



CUTANEOUS CHROMOBLASTOMYCOSIS: AN UNCOMMON PRESENTATION

Pathology

Madhumita Mukhopadhyay

Professor, Dept of pathology IPGME & R, Kolkata

Chhanda Das*

Assistant Professor Dept of Pathology IPGME & R, Kolkata *Corresponding Author

Moupali Ghosh

Pgt MD, Dept of Pathology, IPGME & R, Kolkata

Brati

Mukhopadhyay

MBBS Student, Department of Pathology, Kolkata

ABSTRACT

Chromoblastomycosis, is a rare superficial mycoses, is caused by pigmented fungus and having an indolent course, mainly found in tropical and sub tropical regions. Here, we are reporting a case of cutaneous chromoblastomycosis, in a middle aged women in the left leg, presented with non healing ulcer for 6 months duration, unresponsive to treatment.

KEYWORDS

Cutaneous ,Mycoses.

INTRODUCTION:-

Chromoblastomycosis, is an extremely rare superficial mycoses, caused by pigmented fungus and has an indolent course. It is mainly found in tropical and temperate regions. Lower extremities are the most commonly affected areas.^[1] Here we discuss a case of cutaneous chromoblastomycosis, in a middle aged women in the left leg.

CASE REPORT:-

A fifty year old diabetic non hypertensive female patient presented with a non healing ulcer and inflammation in the medial aspect of left leg near the medial malleolus for last six months. (Fig 1) The ulcer is reddish-white gradually increasing in extent with development of granulation tissue and scar around the ulcer. One year back the patient suffered from bullous pemphigoid with blisters throughout the body which was treated and cured. A punch biopsy was done from the lesion which showed pseudoepitheliomatous type of hyperplasia with extent of infiltration reaching till the dermal layer along with infiltration of chronic inflammatory cells, consisting of lymphocytes, macrophages, eosinophils. Few foreign body type of giant cells were also noted. Round to oval shaped brownish thick walled spores suspicious of fungal infection were found in focal areas. Fungal stain (PAS) was done, which showed positivity for the staining. Brownish structures resembling copper-penny bodies were found and a diagnosis of chromoblastomycosis was considered. (Fig 2,3,4) The patient was put on antifungal therapy with Itraconazole and there was healing of the ulcer.

DISCUSSION:-

Chromoblastomycosis is a superficial cutaneous infection, which consists of dark-brown coloured spores, thereby justifying its nomenclature. The most common organisms causing this fungal infection is *Phialophora verrucosa*, *Fonseceaea pedrosoi* and *Cladophialophora carrion*.^[2] It progresses slowly with a long term course. It often gets overdiagnosed, as the course simulates that of a carcinoma.^[3,4] There are only a few case reports found on this superficial dermatophytic infestation. The infection mainly occurs due to inoculation of the fungus in the skin and also as an occupational hazard. It commonly affects the people residing in subtropical and tropical areas. It mainly spreads along the lymphatic channels and very rarely follows a hematogenous route. *Cladosporium trichoides* is the most common causative agent for hematogenous spread.^[5]

The lesion most commonly affects the lower extremities followed by upper extremities neck face vulva penile shaft illeocaecal area larynx, trachea, pleura amongst other rarely found sites.^[5,6,7] In our case the patient presented with a non healing ulcer in the medial aspect of the left foot. The lesion may present as variegated morphological appearance often as pigmented pruritic nodular forms to papular necrotic verrucous forms. Owing to its lymphatic spread it can rarely presents as elephantiasis of the leg.^[8]

The important differential diagnosis includes tuberculosis, leprosy, leishmaniasis, psoriasis, sporotrichosis, verrucous cutis, syphilis and often carcinoma.^[6,7,9] In our case it simulated that of a carcinoma because of its prolonged course. A confirmed diagnosis was based on the histopathology and the special stains (PAS) where dark brown coloured oval to spherical shaped bodies were found resembling copper pennies. Cytology is not that useful in detecting these lesions and is often misdiagnosed with that of a cluster of RBCs due to the resemblance in shape and orangish colour. Septations found in the fungus is characteristic, but is not present in all the cases.^[6] Also there is no specific serological tests available for this lesion.

Earlier surgery was considered to be the treatment of choice for chromoblastomycosis but nowadays treatment with antifungal drugs are more prevalent. Currently to cut short the chemotherapy duration, and for being economically beneficial Itraconazole is given in pulse therapy doses.^[10] Besides surgery the emerging treatments modalities include cryotherapy therapy with laser and thermotherapies.^[11,12] An early recognition of this lesion might lead to an early and cost-effective treatment, and also restricts its progression to epidermoid carcinoma, an extremely rare possibility.^[13]

CONCLUSION:-

Here we take the opportunity to discuss the histological features of a case of chromoblastomycosis in a middle-aged women. Chromoblastomycosis, though unusually found and is rarely fatal, but due to its slowly progressive course it should always be considered in the differentials of patients suffering from long term non healing cutaneous ulcers.



Fig 1 Pic showing nonhealing ulcer of leg

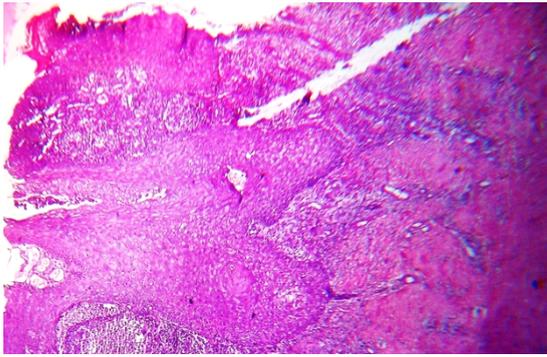


Fig 2 H&E stain shows pseudoepitheliomatous epidermal hyperplasia with microabscess formation and mixed inflammatory infiltrate x100

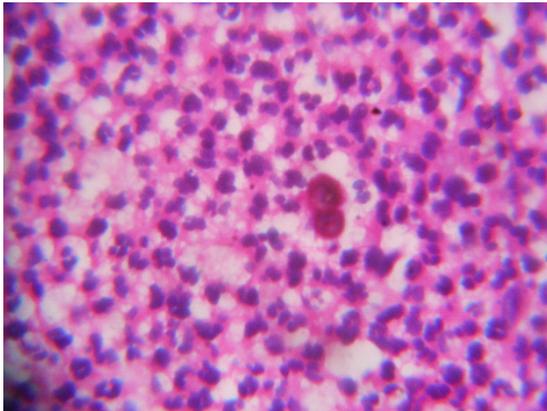


Fig 3 Pigmented spores resembling copper pennies are surrounded by a neutrophilic PAS X400

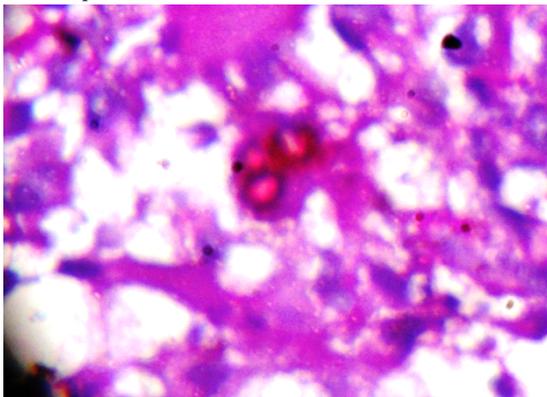


Fig 4 :PAS stain showing copper penny appearance of organism

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