Primary Cutaneous Aspergillosis in an Immunocompetent Host

Sir,

Primary cutaneous aspergillosis is rare and when seen it is usually associated with compromised immune status of the host. The lesions usually occur at the site of trauma, e.g. in a sick patient at the site of armboards, tapes or intravenous catheters. The fungus, *Aspergillus*, is a saprophytic dimorphic mould present in soil, decaying vegetation and organic debris. Clinically it involves the lungs, central nervous system, naso-orbital area, skin and sometimes it may be disseminated.

CASE REPORT

A 30-year-old male developed a pea-sized nodule in the right axilla 15 years earlier. There was no history of trauma preceding the lesion or of pain, ulceration or discharge of granules from the lesion. The nodule increased in size to approximately 7 × 2 cm in 4 years. At this stage, it was excised and the patient was given 9 months of antitubercular therapy. Eighteen months after the excision, he developed a nodule again at the excision site, which reached the previous dimensions in 2 years with overlying ulcers occasionally exuding seropurulent discharge. There was no history of fever, cough, dyspnoea, chest pain, haemoptysis, nasal or ear discharge, weight loss, loss of appetite, diabetes or hypertension, nor any symptoms suggestive of ophthalmological, neurological, bladder or bowel involvement.

At the time of presentation, cutaneous examination showed a subcutaneous nodular, lobulated swelling in the right axilla, extending linearly from the posterior axillary to the mid-clavicular line. It was 14 cm long and 5 cm wide and broadest at the centre (Fig. 1). The margins of the lesion were well defined and at the anterior and posterior ends, the finger could be insinuated under the margins slightly. The consistency was soft in the centre and firm towards the periphery, with a few puckered sinuses over the lesion, which on pressure yielded scanty seropurulent discharge. The skin overlying the lesion was erythematous, with loss of hair and the excisional scar slightly. The central portion of the lesions had an ulcer, 6 cm long and 3 cm wide, with irregular bluish margins and granulation tissue on the floor. Just below the lesion, there was a nodule again at the excision site, which reached the previous size in 4 years. At this stage (1 – 5). It is usually caused by *A. flavus* or *A. niger*. Clinically, cutaneous aspergillosis usually appears as erythematous to violaceous papules or plaques that may progress to form necrotic ulcers with a central eschar (6). Unusual cases have been reported resembling lepromatous leprosy (7), mycetoma (8), dermatophytoses (9), purpura, panniculitis and molluscum contagiosum. The nodular subcutaneous lesion in our patient resembled subcutaneous phycomycosis.

Itraconazole, a triazole antymycotic, acts against the fungal cell wall and collects in cytoplasmic vacuoles. Studies have shown a therapeutic response comparable to that of Amphotericin-B with a lower incidence of side-effects (10). Other drugs found to be effective in the treatment of aspergillosis include potassium iodide, 5-fluorotymosine, superconazole, fluconazole, terbinafine and granulocyte colony stimulating factor (10). Our patient did not show any response to treatment with potassium iodide, but had complete clearance of the lesion clinically and histopathologically with itraconazole 400 mg, given for 7 weeks. There were no side-effects of the therapy.

DISCUSSION

Primary cutaneous aspergillosis in immunocompetent hosts, as seen in our patient, has been reported in only 5 patients to date (1 – 5). It is usually caused by *A. flavus* or *A. niger*. Clinically, cutaneous aspergillosis usually appears as erythematous to violaceous papules or plaques that may progress to form necrotic ulcers with a central eschar (6). Unusual cases have been reported resembling lepromatous leprosy (7), mycetoma (8), dermatophytoses (9), purpura, panniculitis and molluscum contagiosum. The nodular subcutaneous lesion in our patient resembled subcutaneous phycomycosis.

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REFERENCES

Asymptomatic Bilateral Optic Perineuritis in Secondary Syphilis

Sir,

The importance of syphilis as a cause of ocular disease has been recognized since 1858 (1); however, over the years, the spectrum of ocular manifestations of this disease has changed, possibly due to the advent of antibiotic therapy (2). Early diagnosis is important, in view of the potentially sight-threatening sequelae of syphilitic eye disease, which strongly suggests involvement of the central nervous system and requires aggressive therapy with high-dose aqueous penicillin (3, 4). In an attempt to increase awareness among dermatologists of this manifestation, we describe here 2 cases of asymptomatic bilateral optic perineuritis in HIV-negative patients with secondary syphilis.

CASE REPORTS

Case 1
A 20-year-old Caucasian female presented with a 2-month history of generalized rash, malaise and fatigue. She denied knowledge of exposure to syphilis and of previous skin lesions on the genital region or elsewhere. She revealed diffuse lymphadenopathy and a generalized rash consisting of multiple round, indurated, erythematous papules on the palms and soles. These lesions were hyperkeratotic, whereas in the anogenital and buccal regions they were flattened and macerated. Dark-field microscopy of these lesions showed the presence of spirochetes. Routine laboratory investigations revealed a positive (1:10,240) Treponema pallidum haemagglutination assay (TPHA). Lumbar puncture showed normal opening cerebrospinal fluid (CSF) pressure, negative syphilis serology and cryptococcal antigen assay, a total protein level of 40 mg/100 ml, a glucose level of 53 mg/100 ml and a white blood cell count of 13/mm³.

Case 2
A 32-year-old Caucasian female patient presented with a 3-week history of painless, papular lesions in the anogenital region. She denied knowledge of previous exposure to syphilis and any constitutional symptoms. Her medical history was unremarkable. She revealed several erythematous, painless, oozing papules with partially papillated surface in the anogenital region and a generalized lymphadenopathy. Dark-field microscopy of the lesions showed the presence of spirochetes. Routine laboratory investigations revealed a serum TPHA of 1:2560 and a positive (4+) fluorescent Treponema pallidum antibody absorption. Lumbar puncture demonstrated a normal opening CSF pressure, a total protein level of 37 mg/100 ml, a glucose level of 43 mg/100 ml and a white blood cell count of 15/mm³.

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Fig. 1. Blurred optic disc margins and a superficial flame-shaped haemorrhage at 11 o’clock position in the left eye of case 1.

Fig. 2. Fuzzy hyperfluorescence at the optic disc due to leakage from the dilated capillaries in the right eye of case 2.