Atypical chromoblastomycosis presented as generalized eczema-like lesions

CASE REPORT

ORIGINAL ARTICLE BY

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PRESENTATION OF THE CASE

A 65-year-old gardener came to the hospital with pruritic, erythematous indurated plaques and patches on his face, trunk, and scrotum for 1 year. He was treated with topical corticosteroid for eczema before the consultation. A skin examination showed ill-defined erythematous pruritic patches and plaques with scattered scales and small areas of brownish-black dots on the chest and both axilla. Similar lesions were seen on the scrotum, but no brownish dots were noted (Figures 1). Other symptoms were unremarkable.

Table 1: Direct examination under 40x microscopy: Brownish, coin-like yeasts (sclerotic bodies).

Differential diagnosis		
Disease	**Accessible issues**	**Inaccessible issues**
Atypical chromoblastomycosis presented with generalized eczema-like lesions	Lesions with black dots Staining from lesions found sclerotic bodies Non-responsive lesions to steroids Culture for fungi found Cladosporium spp.	Due to the number of lesions are greater than in classical cases.
Eczema	Itching at the lesional areas The distribution of the rash could be generalized	Non-responsive lesions to steroids. Despite the positions of lesions should respond well to it.
Scabies	The position of the disease is compatible with scabies.	Lesions with black dots Staining from lesions found sclerotic bodies
Dermatophytosis	Itching which is found in patients with dermatophyte infection.	Characteristics of lesions without circular characteristics Lesions with black dots Staining from lesions found sclerotic bodies

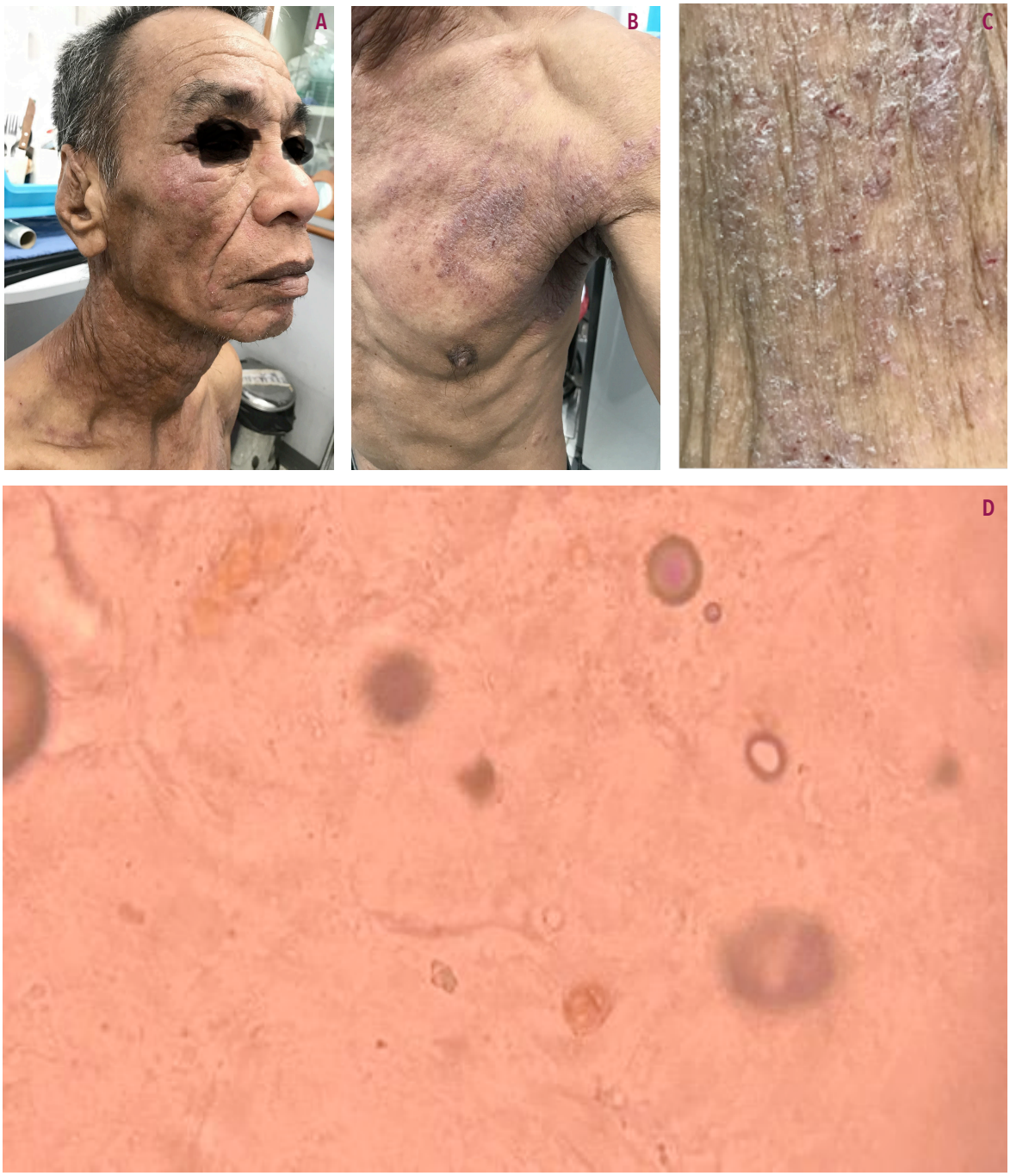


Figure 1.Eczematous-like eruptions
Panel A, a lesion on the face; Panel B, a lesion on the chest; Panel C, a scrotal lesion; Panel D, brownish dots from direct examination under a microscope from the scaly area on the chest



Figures 2: Improvement of all lesions after 5 months treatment with oral itraconazole 100 mg daily
Panel A, the subsided lesions on the face; Panel B, the subsided lesion on the chest; Panel C, the subsided scrotal lesion.

Direct skin examination under a microscope showed brownish, coin-shaped, sclerotic bodies. *Cladosporium spp*. was identified from a specimen culture. The blood biochemistry results were unremarkable.

CLINICAL DIAGNOSIS

Eczema with id eruption as the first visit. Laboratory data above aiding in forming the definite diagnosis as atypical chromoblastomycosis (CMB) presented as generalized eczema-like lesions later due to atypical presentations.

TREATMENT & DISCUSSION

The diagnosis of CMB was made based on the clinical presentation and mycologic confirmation. An oral itraconazole 100 mg once the daily dosage was initiated. Skin lesions improved after 4 weeks and cleared after 5 months (Figures 2). Mild itching persisted at the scrotal area but a KOH scraping was negative for evidence of fungus. CMB is a chronic fungal infection of the skin and subcutaneous tissue caused by a skin-to-skin fungal infection of a specific fungal group that occurs in tropical and subtropical areas around the world.[1]

Most cases affect the legs, especially the feet that are exposed to infected material. Palms, arms and buttocks are frequently infected while ear, cornea, neck, face, breast, chest and stomach are sporadically reported in the literature.

The disease can be presented clinically in 5 different forms: nodular, tumoral, verrucous, plaque and cicatricial. Our patient may be classified as plaque type. Normally, the pathogen for CMB is usually caused by *Fonsecaea pedrosoi*, *Phialophora verrucosa, Cladophialophora carrionii.* [2] Punkae Mahaisavariya et al, presented that CMB was caused by *C. carrionii and F. compactum* and responded well with itraconazole orally.[3]

The choice of treatment methods and the success of treatment depends on the etiological organism, size, extent, and location of the lesion. Bonifaz et al. analyzed 52 cases showing that itraconazole therapy can be applied for extensive lesions.[2] Mild and moderate forms may be successfully cured after 6–12 months. After the termination of therapy relapses are frequent, presumably because itraconazole is fungistatic. In the case of generalized CMB, as with this patient, the treatment is expected to be prolonged and have possible recurrences.[2,4]

There has been no report of patients with widespread eczematous-like rashes with neither the specific disease nor systemic symptoms as in this patient [5,6]. The diagnosis requires experienced clinical observation. The patient's profession may have relevance to the source of the infection.

CONCLUSION OF THE CASE

This is a rare atypical case report of CMB presented as generalized eczema-liked lesions without systemic symptoms. The detection of sclerotic bodies on the lesions helped lead to the diagnosis. Treatment with oral itraconazole was effective. Neither complications nor recurrences were found.

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