Subcutaneous Mycosis Linked to Chromoblastomycosis. 
An Unattended Entity, but with a Re-Emerging Trend

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Abstract

Chromoblastomycosis is an infrequently communicated entity, it has a very varied clinical presentation, with an estimated incubation period, but not demonstrated that it goes from weeks to months, with skin lesions that progress slowly to multiple forms. The most frequently affected sites are the extremities, mainly the lower extremities due to the greater possibility of contact with the environment and its vegetation is followed by the upper extremities and less frequently the atrial pavilion and torso. The case of a migrant and farmer male with approximately 1 year of appearance of edema of the right lower limb and progression of lesions of nodular and verrucous patterns from the right leg in the anterior and posterior face, extended ipsilateral thigh in the anterior and posterior 1/3 is presented, in different diameters and stages, in whom a skin biopsy was performed validating direct stains and cultivation of common germs and fungi; with the finding of Medlar corpuscles defining a case of chromoblastomycosis subcutaneous mycosis and guiding treatment with Itraconazole for 1 year with favorable clinical response.

Keywords: Subcutaneous; Chromomycosis; Medlar Corpuscles; Chromoblastomycosis

Introduction

Chromoblastomycosis (chromomycosis) is a deep fungal infection, with a larval and chronic clinical presentation, caused by dematiaceous fungi (due to the microscopic characteristic due to intrinsic pigmentation production) belonging to the Herpotrichiellaceae family of which we have agents such as Fonsecaea spp., Phialophora verrucosa, Cladophialophora carrionii, Exophiala dermatitidis, Rhinocladiella aquaspersa, being the first 3 agents the most frequent isolated agents within this pathology. Fonsecaea spp. and subtypes are the most frequent in America and Asia. It is considered as a disease neglected by WHO/PAHO.

It has been reemerging in recent years due to climatic changes and an increase in the diagnostic arsenal with better yields in microbiological tests.

The incidence of this disease is not elucidated in many countries, possibly due to the lack in the report of this pathology and the low diagnostic suspicion.

The first case recorded in the literature is presented in 1911 by Pedroso and Gomes but was published until 1922 along with 3 other cases in Brazil. In India, a systematic review of 169 cases was carried out from 1957 to 2016 in which they found an increase in the report since 2012 with more than 50% of the cases reported as of the date.

**Case Report**

A 60-year-old male, born in Yolombó, resided in Venezuela in the state of Portuguesa for approximately 40 years ago, 2 months ago he returned to Colombia, worked in coffee/cocoa/banana/avocado agriculture, lived alone, HSM, 2 children aged 10 and 23, widower, toxic former tobacco user (10 years ago), allergies denied, surgical, Deny, Patol. He denies, had been hospitalized for leishmaniasis in 1986 (treated with glucantime), was hospitalized by an official left lower limb accident in 1996.

**Clinical findings**

Weight 55 Kg, fc 70xmin. Presence of nodular/verrucous lesions from the right leg on its anterior and posterior sides extended to the thigh in its anterior 1/3 superior and posterior, in different diameters and stages (the largest of Approximately 5 x 4 cm), violaceous and rosacea, sensibility and conserved pulses.

**Calendar**

It refers to approximately one year of the appearance of nodular and verrucous lesions at the level of the right lower limb, painless, not suppurative, with no apparent entry door. Polyconsultant for this cause with various topical treatments based on clotrimazole, ciprofloxacin and oral fluconazole, with intermittency and without clinical improvement.

**Diagnostic evolution**

DBT immunocompromise and HIV infection with normal HBA1C were ruled out and ELISA HIV negative 4th generation, deep venous thrombosis was also ruled out by venous doppler which revealed right inguinal adenomegalies of 27 x 10 and 24 x 9.5 mm.

Scarification of the skin was performed, validating large with abundant large positive coconuts and subsequent culture to *Staphylococcus aureus* resistant to oxacillin and KOH revealing abundant blastoconidia, with subsequent skin biopsy of the lesion of the right face of the right leg that revealed sclerotic Medlar cells associated with blastoconidia and abundant pseudo-hyphae.

**Therapeutic intervention**

Antibiotic treatment was offered with trimethoprim sulfamethoxazole 160/800 mg vo every 12h for 7 days and Itraconazole 200 mg vo every 12h for 24 weeks.

**Monitoring and results**

It evolved favorably, with good digestive tolerance to the scheme, it did not require surgical measures, favorable clinical response was obtained by being discharged from the medical controls.

**Discussion**

Chromoblastomycosis (chromomycosis) is a deep fungal infection, with a larval and chronic clinical presentation, caused by dematiaceous fungi (due to the microscopic characteristic due to intrinsic pigmentation production) belonging to the *Herpotrichiellaceae* family of which we have agents such as *Fonsecaea* spp., *Phialophora verrucosa*, *Cladophialophora carrioni*, *Exophiala dermatitidis Rhinocladiella aquaspersa*, being the first 3 agents the most frequent isolated agents within this pathology. *Fonsecaea* spp and subtypes are the most frequent in America and Asia [1-7].
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It is considered as a disease neglected by WHO/PAHO and is reemerging in recent years due to climatic changes and an increase in the diagnostic arsenal with better yields in microbiological tests [8,9].

The first case recorded in the literature is presented in 1911 by Pedroso and Gomes but was published until 1922 along with 3 other cases in Brazil [7]. In the following years different cases began to emerge in South America, mainly Venezuela, Peru, Argentina Brazil, Africa (mostly Madagascar), Asia (in China and India most cases) and Oceania, in mainly tropical and subtropical areas between latitudes 30° north and south [1-7].

The incidence of this disease is not elucidated in many countries, possibly due to the lack in the report of this pathology and the low diagnostic suspicion. Some case reports and reviews show near-reality data, suggesting incidents of 1 per 6800 (Madagascar) and 1 per 8625 (United States of America) of the total population of these countries [3]. In other reviews the number of reported cases is observed. In China, more than 500 cases have been reported in a systematic review conducted from 1952 to 2018 [4]. In America, Mexico is one of the countries considered highly endemic with reports up to 2013 of 603 patients with proven chromoblastomycosis. Peru has reported between 10 to 49 cases until 2016, similar to what was seen in Argentina. Venezuela and Brazil have the highest incidence in South America, the latter with the highest case report (872 cases) with an incidence rate of approximately 1 per 196,000 inhabitants [1,2]. In Colombia there are no reviews that can determine the incidence of this disease. In two case reports, mention is made of a series of 10 cases by F. Pedrossoi, in addition to two cases by two different microorganisms (*Rhinocladiella aquaspersa* and *Exophiala psychrophila*) [10,11].

In India a systematic review of 169 cases from the year 1957 to 2016 was carried out in which they find an increase in the report since 2012 with more than 50% of the cases reported as of the date, with an average age of 43.3 years, affecting more men than women with a 4.2: 1 ratio, with a history of previous trauma in 33.8%, 74.1% had agricultural work as a profession and clinically found themselves with greater limb involvement inferior over superior. Additional reported few cases related to immunosuppression (5.9%) [5].

In other case reports, people who are in rural areas, farm workers as farmers, with trauma related to vegetation or organic material are initially characterized as a risk factor [12,13]. In different case reports it is also frequent observe a certain association between infection and some degree of immunosuppression of patients such as diabetes mellitus and more importantly organ transplantation, where the most invasive, aggressive and morbidity and mortality clinical pictures are observed [14-17].

Chromoblastomycosis has a very varied clinical presentation, with an estimated incubation period, but not proven to go from weeks to months, with skin lesions that progress slowly to multiple forms. The most frequently affected sites are the extremities, mainly the lower extremities due to the greater possibility of contact with the environment and its vegetation is followed by the upper extremities and less frequent atrial pavilion and torso [11,18]. The most frequently observed patterns of skin lesion are: nodular, tumor, verrucous, plaque and scar, for this reason, differential diagnoses can be varied such as skin carcinomas, autoimmune lesions, other skin infections, among other diagnoses [2,5,19].

The initial diagnosis is clinical, observing the lesions and by medical history. Biopsy and culture of the lesions with suspected fungal infection should be performed. The biopsy findings are mainly granulomatous infiltrate with different degrees of fibrosis, hyperparakeratosis, intracorneal microbasses and fungal bodies that can be visualized from the biopsy or live with KOH to appreciate the muriform bodies that are pathognomonic for this infection [1,2,7,20]. It may also be useful, although it is still under validation, molecular studies to identify and determine resistance to antifungals [21].

The treatment for chromoblastomycosis does not have a standardized protocol or guide. According to literature reviews, the management is carried out with dual or combined treatment consisting of physical therapies such as cryotherapy, laser therapy to conventional surgery, according to the patient's clinical status and the lesions that are observed by adding itraconazole-type antifungals.
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that would be the first line of treatment, although other azoles may be used depending on the context. The dose is between 200/400 mg a day and the duration according to reports would be between 8 - 12 months with cure rates between 15 - 80%. Terbinafine would be the second handling line also with good tolerance. The combined use of systemic antifungals is considered in patients with refractory systemic mycoses, although triazoles such as posaconazole and voriconazole are being in vitro the new option for any clinical state of chromoblastomycosis due to its spectrum and better pharmacokinetics and dynamics [2,7].

Conclusion

In our experience, the diagnosis was made in a migrant patient in Colombian territory, from which it is inferred that the population exodus affects the public health indicators of the receiving territories. A call is made to standardize the report of superficial, subcutaneous and deep fungal infections in the Colombian territory to have data on the incidence and prevalence of these entities.

In Colombia, more case reports and reviews are required to elucidate the current situation of the country with respect to chromoblastomycosis, determine incidence, morbidity, mortality, sequelae, treatment, efficacy among other aspects that allow health personnel to carry out an adequate approach, a timely diagnosis and a complete and effective treatment.

Annexed

Figure 1: A: Photograph right foot. Verrucous and nodular pattern lesions are visualized in all the extension of the right lower limb. B: Photograph of the side of the right leg. Multilobed verrucous lesion. C: Photograph of the right external malleolus with verrucous lesions of the scaly center due to the transepithelial release of the fungus. Sources patient consent, image bank Latin American Research Team in Infectology and Public Health-ELISAP.

Bibliography


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