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Case Report *Volume 5 Issue 1*

Extensive Chromoblastomycosis on the Face with Dissemination Caused by Cladophialophora Carrionii

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Abstract

Chromoblastomycosis is a subcutaneous fungal infection caused by dematiaceous fungi of various genera, commonly presents with asymptomatic verrucous plaques mostly on extremities after a history of injury.

Rarely it disseminates to other parts of the body and poses a difficulty in diagnosis and treatment. Here we report a case of extensive chromoblastomycosis on the face caused by Cladophialophora Carrionii with dissemination to extremities in an immunocompetent elderly woman.

Keywords: Chromoblastomycosis; Dissemination; Cladophialophora Carrionii

Introduction

Chromoblastomycosis is a member of the *Herpotrichiellaceae* family which is a dematiaceous / pigmented fungi causing cutaneous/subcutaneous fungal infection with rare lymphatic and hematogenous dissemination and cerebral involvement [1,2]. Various genera like *Cladophialophora*, *Exophiala*, *Fonsecaea*, and *Rhinocladiella* were implicated in pathogenesis [3]. In most instances, it presents as an asymptomatic slow-growing verrucous lesion mostly over extremities in rural/agricultural areas post-trauma [1].

A Review of the literature shows that roughly less than 200 cases have been reported in India to date [4]. Extra cutaneous spread is low in chromoblastomycosis [5]. Dissemination is most commonly seen with Fonsecaea Pugnacius because of its neurotropic nature [6,7].

Case Report

A 65-year-old woman, an agricultural worker by occupation presented with multiple growths on her face for 2 asymptomatic years. Started as a single lesion on the left cheek and later developed into multiple similar lesions on the nose and ears within 6 months. She noticed similar lesions on her forearms and legs after 6 months. On local examination, multiple papules and verrucous plaques of different sizes from 1*1cm to 8*7cm. Some lesions showed central hemorrhagic crusts, umbilication, and lichenoid hue. Local cartilage and bone destruction were noted. Lymph nodes were normal (Figure 1-5).

Figure 1: Multiple verrucous plaques with crusting and lichenoid hue on face.

Figure 2: Right side of the face showing lesions with lichenoid hue and umbilication.

Figure 3: Left side of the face showing lesions on left ear helix.

Figure 4: Disseminated lesion on left forearm with central crusting.

Figure 5: Disseminated lesion on left leg.

On Dermoscopic examination, a reddish-pink background with multiple yellow-orange ovoid structures interspersed brown dots, crusts, and scales were observed. Potassium hydroxide mount (KOH) smear from the lesion showed sclerotic bodies (Figure 6).

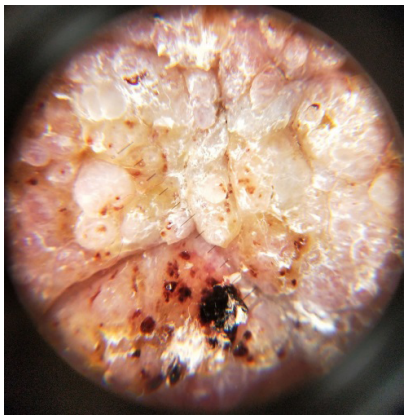

Figure 6: Dermoscopy image from facial lesion.

The specimen was sent for fungal culture on Sabouraud's dextrose agar (SDA) media with antibiotics at 25-30 degrees Celsius. Culture showed olive green to black fungal colonies after 2-3 weeks (Figure 7).

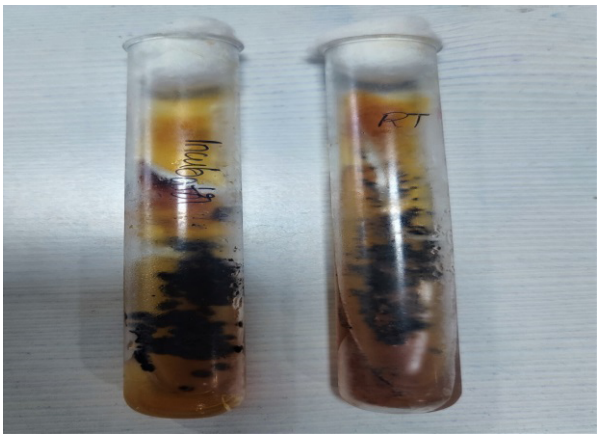

Figure 7: Colonies on Sabouraud's dextrose agar (SDA) medium.

Lactophenol cotton blue (LPCB) mount of colonies showed septate, compactly sympodial conidiophores with swollen tips and short chains suggestive of Cladophialophora Carrionii (Figure 8).

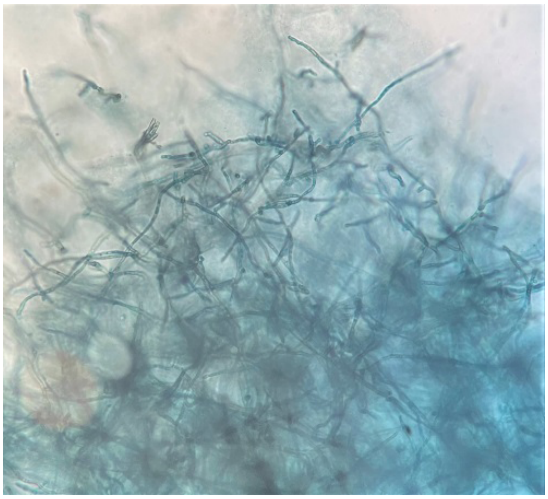

Figure 8: Lactophenol cotton blue (LPCB) mount from colonies.

Histopathological examination (HPE) from facial lesions showed thick-walled dark brown sclerotic cells/Medlar bodies/ copper penny bodies in a foreign body giant cell within granuloma in the dermis along with lympho-eosinophilic infiltrate (Figure 9).

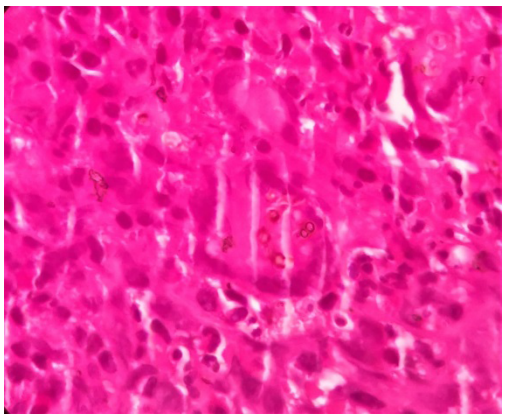

Figure 9: Image from Histopathological examination (HPE) slide - 40 X showing Medlar bodies within giant cell in a granuloma.

All other lab and radiological investigations were normal. Case diagnosed as Chromoblastomycosis with dissemination. The patient was treated with Capsule Itraconazole 200mg twice in a day and a Super Saturated solution of Potassium Iodide 25 drops thrice in day. The Patient showed dramatic improvement and near-complete resolution of lesions within 3 months without any iatrogenic side effects. Patient is continued on the above treatment and periodical follow-up waiting for complete resolution (Figure 10).

Figure 10: Dramatic response after treating with Super Saturated solution of Potassium Iodide (SSKI) 25 drops thrice in a day and Tab. Itraconazole 200 mg twice in a day.

Discussion

Chromoblastomycosis is a subcutaneous mycosis, most commonly caused by Fonsecaea species generally limited to the site of injury [8,9]. In this case, the causative agent was Cladophialophora. Very few case reports have reported facial chromoblastomycosis but without dissemination [10-13].

The risk of dissemination is very low with Cladophialophora, and it is through the lymphatic and hematogenous route [14]. There are other reported rare presentations of chromoblastomycosis like hypopigmentation [15,16], Disfiguring lesions [12], verrucous plaques with underlying osteolytic lesions [17], nodules [18], in skin graft recipient area [19], ulcerative lesions [20], sporotrichoid pattern [21,22]. Dissemination was not observed in any of the above-mentioned case reports [23-26].

Conclusion

We report a rare case of chromoblastomycosis which presented with large warty facial lesions without any disfigurement with distant hematogenous dissemination in an immunocompetent elderly female.

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