sinuses and crusts. The skin over the entire foot was hyperpigmented and thickened; regional lymph nodes did not show any significant enlargement, and systemic examination was unremarkable. All the routine investigations, including foot radiographs and hematological and biochemical tests, were within normal limits. A few black, irregular granules of variable size measuring 0.5 to 2 mm were collected from the patient and subjected to microscopy and culture. Potassium hydroxide (KOH) wet mount revealed brown-colored, septate hyphae approximately 2 × 4 µm in width, interwoven with each other. On Sabouraud's dextrose agar (containing chloramphenicol without cycloheximide), black-colored colonies with white aerial hyphae were isolated after 1 week of incubation. Microscopically, lactophenol cotton blue wet mount of the colony showed erect, unbranched, septate, flexuous, brown-colored conidiophores, along with conidia. The conidia were approximately 20-30 × 8-10 µm in size, smooth walled, olivaceous brown in color, were four-celled with 3 septae and had a larger sub-terminal cell [Figure 1]. The fungal isolate was identified as *Curvularia lunata.*

The patient was treated with oral itraconazole 200 mg twice daily. The patient started improving as shown by the reduction of swelling with resolution of the sinuses. He is currently under observation with continued medical treatment. Curvularia infections in humans are relatively uncommon despite the ubiquitous presence of this soil-dwelling dematiaceous fungus in the environment. There are 31 known species, and the most commonly recovered species in man has been *C. lunata,* followed by *C. geniculata.*[4] Originally thought to be solely a pathogen of plants, *Curvularia* has been described as a pathogen of humans and animals in the last half century, causing respiratory tract, corneal, and cerebral infections. However, only a few cases of mycetoma have been reported till date.[5]

Proper management of mycetoma strongly depends on the identification of the causative organism; as eumycetoma should be treated with adequate antifungal therapy and surgery, whereas actinomycetoma generally responds well to antibacterial treatment and, in a few cases, surgery is indicated. Early cases are curable, but advanced cases are difficult to treat and may require amputation. Currently, itraconazole and ketoconazole are the best treatment options for eumycetoma, and Mycetoma Research Center (Khartoum, Sudan) recommends ketoconazole (400-800 mg daily) or itraconazole (400 mg daily) for first-line use. In the present case, treatment of the patient was commenced with itraconazole, with signs of improvement.


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Schamberg’s disease:
Involvement of the genitalia

Sir,

Schamberg’s disease (SD), (progressive pigmented dermatosis), is of uncertain etiology.[1] Irregular patches of brown pigmentation due to hemosiderin deposits, with
characteristic ‘cayenne pepper’ spots, are clinically seen. Though most frequent on the lower limbs, they may occur anywhere in the body, including the palms.[2] To the best of our knowledge, this is the first case of SD involving the genitalia.

A 21-year-old bachelor, a shop owner, reported to our OPD with a 3-year history of progressive asymptomatic red-brown lesions scattered over the dorsa of feet, ankles, and distal two thirds of the limbs. A year later, similar lesions appeared over the glans penis [Figure 1]. Circumcised during childhood, there was no history of any medications, local trauma, infection, sexual contact, genital ulcers, or a familial occurrence of similar disorders. The skin lesions in the legs and genitalia were similar, with grouped pinhead-sized coalescent purpuric macules with the typical ‘cayenne pepper’ spots in the center and edges. The penis shaft and scrotum were not affected. The patient had a thin build, and there was no pedal edema, varicose veins, regional lymphadenopathy, or systemic abnormality.

Routine hematology, biochemistry, and the coagulation profile yielded normal results. A Doppler study of peripheral veins was normal. Hematoxylin and eosin–stained sections from the leg showed a slightly hypertrophic epidermis. The dermis showed vascular prominence in some areas with a scattered perivascular infiltrate of mononuclear cells. Histopathology from the glans showed an almost normal epidermis with acanthosis and papillomatosis in some places and a few odd capillaries with a mononuclear infiltrate in the perivascular area. Scanty pigmented deposits were present in the mid and lower dermis. Pearl’s staining for hemosiderin deposit was positive. The clinical and histological features led to the diagnosis of SD with unusual involvement of the male genitalia.

Venous hypertension, exercise, gravitational dependency, capillary fragility, focal infections, and chemical ingestion have all been suggested as etiological factors of SD.[3] However, doppler study of peripheral veins was normal in our patient.

The disease began on the legs, as is commonly seen, with a slow proximal extension. However, subsequent involvement of the glans makes this case unique. SD occurring on sites other than legs has been reported on several occasions before this. Harris et al,[4] described a case of SD on the abdomen of a young male and emphasized the need for careful vigilance for progression to purpuric mycosis fungoides. Another report describes 2 cases with SD on the left elbow and right leg.[5] Histology in both patients was compatible with SD. The authors suspected that aspirin use by the patients could have been an etiologic or contributing factor. Though SD is a rare occurrence in children, a review of 13 cases by Torello et al, showed involvement of the upper limb and trunk in 1 and 3 cases respectively.[6] However, none of these studies or reports refer to any cases of involvement of the genitalia by SD.

A peculiar quadrant capillaropathy was described by Higgins and Cox[7] and they proposed pelvic vascular obstruction as the possible mechanism for the rare distribution. But our patient had SD on both legs, in addition, and we have not been able to explain the etiology of capillaropathy on the genitalia in the same light. No triggering factor for vascular damage due to a local cell-mediated immunological event could be elicited.

In spite of the clinicopathological resemblance between the genital and limb lesions, we did consider a few other differential diagnoses for pigmented lesions over genitalia, like penile lentiginosis, penile melanoma, and fixed drug reactions.[8,9] However they were excluded on clinical and histologic grounds.

Pigmented purpuric eruptions are quite resistant to treatment. We prescribed topical steroids and oral pentoxifylline, 400 mg thrice daily, for our patient, leading to partial clearance of both leg and glans lesions in 3 months.

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Solitary eccrine syringofibroadenoma

Sir,

Eccrine syringofibroadenoma (ESFA) is a rare benign proliferation with differentiation towards ductal eccrine structures. It was first described by Mascaro in 1963. [1] It may show variable presentation, ranging from a solitary lesion to multiple papules and nodules arranged in a symmetrical or linear nevoid pattern. The age of onset ranges from 16 to 80 years, but most patients present in the seventh and eighth decades. Distribution of lesions is wide and includes the face, back, abdomen, buttocks, extremities, and rarely the nails. Histopathology of ESFA shows slender anastomosing cords of epithelial cells with or without lumina embedded in a loose fibrovascular stroma. The epithelial cells may show ductal differentiation, often associated with a well-formed cuticle.

Approximately 50 cases of ESFA have been reported in the literature till date.[2]

An 84-year-old female presented with a slowly growing multinodular lesion on the plantar aspect of foot since 3 years. The lesion was very small (peanut sized) when the patient first noticed it. It increased slowly to attain the present size (5×5 cm). Initially the overlying skin was intact and developed ulceration two and a half years later. There was no history of diabetes mellitus or any other cutaneous lesions.

A clinical diagnosis of squamous cell carcinoma was considered. A specimen of ulcerated nodular growth with wide local excision of surrounding lace-like skin was received in our department. It was an ulcerated multinodular growth measuring 5×4.5×1 cm. Multiple variable-sized nodules were present in the growth. The largest nodule measured 1×1 cm. Multiple small nodules were also present. Ulcer measured 2×1.5 cm [Figure 1A]. Sections revealed stratified squamous epithelium. Underlying tumor mass was composed of long, branching, anastomosing thin strands or cords of small cuboidal epithelial cells extending from the epidermis into the dermis. Occasional duct-like lumina lined by cuboidal epithelial cells were present in the epithelial strands. The stroma was loose and fibrovascular [Figure 1B].

Clear cell variant of ESFA was reported by Hu et al. in 2005. They studied the immunohistochemistry of ESFA. Their results suggest dual differentiation towards ductal and secretory portions of the eccrine sweat glands. [3] ESFA may occur as a reactive proliferation associated with other conditions like ulcer of skin, chronic lymphedema, venous stasis, nail trauma, burn scar, nevus sebaceous, bullous pemphigoid, and epidermolysis bullosa. [2,4] Ichikawa et al,[5] studied ESFA in a patient with burn scar ulcer. The authors came to the conclusion that this variant of ESFA seems to be an eccrine duct hyperplasia developing during the restoration and remodeling of skin structures damaged by trauma or ulcerative lesions.[5]