ORIGINAL RESEARCH PAPER

General Surgery

PHAEOHYPHOMYCOTIC CYST- A RARE SUBCUTANEOUS PRESENTATION

KEY WORDS:
Phaeohyphomycosis, Fungi, Cyst, E.jeanselmi

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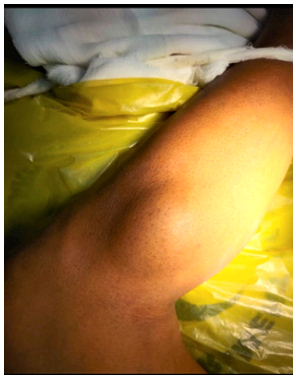
CASE REPORT:

A 48 year old female came with c/o swelling in R leg for 4 years. No H/o penetrating trauma. No H/o pain over the swelling. No H/o swelling anywhere in the body. Patient a known diabetic for 4 years on medications. Patient was previously treated with therapeutic aspiration of the swelling – in the culture showed septate hyphae s/o phaeohyp hom yc osis. Patient was treated with Tab itraco nazole. Patient is a known HBSAG+ve. No other comorbids. On examination 8*6cm swelling over postero lateral aspect of right leg. Oval in shape ,smooth surface, skin over swelling is normal. On palpation swelling is not warm, not tender and fluctuant. On investigation HFUSG- cystic swelling in subcutaneous plane. FNAC- showed septate hyphae. Patient was proceeded with excision with post op Tab itraconazole. On follow up showed no relapse.

PRE OP PICTURE



INTRA OP PICTURE

DISCUSSION:

PHAEOHYPHOMYCOSIS-

pigmented dematiaceous fu ngi(melanin) grouped into ph ae ohyphomycosis, chromoblastomycosis, mycetoma. Presents as cutaneous, subcutaneous and systemic infection. Subc uta neous infection most common in extremities and most com mon in immunocompromised individual and mostly by traumatic inoculation. Most common etiological agent is E.J EANSELMI and E.DERMATIDIS. E.JEANSELMI- usually presents as subcutaneous cysts or abscesses and usually spares the overlying skin. All dematiaceous fungi are similar in morphology and differentiated by culture. So far 23 cases of subcutaneous phaeohyphomycosis have been reported from india predominantly involving extremities. Majority are caused by E.JEANSELMI.m our case is not associated with immunocompromised state and traumatic inoculation. Surgical excision is the treatment of choice with or without Tab Itraconazole. Surgical excision alone has not showed any relapse so far.

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