Authors' reply

Sir,

We thank Nair and Kota for their interest in our article. We concur with the points they raise, and it is possible that our patient developed eumycetoma either incidentally or iatrogenically. However, we preferred the term "misdiagnosis" over incidental or iatrogenic because our patient received a diagnosis of fibroadenoma based on clinical, ultrasonography and histopathology reports when she first developed the lesions. There is always a chance to miss mycetoma (both fungal or actinomycotic) on histopathology if multiple sections are not examined.

When the patient developed recurrent lesions of similar morphology, she was once again diagnosed as fibroadenoma by a surgeon, both clinically and on sonography. She sought a second opinion from our department where it was felt that the clinical appearance did not match that of a fibroadenoma and she was advised skin biopsy which revealed black grains of eumycetoma. These facts were not mentioned in the original article because of the word limit on Letters to the Editor.

It is not unusual to miss the diagnosis of mycetoma of uncommon sites in early stages of disease where sinuses and grains are absent and it may mimic other common diseases at that site.[1] Our patient is a homemaker who lives in a suburban area. She is not involved in any work related to farming. She does not remember any history of trauma prior to the development of lesions; incidentally, this history is not uncommonly missing in mycetoma patients in our clinical practice. The time duration between original lesion and recurrence was around 14–15 months. It is true that distal extremities are the most common site for mycetoma but there are several reports which have described unusual locations. Actinomycetoma of the chest wall has been reported previously, but there is a scarcity of published reports of eumycetoma on the chest wall or breast.[2,3]

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Conflicts of interest

There are no conflicts of interest.

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REFERENCES

1. Springer P, Buchberger W. Mycetoma simulating, cystic fatty tissue necrosis after breast augmentation with autologous fatty tissue injection. Rofo 1999;171:263-4.
2. Sood A, Khanna N, Gandhi D, Mukhopadhyay S, Singh MK. Mycetoma involving the anterior mediastinum and chest wall. J Eur Acad Dermatol Venereol 2002;16:294-5.
3. Shafei H, McCormick CS, Donnelly RJ. Madura foot of the chest wall; cure after radical excision. Thorac Cardiovasc Surg 1992;40:198-200.

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