

Dermato-venereological Quiz

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A 55-year-old Chinese man presented with non-itchy skin lesion over his right knee for six months which enlarged progressively (Figure 1). He denied any local trauma. He had heart transplantation three years ago and was on immunosuppressants. Physical examination revealed two adjacent pigmented warty plaques over his right knee measured about 2 cm in diameter each. There were no significant systemic symptoms and signs.

Questions

1. What are the clinical differential diagnoses?
2. Histology showed a mixed granulomatous response with pseudoepitheliomatous hyperplasia, hyperkeratosis, intraepidermal neutrophilic abscesses and Medlar bodies. What is the diagnosis?
3. What are the causative agents?
4. What are the treatment options?



Figure 1.

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1. The clinical differential diagnoses are chromoblastomycosis, blastomycosis, tuberculosis verrucosa cutis, mycobacterium marinum infection, verruca vulgaris, foreign body granuloma, tertiary syphilis and squamous cell carcinoma.
2. Medlar bodies, also known as copper pennies, refer to the characteristic brown yeast seen in the biopsy and is diagnostic of chromoblastomycosis.
3. Chromoblastomycosis is caused by dematiaceous (darkly pigmented) fungi: *Fonsecaea pedrosoi*, *Phialophora verrucosa*, *F. compactum*, *Wangiella dermatitidis* and *Cladosporium carrionii*. They can be found in the soil, decaying vegetation and rotting wood. Chromoblastomycosis usually affects the lower extremities of male patients. There may be a history of trauma from wood products and soil exposure.
4. Itraconazole used alone or in combination with flucytosine is the main treatment of choice. Terbinafine, amphotericin B and thiabendazole are other options available. Treatment should be continued until there is clinical resolution of lesions, which usually takes several months. Cryotherapy, CO₂ laser and surgical excision may be considered. Surgical excision may spread the lesions and should be used as an adjunctive therapy after drug treatment. Heat as an adjunctive therapy may be beneficial at cooler acral sites. Despite these options, some lesions remain resistant, and amputation may be unavoidable in very extensive cases.