Molluscum-like lesions in a patient with sporotrichosis *

Lesões molusco-símiles em paciente com esporotricose

Regina Casz Schechtman[1]
Mercedes Prates Pockstaller[3]
Leonardo Pereira Quintella[5]
Giselly Silva Neto De Crignis[2]
Luna Azulay-Abulafia[4]
Márcia Belo[6]

Abstract: Sporotrichosis is a subcutaneous fungal infection caused by *Sporothrix schenckii* and acquired by direct inoculation. Although the majority of cases consist of the classic lymphocutaneous presentation, the frequency of atypical and severe clinical forms of the disease has increased progressively. Systemic and disseminated cutaneous sporotrichosis constitute rare variants and such cases are generally associated with cellular immunodeficiency or debilitated states. The present paper describes the first published case of molluscum-like lesions in disseminated mucocutaneous sporotrichosis. Direct mycological examination and histopathology revealed numerous yeast cells.
Keywords: Itraconazole; Mycoses; Molluscum contagiosum; Sporotrichosis

Resumo: Esporotricose é uma infecção fúngica subcutânea, adquirida por inoculação direta, causada pelo *Sporothrix schenckii*. Embora a apresentação clássica linfocutânea represente a maioria dos casos, as formas clínicas atípicas e graves têm aumentado em ocorrência. Esporotricose sistêmica e esporotricose cutânea disseminada são variantes raras, usualmente associadas à imunodeficiência celular ou a estados debilitantes. Relatamos o primeiro caso na literatura de lesões molusco-símiles em esporotricose cutaneomucosa múltipla. Os exames micológico direto e histopatológico apresentavam-se ricos em células leveduriformes.
Palavras-chave: Esporotricose; Itraconazol; Micoses; Molusco contagioso

The increased incidence of sporotrichosis in Brazil has led to a rise in the number of cases involving unusual sites, lesions that are morphologically different from the classic types, and to generalization and systematization of the involvement of *Sporothrix schenckii*. [1-4] This report describes a 52-year old male patient with a history of alcoholic hepatopathy. He reported myalgia, nighttime fever and sweating over the previous three months, as well as a weight loss of 23 kilos. Thirty days previously, he noted an erythematous papule on his left thigh that subsequently ulcerated, with rapid dissemination of lesions to the rest of his body. Dermatological examination revealed papules, nodules and ulcerations with honey-colored crusts and raised borders over his entire body (Figure 1). Molluscum-like lesions were found on his face and cervical region, sialorrhea and ulcerations on the tonsillar pillars and nasal mucosa (Figure 2). Direct mycological examination showed numerous yeast cells. Histopathology showed chronic granulomatous der-

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[1] PhD in Dermatology awarded by the London University. Coordinator of the Postgraduate Program in Dermatology and Head of the Micology Department, Prof. Rubem David Azulay Institute of Dermatology, Santa Casa de Misericórdia do Rio de Janeiro, Rio de Janeiro, RJ, Brazil.
[2] MD, specialist in internal medicine. Postgraduate student, Prof. Rubem David Azulay Institute of Dermatology, Santa Casa de Misericórdia do Rio de Janeiro, Rio de Janeiro, RJ, Brazil.
[3] Master's degree in Dermatology awarded by the Federal University of Rio de Janeiro. Assistant Professor, Prof. Rubem David Azulay Institute of Dermatology, Santa Casa de Misericórdia do Rio de Janeiro, Rio de Janeiro, RJ, Brazil.
[4] PhD in Dermatology awarded by the Federal University of Rio de Janeiro. Adjunct Professor, State University of Rio de Janeiro and the Postgraduate Program of the Prof. Rubem David Azulay Institute of Dermatology, Santa Casa de Misericórdia do Rio de Janeiro, Rio de Janeiro, RJ, Brazil.
[5] Master's degree in Anatomopathology awarded by the Federal University of Rio de Janeiro. Pathologist, Clementino Fraga Filho Teaching Hospital, Federal University of Rio de Janeiro and the Prof. Rubem David Azulay Institute of Dermatology, Santa Casa de Misericórdia do Rio de Janeiro, Rio de Janeiro, RJ, Brazil.
[6] Master's degree in Internal Medicine awarded by the Federal University of Rio de Janeiro. Assistant Professor of Internal Medicine, Gama Filho University and the Souza Marques Foundation for Technical Education, Rio de Janeiro, RJ, Brazil.

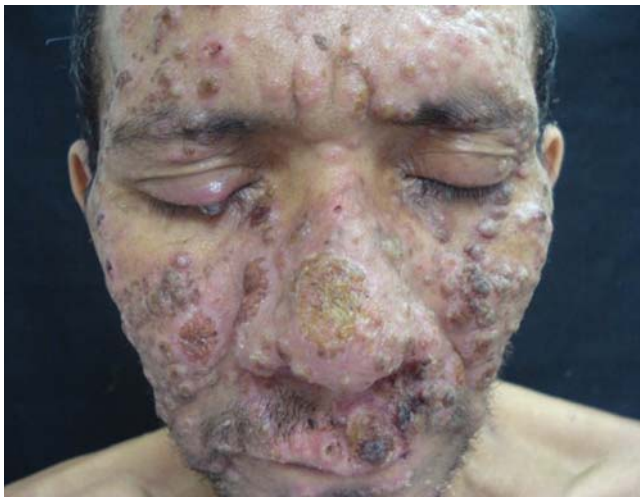

Figure 1: Disseminated cutaneous sporotrichosis. Patient presenting papules, pustules with honey-colored crusts, nodules and ulcerations all over his face

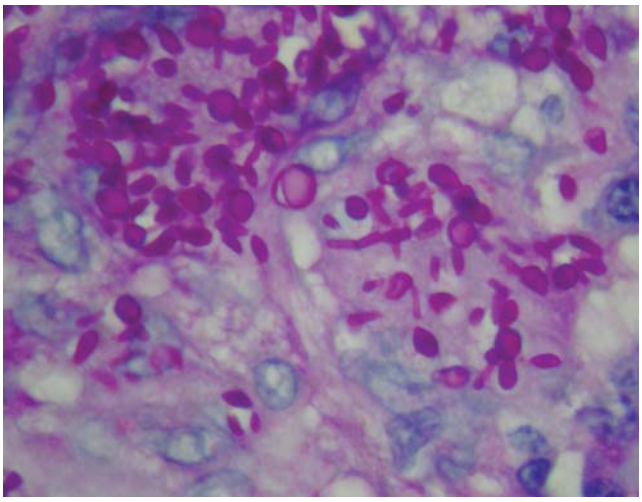

Figure 3: Histopathology of skin in a PAS stained section showing numerous oval, cigar-shaped spores

matitis and numerous cigar-shaped and club-shaped forms (Figures 3 and 4). *Sporothrix schenckii* was identified in the culture of a skin fragment and in the nasal mucosa, while micromorphology showed pyriform microconidia arranged in flower-like clusters. Serology for human immunodeficiency virus (HIV), hepatitis B and C and VDRL were negative. Laboratory investigation showed no evidence of systemic involvement and the findings were compatible with disseminated mucocutaneous sporotrichosis. [5-8] Treatment was initiated with amphotericin B for 10 days but was discontinued due to refractory hypokalemia. Treatment was then initiated with itraconazole 400 mg/day for 40 days; however, recrudescence of the condition occurred and amphotericin B was reinstated for another 10 days; nevertheless, the patient died. This is the first case described in the literature of sporotrichosis with molluscum-like lesions. [9] ❑

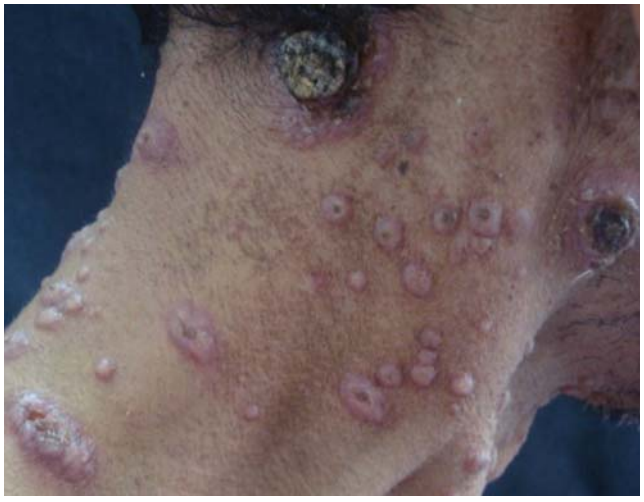

Figure 2: Molluscum-like lesions. Umbilicated lesions characterized as molluscum-like in the cervical region

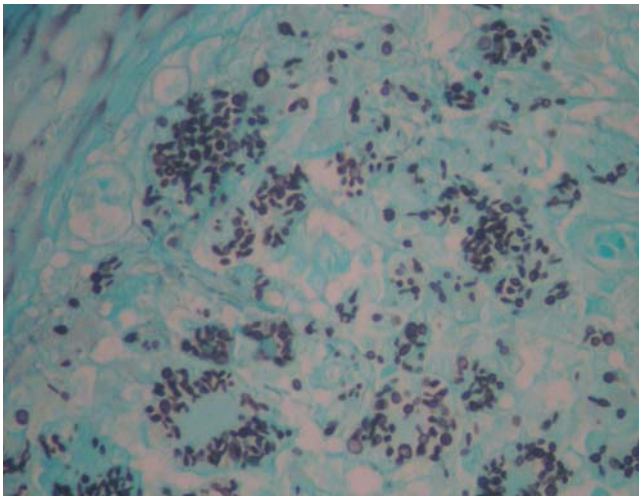

Figure 4: Histopathology of a skin lesion showing club-shaped conidia (Grocott silver stain)

REFERENCES

1. Lopes-Bezerra LM, Schubach A, Costa RO. Sporothrix schenckii and Sporotrichosis. An Acad Bras Cienc. 2006;78:293- 308.
2. Ramos-e-Silva M, Vasconcelos C, Carneiro S, Cestari T. Sporotrichosis. Clin Dermatol. 2007;25:181-7.
3. Schechtman RC. Sporothrichosis: part I. Skinmed. 2010;8:216-20.
4. Schechtman RC. Sporothrichosis: part II. Skinmed. 2010;8:275-80.
5. Schamroth JM, Grieve TP, Kellen P. Disseminated sporotrichosis. Int J Dermatol. 1988;27:28-30.
6. Edwards C, Reuther III BWL, Greer DL. Disseminated osteoarticular sporotrichosis: treatment in a pacient with acquired imunodeficiency syndrome. South Med J. 2000;93:803- 6.
7. Pereira JCB, Grijó A, Pereira RRM, Oliveira ANS, Andrade AC, Ferreira ACM, et al. Esporotricose disseminada- Caso clínico e discussão. Rev Port Pneumol. 2008;14: 443- 9.
8. Neto RJP, Machado AA, Castro G, Quaglio ASS, Martinez R. Esporotricose cutânea disseminada como manifestação inicial da síndrome da imunodefiência adquirida- relato de caso. Rev Soc Bras Med Trop. 1999;32:57-61.
9. Kauffman CA, Bustamante B, Chapman SW, Pappas PG; Infectious diseases society of America. Clinical practice guidelines for the management of sporotrichosis: 2007 update by the Infectious Diseases Society of America. Clin Infect Dis. 2007;45:1255- 65.

MAILING ADDRESS / ENDEREÇO PARA CORRESPONDÊNCIA:
Regina Casz Schechtman
Rua Vonluntários da Pátria, 435 / 5º andar, Botafogo
22270-000 Rio de Janeiro, RJ, Brazil
Telefones: +55 (21) 2527-2103
E-mail: regina.schechtman@gmail.com

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