Disseminated Cutaneous Sporotrichosis in an Immunosuppressed Patient

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Abstract
The authors present a case of sporotrichosis, a systemic fungal infection frequently observed in Rio de Janeiro, where nowadays most cases are transmitted by cats. The disseminated cutaneous form, as seen in our patient, is rare and shows multiple cutaneous lesions. This form is almost always associated with immunosuppression, as the case we present, who was diagnosed as HIV+ during the diagnostic evaluation of the mycosis.

Keywords: Sporotrichosis; Sporothrix; Immunosuppression

Introduction
The case presented exemplifies disseminated cutaneous sporotrichosis, affecting an immunocompromised individual.

This disease is a subacute or chronic infection caused by the Sporothrix complex [1,2]. It is a primary cutaneous infection with different clinical forms: disseminated by lymphatic vessels, the most frequent, localized cutaneous, disseminated cutaneous and rarely extracutaneous form. The cutaneous disseminated and systemic forms of sporotrichosis are considered very severe opportunistic infections and usually occur in immunodepressed patients [2]. It is endemic in Rio de Janeiro, Brazil, where transmitted mainly by traumatic skin inoculation, as can occur with owners and professionals leading with cats [3]. Several cases have been reported to be associated with HIV [1,4].

Case Report
A 30-years-old black man presented ulcerocrusted disseminated cutaneous lesions associated to dysphagia for around three months. He referred loss of weight, odynophagia, productive cough and afternoon fever for the past six months. When asked, the patient stated he did not have any contact with animals, including cats, or worked with plants.

On examination, he showed ulcerocrusted round lesions. They were individualized, non-confluent affecting the face (Figure 1), upper and lower limbs, antero-posterior trunk (Figure 2) and nasal and oral mucosa. (Figure 3). The main differential diagnoses were: systemic mycosis, cutaneous tuberculosis, cytomegaloviroisis, atypical

Figure 1: Lesions on the left side of the face.
Figure 2: Lesions on the right side of the face.
Figure 3: Lesions on the left arm and trunk.

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mycobacteriosis and leishmaniasis. The patient stayed in the in-patient clinic, where skin biopsy, radiological and laboratorial investigation were performed, which ruled out the most common opportunistic infections seen in AIDS patients.

The laboratory exams showed that the patient was HIV positive (viral load: 76,023 copies, CD4: 114 cells/mm³). Chest tomography revealed presence of opacity similar to dull glass and bronchial thickening. He had ulcerated esophagitis with negative biopsy for fungi, virus and bacteria in the digestive endoscopy, and negative induced sputum negative for fungi or BAAR.

Mycological exam of the fragment of one of the lesions of the left arm demonstrated growth of colonies of membranous aspect on agar Sabouraud. It was initially white, becoming black after a few days, and forming a halo in the form of a horseshoe (Figure 4). In micro culture, delicate conidiophores, thin, septated hypha and, in the extremity, conidia in an arrangement similar to a daisy (Figure 5), confirming the diagnosis of sporotrichosis.

Histopathological exam of the skin biopsy of a lesion of the left arm was inconclusive and showed hyperkeratosis, parakeratosis, acanthosis, vascular proliferation, fibrosis and perivascular mononuclear inflammatory; absence of granuloma, neoplasia or viral cytopatic effect. Grocott and PAS techniques did not show microorganisms.

Amphotericin B, 3 mg/kg per day, was initiated, but because of the toxicity of the drug it had to be discontinued. Itraconazol, 400 mg/day, was given with clinical improvement of the patient. Maintenance of this dose is planned for at least 6 months.

Discussion

Sporotrichosis is a subcutaneous mycosis with sub-acute or chronic progression. It is caused by direct inoculation of a dimorphic fungus, one of the species of the Sporothrix complex, especially *Sporothrix schenckii*, through breakage of continuity of skin or mucosa [1,5,6]. More than 6 species have been identified in different locations of the globe by molecular techniques, such as *S. schenckii sensu stricto*, *Sporothrix brasiliensis*, *Sporothrix globosa*, *Sporothrix mexicana*, and *Sporothrix albicans* [7].

In the skin, lymphocutaneous, fixed and disseminated cutaneous forms can be clinically observed, with or without involvement of ocular, nasal and oral mucosa. Besides those, extracutaneous, pulmonary, osteoarticular, meningeal and generalized forms can be observed [5,6].

In the city of Rio de Janeiro, Brazil, there has been an epidemic of sporotrichosis transmitted mainly by cats since 1997 [1,4,8,9]. Freitas et al. [4], studying 21 cases of sporotrichosis associated with HIV in Rio de Janeiro, found that the most frequent clinical presentation were lymphocutaneous (seven patients, 33.3%), disseminated (seven patients, 33.3%), disseminated cutaneous (five patients, 23.8%), and fixed form (two patients, 9.5%).

The form of presentation seen in our patient occurs in greater frequency in immunodepressed individuals, especially HIV positive patients, and result from fungal hematogenic dissemination from an initial inoculation site [10,11]. It is characterized clinically by disseminated, nodule-gummatous and frequently ulcerated lesions [5]. Treatment of choice is amphotericin B, but its use is often limited due to its high toxicity. Terbinafine, ketoconazol, itracanozol, fluconazol and saturated solution of potassium hydroxide can be used as alternative therapy, and among them itraconazol is the most effective [12-14].

Conclusion

It was found that the patient had a positive serology for HIV associated to the disseminated cutaneous form of sporotrichosis with nasal and oral mucosa involvement, as described in the literature.

References