. Same feature may be encountered when a whole family moves on to an endemic area.

- Cases of C.L. in the South (see slides) were of the "rural form" L. Major. Lesions were mainly "wet", red, raised and ulcerated. Duration of the lesions was relatively short, and healing took place within 6 months.
- Cases of C.L. from the North (Aleppo, Idlib,..) were more of the "urban form" L. Tropica. Lesions were "dry", slightly ulcerated and some may stay without ulceration. Duration of the lesions was relatively longer (1 year or more).

- All forms of C.L., the acute form (the "wet" and the "dry") and the chronic forms (the lupoid and the recidivans) do exist in Syria (see slides), but NO disseminated cutaneous leishmaniasis has been reported.

Epidemiological Remarks:

- C.L. in the South seems to be Zoonotic. Proven cases were L. Major (Dr. Khiami). The common vector is P. papatasi. Reservoir possibly gerbils?

- C.L. in the North seems to be mainly Anthroponotic. Most cases are typical urban forms for L. Tropica. The vectors are P. papatasi and P. sergenti. Possible reservoirs are infected men, rodents and dogs.

Conclusion

The new outbreaks of C.L. in Syria represent a serious problem and interesting fields for investigation. Further Epidemiological studies and control measures are badly needed.

References


MAP I: Geographical Distribution of Cutaneous Leishmaniasis in (prior to 1960)
MAP II: Geographical Distribution of Cutaneous Leishmaniasis in Syria and the New Outbreaks (after 1960)
MAP III: Geographical Distribution of Cutaneous Leishmaniasis in Syria (prior to 1960)