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Original Research Paper

Dermatology

SPOROTRICHOID PATTERN: AN INTERESTING CLINICAL ENTITY IN DERMATOLOGY.

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KEYWORDS :

INTRODUCTION

Sporotrichoid pattern is a well-known interesting terminology in dermatological parlance which refers to infections which can be clinically mistaken for lymphocutaneous sporotrichosis. The pattern results in somewhat linearly arranged lesions from the parent lesion ascending upwards along the course of lymphatics. This appearance classically mimicking sporotrichosis can be present in other infections clinically, which may require histopathological confirmation.

Case1

This 40 years old, otherwise healthy male patient presented with history of developing progressive ascending nodular lesions in a sporotrichoid pattern over the left forearm after history of developing a single painless nodular lesion over the wrist. There was no history of frank trauma but patient had manipulated the initial lesion with his nails.

Figure 1: Classical Lymphocutaneous Sporotrichosis With Linearly Arranged Nodular Lesions

Clinically patient was diagnosed as a case of lymphocutaneous sporotrichosis and the same was confirmed histopathologically. The patient responded well to super saturated solution of potassium iodide (SSKI) and lesions resolved with residual post inflammatory hyperpigmentation over next three months.

Case 2

This 27 years old, otherwise healthy male patient presented with history of developing multiple pyodermas over right upper limb over a period of five to seven days ascending proximally from first palmer lesion, in a sporotrichoid pattern. They were associated with crusting and purulent discharge with corresponding lymphadenopathy.

Figure 2: Pyogenic Infection With Crusting And Purulent Discharge In A Sporotrichoid Pattern

There was no frank history of trauma and histopathological or microbiological evaluation could not be done because of patient's economic constraints. Based on short history and clinical evaluation patient was presumptively treated as a case of pyogenic bacterial infection with tab cotrimoxazole ,topical fusidic acid, analgesics and general wound care to which he responded well over next one week.

Case 3

This 47 years old, otherwise healthy male patient presented with history of painless, occasionally itchy developing firm nodular plaque with a verrucous surface over the right lower shin after penetrating trauma in the fields with vegetable matter about one year back. Subsequently patient developed two more plaques of similar morphology in a sporotrichoid pattern.

Figure 3: Verrucous Plaques With Sporotrichoid Pattern In Chromoblastomycosis

Clinically possibility of chromoblastomycosis and tuberculosis verruca cutis was kept and histopathology confirmed chromblastomycosis. Patient was treated with capsule itraconazole for 6 months after which patient showed satisfactory resolution of the lesions.

Case 4

This 27 years old male patient presented with spontaneous onset crusted lesions arranged linearly over the lateral aspect of left hand since past 3-4 weeks.The patient was only concerned for these lesions and could not recall any specific progression pattern of these lesions but on thoroughly asking associated history of sensory motor loss over the ulnar aspect of hand was elicited.

Figure 4: .crusted Lesions With Sporotrichoid Pattern In A Patient Of Hansen's Disease

On thorough clinical evaluation and confirmation on slit skin smear and histopathological examination, the patient was found to be a case of Hansen's disease (Borderline lepromatous pole) and treated accordingly with multidrug therapy and general wound care of these hand lesions to which he responded well.

DISCUSSION

The clinical recognition of a sporotrichoid pattern helps the dermatologist to converge to well recognized infections with this pattern. The individual lesions resemble each other in morphology and may present as ulcers with regional lymphadenopathy or with associated nodules. The most common causes include atypical mycobacterial infections, nocardiosis and pyogenic bacteria. Other causes mainly on basis of local endemicity include leishmaniasis, other dimorphic fungi, tuberculosis, glanders, cat-scratch disease, anthrax, tularemia ,cowpox and rarely leprosy.[1,2] Occasionally some non-infective conditions like lymphomas, Langerhans cell histiocytosis and metastases may present with similar looking pattern.[3] The history, local endemicity ,course of progression, the morphology of individual lesions and knowledge about some rare non infectious conditions with this pattern along with histopathological and microbiological confirmation are essential to confirm the diagnosis from a wide array of differentials of this interesting clinical entity.

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