



LETTER TO THE EDITOR

A Rare Etiology for Injection Related Gluteal Abscess

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Chromoblastomycosis is a rare, chronic, indolent, granulomatous fungal infection of skin and subcutaneous tissue caused by dematiaceous fungi. Chromoblastomycosis, though can be found throughout the world, is most prevalent in tropical and subtropical regions. Primary lesions appears as an erythematous papule or a warty growth that gradually enlarges to various forms and sizes. The infection most frequently affects lower extremities, especially feet and shins, but can rarely affect buttocks, trunk, and face [1,2]. The diagnosis of this rare entity requires clinical suspicion. Here we describe a case of chromoblastomycosis presenting as bilateral gluteal abscesses.

A 49-year-old male with history of coronary artery disease, hypertension, chronic kidney disease, and rheumatoid arthritis presented with a 5 months history of swelling in the both buttock region. He was receiving frequent gluteal intra-muscular injections for rheumatoid arthritis reportedly with the recent one being a week prior to his presentation. He denied fever, pain, chills, and discharge. Examination revealed non-tender, and non-warmth firm swellings involving bilateral gluteal regions with multiple openings and discharge. Remainder of the examination was unremarkable. Surgical consultation was sought. He underwent excision and debridement of the abscesses under spinal anesthesia. Multiloculated cavities with black colored discharge were noted. Histopathology examination showed multiple sinus tracts and abscesses involving skin and subcutaneous tissue with fugal sclerotic bodies and mul-

tinucleated giant cells and abscess formation around the fungus. The findings were consistent with chronic fungal infection with morphology indicative of chromoblastomycosis. He was treated with itraconazole 400 mg per day for 8 months. There was no recurrence of the infection.

Chromoblastomycosis is caused by a large number of melanized fungi in the *Herpotrichiellaceae* family. The two common causative genera include *Fonsecaea* and *Cladophialophora* species. The most frequent causes are *F. pedrosoi*, and *C. carrionii*. Rare cases of *Exophiala* and *Phialophora* species and *Rhinocladiella aquaspersa* were reported in patients with chromoblastomycosis [1-3]. Unfortunately, we were unable to find the etiological agent in our patient. The fungi enter the body usually following a trauma and they produce thick-walled, single or multicelled clusters (sclerotic or muriform bodies). Chromoblastomycosis cause diverse morphological lesions including nodular, verrucous, tumorous, cicatricial, and plaque. Local pain and pruritis are common. Clinical manifestations depend on fungal virulence, anatomic location of the infection, and the host response. Key diagnostic feature is detection of muriform cells in potassium hydroxide mount or histopathology. Fungal cultures may identify the organism. Treatment depends on the severity of the disease. Oral antifungals are the main stay of treatment with surgical excision as and when possible. The antifungal drugs of choice are, itraconazole 200-400 mg per day or terbinafine, 250-500 mg per day for 6 months to a year. The

disease can be treated to the point of cure. Long-term follow-up is necessary to confirm eradication of infection. Prevention is by avoiding cutaneous trauma [1,2].

Clinicians should be aware of this rare fungal infection for prompt recognition and appropriate treatment.

References

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