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Case Study

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A RARE CASE OF ACTINOMYCETOMA AT AN UNUSUAL SITE: A CASE REPORT

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ABSTRACT

Mycetoma is a chronic suppurative infection affecting skin, subcutaneous tissue, and bones prevalent in tropical and subtropical regions. We report a 70 years old male who presented with an itchy oozy lesion over left buttock and back since two to three months which showed drastic improvement with Welsh regimen. Although full eradication of the lesion was not possible, but patient improved symptomatically.

INTRODUCTION

Mycetoma is a chronic suppurative infection affecting skin, subcutaneous tissue, and bones prevalent in tropical and subtropical regions.[1] Two groups of mycetoma exist, eumycetoma caused by true fungi and actinomycetoma caused by fungi-like aerobic bacteria from actinomycomycetes species.

CASE REPORT

A 70-year-old male presented to the dermatology OPD with an itchy oozy lesion over left buttock and back since two to three months. It was associated with mild pain and was non-foul smelling. Local examination showed three to four well to ill defined skin to brown coloured nodulo-plaques of size 2*1 to 4*3 cm with evidence of central crusting and bloody discharge. Two to three well defined ulcers of size 5*4 cm with reddish brown slough, base with granulation tissue at base with elevated edges (shown in figure 1 and 2). On palpation, it was tender and indurated. On the basis of preliminary history taking and local examination scrofuloderma, lupus vulgaris, actinomycosis, and sporotrichosis were kept as differential diagnosis. Investigations done were and histo-pathological examination showed granulomatous inflammation. Pus culture revealed growth of *Staphylococcus aureus* which was attributed to secondary bacterial infection. PCR and fungal culture were was negative. Based upon the investigations, a final diagnosis of Actinomycetoma was made and the patiemt was treated with inj. Amikacin 15 mg/kg/iv divided into 2 doses for 21 days which constituted 1 cycle. 3 such cycles at the interval of 15 days were given. Hemogram, liver and renal function studies and audiogram were done before and after each cycle. In the interval period of 15 days tablet Trimethoprim-sulfamethoxazole was given.[2] Patient showed drastic improvement after welsh regimen. Lesions healed to a great extent. Even if investigations are not suggestive of a particular diagnosis, an empirical therapy can provide clue towards diagnosis.

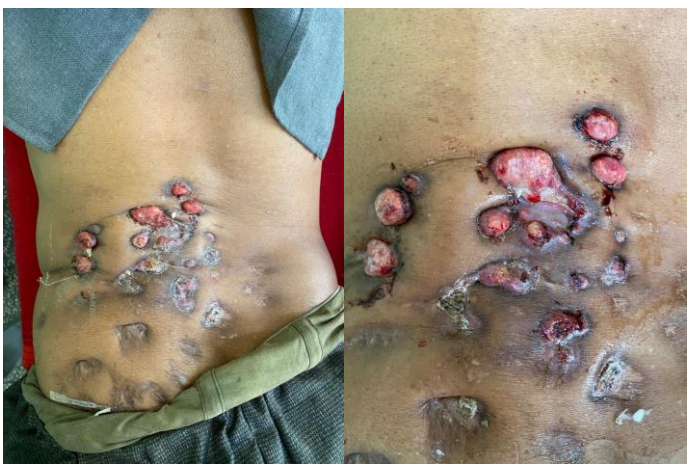

Figure 1 and 2: Before treatment.

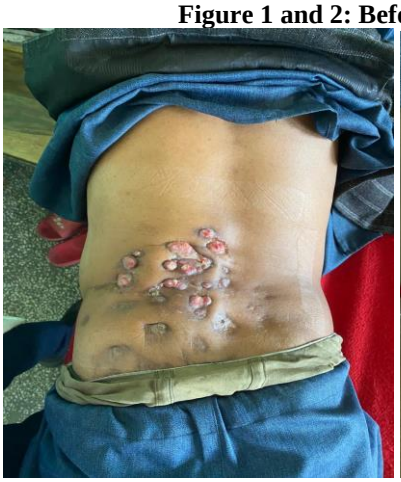
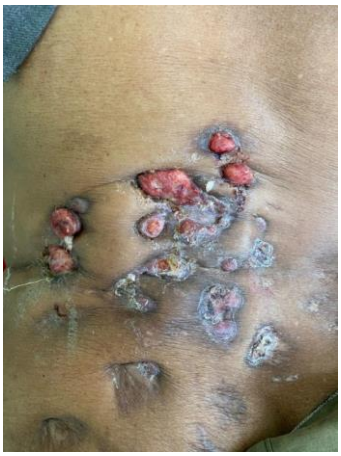

Figure 3 and 4: After treatment.

DISCUSSION

Mycetoma is a rare pathology caused by either a true fungi (eumycetoma) or by filamentous bacteria (*Actinomycetes* species).[3] It is predominantly a disease of tropical or subtropical countries whereby eumycetoma are commonly associated with soil or plants. *Actinomyces* species are Gram-positive facultative anaerobic bacteria that normally colonise the human mouth, digestive and genital tracts. While it is necessary for anti-infective treatment purposes to distinguish between the infectious agent responsible for mycetoma, the clinical manifestations of either microorganism are similar. The pathology often presents as a chronic infection of the skin and subcutaneous tissues in the presence (or sometimes absence) of tumefaction, discharging sinuses with the presence of black, yellow or white grains (hyphae). Due to its often-slow progression, many cases present as chronic pathologies as they initially cause no impairment to function. In our case, patient was a farmer, having lesions on back, which is an atypical site for actinomycetoma. Thus, for the diagnosis of such deep-seated granulomatous conditions, multiple investigations become a necessity. Prompt diagnosis paves the way to early treatment which further stops the disease progression. The bone involvement in mycetoma can prove to be a chronic complication and is difficult to treat. Early diagnosis can prevent complications and decrease the morbidity associated with mycetoma.

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