Two cases of axillary chromoblastomycosis

Sir,

Chromoblastomycosis is a chronic fungal infection of the skin and subcutaneous tissue caused by dematiaceous fungi, the most common causative organisms being *Fonsecaea pedrosoi*, *Phialophora verrucosa*, *Fonsecaea compacta* and *Cladophialophora carionni*.[1] The hallmark of chromomycosis is sclerotic bodies which can be demonstrated in potassium hydroxide mount and routine hematoxylin and eosin staining.[2] Lower limbs are the most commonly affected sites. Unusual extracutaneous sites of involvement include pleural cavity, ileocecal region, laryngotracheal area and tonsils.[3] Dissemination, though rare, presents with multiple verrucous nodules and plaques over limbs, neck, face, lymph glands and tonsil according to reports.[4] The most frequent complication is secondary bacterial infection but malignancies have also been recorded.[2]

A 54-year-old farmer with no prior history of trauma presented with an asymptomatic erythematous plaque over the right axilla for 1 year. General physical and systemic examination was unremarkable and baseline investigations were found to be within normal limits. On cutaneous examination, a solitary, well-defined erythematous plaque measuring about 6 cm × 4 cm was present over the lateral wall of right axilla [Figure 1]. On closer examination, a few black dots were present over the surface of the lesion. There were no satellite lesions. A provisional diagnosis of lupus vulgaris and chromoblastomycosis was made.

A 37-year-old cook presented with asymptomatic skin lesions over the axilla for 2 years. It started as a papule which slowly increased in size over the next 2 years. The second lesion developed after a span of 4 months. The rest of the physical examination and baseline investigations were within normal limits. On cutaneous examination, there were two well-defined polycyclic plaques; the larger lesion measuring about 9 cm × 5 cm on the lateral wall of axilla and smaller lesion with central scarring measuring about 5 cm × 7 cm on the medial wall of left axilla [Figure 2]. No regional lymphadenopathy was detected. Lupus vulgaris, chromoblastomycosis and atypical mycobacterial infection were considered in the differential diagnosis.

Skin scrapings with ten percent potassium hydroxide mount revealed typical brownish round thick-walled sclerotic cells in both cases. A skin biopsy was obtained from the verrucous plaque in both the cases and histopathological examination revealed hyperkeratosis, pseudoepitheliomatous hyperplasia and granulomatous inflammation with mixed cell infiltrate consisting of neutrophils, lymphocytes, epithelioid cells, multinucleated giant cells and sclerotic bodies which were diagnostic of chromoblastomycosis [Figure 3]. Fungal culture on Sabouraud's dextrose agar yielded growth of *Fonsecaea* in one case and in the other case no organism associated with chromoblastomycosis could be isolated. Both were treated with itraconazole, 200 mg/day. The first patient was also administered monthly sessions of cryotherapy using liquid nitrogen. At the end of

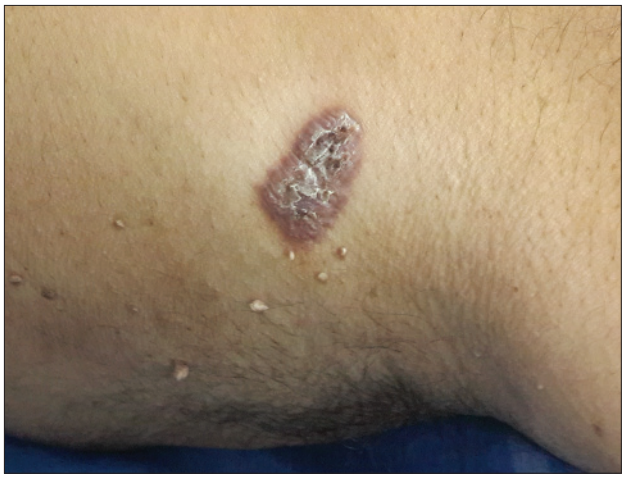

Figure 1: A single, well-defined erythematous plaque over lateral wall of right axilla

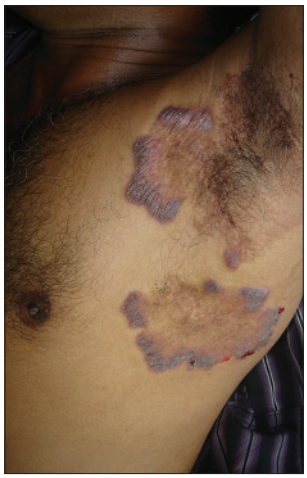

Figure 2: Two polycyclic plaques present over lateral and medial wall of left axilla

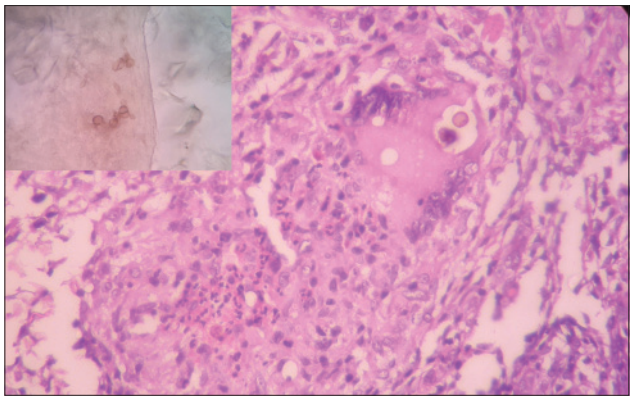

Figure 3: Skin biopsy showed mixed inflammatory cell infiltrate consisting of neutrophils, lymphocytes, epithelioid cells, multinucleated giant cells and sclerotic bodies (H and E, ×400). Inset showing sclerotic bodies on potassium hydroxide mount

2 months, there was noticeable improvement with reduction in size of the plaques.

We found a single previous report of axillary involvement in chromoblastomycosis in a patient who presented with genital elephantiasis due to lymphatic obstruction along with discharging sinuses and involvement of lower abdomen, face, neck, thighs and axilla.[5]

In both cases, our initial diagnosis was lupus vulgaris. Lupus vulgaris commonly affects the head and neck followed by the arms and legs. Atrophic scarring of lesions and apple jelly color on diascopy are characteristic. The clinical presentation of lupus vulgaris and chromomycosis is similar and it is difficult to differentiate between the two, especially in early cases. Despite the rarity of the site affected, potassium hydroxide mount and histopathology aided in arriving at the diagnosis of chromoblastomycosis. When chromoblastomycosis is suspected, scrapings to demonstrate Medlar bodies should be taken from an area where black dots are seen as these represent the transdermal elimination of fungal agents.[2] Potassium hydroxide mount is a simple, cost-effective bedside tool which can be employed to diagnose such cases and also useful when no facilities for fungal culture or histopathology are available.

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Conflicts of interest

There are no conflicts of interest.

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