SPOROTRICHOSIS: A CASE REPORT

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ABSTRACT

Sporotrichosis is a rare disease in the Southern part of India. A sporadic case of sporotrichosis restricted to primary site of inoculation in a 11-years old student from a non-endemic region of Telangana has been described.

KEYWORDS

Sporotrichosis, Dimorphic.

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INTRODUCTION

Sporotrichosis is a subcutaneous/systemic fungal infection caused by dimorphic fungus *sporothrix schenckii*. The fungus occurs in natural environment, presumably in mould form but develops into a yeast like form.^[1] *S. schenckii* is endemic in the sub-Himalayan region.^[2] Agriculturists, foresters, gardeners, florists and nursery workers handling plants or plant material are particularly at risk. Traumatic inoculation is the typical mode for acquisition of skin infection in immunocompetent hosts. *S. schenckii* exhibits temperature dimorphism; it exists as a mold at room temperature (26°C) and as yeast in the host tissues (37°C). Both cutaneous and systemic forms of sporotrichosis exist. Three clinical types are described: (i) Fixed Cutaneous, (ii) Lympho Cutaneous, (iii) Disseminated.

CASE REPORT

Eleven years boy presented with multiple, well defined, red crusted lesions over dorsum of left hand and arm since 3 years. Initially started as small papule over the dorsum of left hand and then progressed to present stage. H/o trauma present 3 years back, after which lesions appeared 2 months later. No H/o itching, pus discharge, pain or fever. H/o partial remission of lesions on taking medication and relapse within one month. There was no H/o cough, hemoptysis or weight loss.

ON EXAMINATION

Well defined erythematous crusted plaques on left forearm of 2x2 cms, about 3 to 4 in number. The surface was covered with dirty yellow crust. On removing the crust, there was slight serosanguineous discharge. No mucosal involvement or similar lesions elsewhere were seen.

Thickened lymphatic cords were not palpable in the vicinity. Epitrochlear and axillary lymphnodes were enlarged. His general physical and systemic examination were normal. His routine laboratory parameters including the liver and renal function tests and x-ray chest were within normal limits. HBSAg, HCV and mantoux test were negative. Fungal culture was negative.

HPE- evidence of chronic inflammatory dermatosis. On KOH mount, fungal hyphae are seen. PAS and ZN staining were negative. Specimen for both histopathology and KOH mount was taken from crusted lesions (Deep biopsy). The patient was treated with oral antibiotics and tab. itraconazole 100mg once daily. The lesions started resolving 2 weeks after starting therapy. D/D considered and ruled out: cutaneous anthrax, atypical mycobacterial infection, cutaneous tuberculosis, cutaneous leishmaniasis, staphylococcal lymphangitis.

DISCUSSION

The lymphocutaneous variety of sporotrichosis presents a distinctive clinical picture with nodules and ulcers arranged linearly along the lymphatics with thickened lymphatic cords between the nodules, usually on exposed skin.^{[3],[4]} The fixed variety, where the pathogen remains localized, is less common.^{[5],[6]} It may be a nodular, acneiform, ulcerated or verrucous form of variable duration.^[7] Although reports say that histopathological examination of tissue stained with conventional H and E lacks sensitivity, a high index of suspicion of sporotrichosis should be exercised whenever a biopsy of a sporotrichoid lesion is received.

Until recently the standard therapy for lymphocutaneous and cutaneous sporotrichosis was saturated solution of potassium iodide concentration. Currently, oral itraconazole has become the drug of choice for lymphocutaneous sporotrichosis.^{[8],[9]} The recommended dosage is 100-200 mg daily, to be administered for 3-6 months. In our patient, the diagnosis of sporotrichosis was suspected clinically and started on tab. itraconazole 100mg daily.

He responded well to the treatment [Figure 3, 4] and followed up for about 3 months. In view of rarity of the disease and occurrence in non-endemic area, lack of response

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to various antibiotics for a duration of 3 years and prompt response to oral itraconazole within 2 weeks of treatment made us to report the case.

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Fig. 1: Pre-Treatment

Fig. 2: Post Treatment

Fig. 3: Post Treatment