Subcutaneous Phaeohyphomycosis in a Renal Transplant Recipient Successfully Treated with Voriconazole

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Sir,

Phaeohyphomycosis is a rare cutaneous, subcutaneous or systemic infection caused by a range of dematiaceous moulds. Alternaria, which is frequently found in soil, polluted water and decaying vegetation, is among the causing organisms (1, 2). Infection due to Alternaria species tends to occur most frequently in immunocompromised patients (3), especially in organ transplant recipients (4). The subcutaneous form of phaeohyphomycosis is most prevalent in the rural population of tropical and sub-tropical areas, and usually arises following minor trauma or from walking barefoot on infected soil. It might not become troublesome until many years after the causal injury. The diagnosis is often delayed, as it is frequently unsuspected. Optimal therapy for chronic subcutaneous alternariosis is unknown. This report describes a case of A. alternata infection in an immunosuppressed patient and its successful outcome following voriconazole treatment.

CASE REPORT

A 43-year-old man born in Somalia, but resident in Denmark since 1989, received his first kidney transplantation in 1998. The post-transplant course was complicated by chronic rejection leading to haemodialysis and graft removal in 2005. During this time immunosuppressive therapy combined azathioprine, cyclosporine and prednisone. A second kidney was grafted in January 2008 and periosteal reaction. At the initial visit a 3-mm punch biopsy was followed by 200 mg twice daily was initiated in October 2008 (Fig. 1A) and discontinued after 5 months under due observation and fine-tuning of the tacrolimus dosage. At this point, the lesions had resolved and the subcutaneous induration decreased dramatically (Fig. 1B). Treatment with voriconazole was well tolerated.

Fig. 1. Clinical feature of subcutaneous phaeohyphomycosis. (A) Before treatment; (B) after 5 months of voriconazole treatment.
DISCUSSION

More than 100 fungi have been reported as agents of phaeohyphomycosis (6) including Bipolaris, Curvularia, Exophiala, Exserohilum, and Alternaria most frequently involved in human infections (7). Among members of the last genus, the most commonly found species is A. alternata. Phaeohyphomycosis caused by this species may be difficult to recognize because lesions are variable in size and characteristics, ranging from crusted lesions to subcutaneous nodules. The sites affected most commonly are those that are exposed, and it is thought that infection is via traumatic implantation. Most reports of pathogenic Alternaria infection occurs in systemic illness or during immunosuppressive therapy (3). The experience of kidney transplantation includes sporadic cases of phaeohyphomycosis (4, 8) as chromoblastomycosis agents are more often described (1). Mycetoma is a clinical syndrome characterized by tumefaction, draining sinuses and granules or grains. The diagnosis is established by identifying the type of grains found in the discharge. However in our patient no grains were visualized from the pus, and histopathology revealed no fungal elements using haematoxylin-eosin stain. The possibility of A. alternata as a contaminant was considered, but was unlikely, as the same species was isolated on two separate occasions from aseptically obtained biopsies with a one-month interval. The patient was born in Somalia, but had been in Denmark for the last 19 years at the time of presentation. A. alternata is a cosmopolitan mould found in soil and on living and dead plants. Thus, whether the present infection was acquired in Denmark, or represents a reactivation of latent infection acquired in his home country due to the immunosuppressive regime, is unknown.

Renal transplant recipients are at increased risk of invasive fungal infections. Despite advances in immunosuppressive therapy, infection remains a leading cause of morbidity and mortality in those patients. Approximately 70% of severe infectious complications occur within 3 months of transplantation (9). During his first period of renal transplant from 1998 to 2005, our patient experienced no clinical signs of any opportunistic infection. Following his second kidney transplantation cyclosporine was substituted with tacrolimus, which is a more potent immunosuppressive agent. It is not known whether tacrolimus-treated patients exhibit a greater risk of deep fungal infection than patients receiving other immunosuppressive regimens, but this has been debated (10).

Optimal treatment of phaeohyphomycosis often includes surgical excision combined with antifungal therapy for several months. Itraconazole has been found to exhibit in vitro activity against Alternaria, but treatment failures with the compound have been reported (11). Both amphotericin B (12) and fluconazole (13) have been used in the treatment, sometimes with only partially response. Voriconazole has been shown to be an efficient alternative to amphotericin B and surgical debridement for the treatment of cutaneous A. alternata infection in a liver transplant patient (14). In the present case a dramatic effect was observed following a few months’ voriconazole monotherapy. As more potent immunosuppressive drugs become available to prevent graft rejection, survival increases, expanding the population of immunocompromised patients and increasing the number of patients with opportunistic infections involving the skin (15).

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REFERENCES