

Case for diagnosis^{*}

Caso para diagnóstico^{}*

Leonardo Mello Ferreira¹
Lucia Martins Diniz³

Rodrigo Negri Pereira²
João Basilio de Souza Filho⁴

HISTORY OF THE DISEASE

Forty-year-old male patient, rural worker, living in the rural area of Afonso Cláudio, ES.

Sought the dermatology department due to joint pain and paresthesias in extremities, besides a lesion in the left lower limb, with four months of evolution, and a few inflammatory episodes. In his past medical history there was a multibacillary multidrug therapy for dimorphic Hansen's disease during 12 months, having been discharged in 2001. Since then, he had episodes of types I and II hansenic reaction. In order to treat them, he made continuous use of thalidomide and prednisone, with or without medical follow-up, and, currently, of 20 mg oral prednisone.

Upon dermatological examination, a yellowish nodular-cystic lesion with some crusts was found, surrounded by a brownish-erythematous halo, on the inner surface of the left leg (Figure 1).

An aspiration of the lesion content was carried out, with a yellowish secretion that underwent direct mycological examination with 20% KOH, in which dematiaceous and septated hyphae were observed (Figure 2).

Surgical exeresis with grafting was programmed, and a steroid withdrawal scheme was initiated, with control of hansenic neuropathy.



FIGURE 1: Solitary yellowish nodular-cystic lesion with some crusts, surrounded by a brownish-erythematous halo, on the left leg



FIGURE 2: Direct mycological examination (KOH 20% 10X): dematiaceous, septated and branched hyphae

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Conflict of interest: None

¹ Post-Graduate student at the Department of Dermatology of EMESCAM - Vitória (ES), Brazil.

² Post-Graduate student at the Department of Dermatology of EMESCAM - Vitória (ES), Brazil.

³ Assistant Professor of Graduate Studies in Dermatology at EMESCAM - Vitória (ES), Brazil. Especialista em dermatologia pela Sociedade Brasileira de Dermatologia.

⁴ Titular Professor of Dermatology at EMESCAM - Vitória (ES), Brazil. Dermatologist of the Brazilian Society of Dermatology.

COMMENTS

Initial clinical hypotheses were those of infected epidermal cyst and subcutaneous pheohyphomycosis. The latter was confirmed by means of direct mycological examination of lesion secretion. Colony macromorphology, obtained under room temperature in agar Sabouraud culture medium, exhibited a black leaven-like aspect, with a white cottonous area on the surface. Micromorphology of the colony identified the fungus *Exophiala jeanselmei*.

Pheohyphomycosis is the term used to designate cutaneous and systemic diseases caused by dematiaceous fungi, which present in tissues as leaven cells, pseudohyphae and dematiaceous hyphae.¹

Incidence of this disease has been increasing importantly over the last few years. It is suspected that one of the reasons for such increase is iatrogenic immunosuppression.²

Mycosis is often an opportunistic infection, occurring in weakened patients, bearing chronic diseases, diabetes, leukemia, and other immunosuppressed, even though in many reported cases there is no evidence for an immunodepression.^{1,3}

Over 100 species have been identified as causing the disease.² Among the most common etiological factors, are *Exophiala jeanselmei* and *Wangiella dermatitidis*.¹

Clinical forms are twofold: subcutaneous and systemic. Subcutaneous form happens in consequen-

ce of a traumatic inoculation, and presents as cysts, abscesses or verrucous lesions, of slow evolution.¹ *E. jeanselmei* is a typical agent in this form,¹ which has a difficult differential diagnosis with epidermal cyst.³ In the disseminated form, infection pathway is usually inhalation, and develops with compromising of several internal organs, in particular the central nervous system, and the most frequently identified etiological factor is *Cladosporium bantianum*.^{1,4}

Diagnosis of the cystic form of the mycosis is usually obtained by means of histopathological examination. Abscesses situated in cellular subcutaneous tissue or deep dermis are surrounded by a thick fibrous capsule. Fungi are found mainly in the inner layer of the cyst wall, although they can be seen in the core of the abscess, under the form of septated hyphae of brownish color.³

First treatment choice for pheohyphomycosis is itraconazol in a prolonged schedule. Located lesions must be treated surgically or with local infiltration of amphoterecin B. For the disseminated cases, an association of amphoterecin B and 5-fluorocytosine is used.^{1,3}

In the present report, even more important than the rarity of the disease and the way it was diagnosed, is the warning for the consequences of prolonged steroid therapy without proper follow-up, which can be far more severe than those hereby presented. □

Abstract: We report a patient suffering from dimorphic Hansen's disease who has self medicated his neuropathy with oral corticosteroid for a long time. A yellowish, nodular-cystic lesion partially topped with crusting, surrounded by a brownish red halo, was noted on the inner aspect of his left leg. Direct mycological examination confirmed the hypothesis of pheohyphomycosis.

Keywords: Cladosporium; Exophiala; Iatrogenic disease; Mycoses

Resumo: Descreve-se caso clínico de paciente tratado de hanseníase dimorfa, que utilizou automedicação, com doses variadas de corticosteroide oral, por longo período, devido à neuropatia hansenica. Desenvolveu lesão nódulo-cística, amarelada, com algumas crostas, envolta por halo eritemato-acastanhado, na face interna da perna esquerda. O exame micológico direto confirmou a hipótese diagnóstica de feo-bifomicose.

Palavras-chave: Cladosporium; Doença iatrogênica; Exophiala; Micoses

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*MAILING ADDRESS:**Leonardo Mello Ferreira**Av. Nossa Senhora da Penha, 2432 - apto. 1406**Edifício Angra dos Reis - Bairro Praia do Canto**29045-402 - Vitória - ES**Telephone: +55 (27) 3225-8904**E-mail: llsmf@globo.com*

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