White Grain Eumycetoma due to *Aspergillus flavus* in Infancy: A Rare Case Report from Assam

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http://dx.doi.org/10.22207/JPAM.11.2.38
(Received: 11 May 2017; accepted: 16 June 2017)

Mycetoma is a slowly progressive, chronic granulomatous infection of skin and subcutaneous tissue caused by traumatic inoculation of either fungi (eumycotic) or bacteria (actinomycotic). The disease is characterized by triad of tumefaction, discharging sinuses and grains. Here, we report a case of eumycetoma in an infant presenting with multiple discharging sinuses in lower limb. Aspirate and biopsy tissue from the sinuses were processed. The discharge revealed presence of white grains. Potassium hydroxide (KOH) mount revealed presence of hyaline septate hyphae. Histopathological examination showed granulation tissue and fungal hyphae. Repeated culture on sabouraud’s dextrose agar (SDA) with chloramphenicol showed growth of *Aspergillus flavus* on each occasion. Antifungal susceptibility testing was done following Clinical Laboratory Standard Institute (CLSI) M38-A2 protocol and showed high minimum inhibitory concentration (MIC) for fluconazole, caspofungin, anidulofungin and micafungin. The patient responded to itraconazole. Hence, exact categorization of lesion is essential for effective therapy and better prognosis.

Keywords: *Aspergillus flavus*, Eumycetoma, White grain mycetoma.
Before investigating the case, a written informed consent was obtained from the parents of the patient. Examination revealed swelling of affected lower limb with multiple discharging sinuses covered with slough with deep induration involving an area of 3.5 X 2.5 inches. The sinuses were fixed to deeper structures discharging purulent fluid with white granules. There was no regional lymphadenopathy. Laboratory investigation revealed low hemoglobin (7.6 g/dl), normocytic, normochromic anemia and a high total leucocyte count (23.32 × 10³/µl). Mantoux and Venereal Disease Research Laboratory (VDRL) tests were negative. Chest X-ray was within normal limit. X-ray (left leg) showed soft tissue swelling with obliteration of fascial planes (Figure 2). Radiologically there was no evidence of osteomyelitis.

After thorough cleaning of the lesions, a pasteur pipette was introduced in to the sinuses. The aspirated material was rinsed in sterile saline and allowed to settle. A few white, irregular granules of variable size were observed in the aspirate and discharges. (Figure 3) The granules were crushed and subjected to microscopy and culture. Biopsy tissue from the sinus was also collected.

Gram stain, potassium hydroxide (KOH) mount, Ziehl-Neelsen stain and modified Ziehl-Neelsen stain (1% H₂SO₄) were done. The specimens were inoculated in to blood agar and MacConkey agar for bacterial culture and incubated at 37°C for 3 days. The granules were also inoculated onto two sets of Sabouraud’s dextrose agar with chloramphenicol (0.05 mg/ml) (SDA-C) and incubated at 30°C and 37°C respectively. These were also inoculated onto two sets of brain heart infusion agar with 5% sheep blood and were incubated at 37°C for 14 days under aerobic and anaerobic conditions. The specimens were also processed to exclude tubercular etiology by standard methods.

The microscopic examination of KOH mount of the aspirate and biopsy tissue showed septate hyaline hyphae and spores. (Figure 4A & B) Gram staining was performed to distinguish between actinomycetoma and eumycetoma which showed gram negative septate hyphae. (Figure 5) Histopathological examination of the hematoxylin-eosin stained tissue revealed nonspecific granulomatous inflammation with

<table>
<thead>
<tr>
<th>Ref. Author &amp; year</th>
<th>Geographical region</th>
<th>Age of patient</th>
<th>Site</th>
<th>Etiological agent</th>
<th>Treatment</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Capoor et al. (2007)</td>
<td>Uttar Pradesh, India</td>
<td>8 years</td>
<td>Foot</td>
<td>Exophiala jeanselmei</td>
<td>Ketoconazole and surgical curettage</td>
<td>Cured</td>
</tr>
<tr>
<td>10 Joshi et al. (2014)</td>
<td>Karnataka, India</td>
<td>2 years</td>
<td>Submandibular region</td>
<td>Agent not identified</td>
<td>Ketoconazole</td>
<td>Not known</td>
</tr>
<tr>
<td>11 Purkayastha et al. (2015)</td>
<td>Karnatala, India</td>
<td>30 week</td>
<td>Right ventricle of heart</td>
<td>Candida albicans</td>
<td>Amphotericin B + Fluconazole + Voriconazole + surgical debridement</td>
<td>Died</td>
</tr>
<tr>
<td>12 Tendolkar et al. (2016)</td>
<td>Uttar Pradesh, India</td>
<td>8 years</td>
<td>Forearm</td>
<td>Madurella mycetomatis</td>
<td>N/A</td>
<td>Relapsed after six months and refused for further treatment</td>
</tr>
</tbody>
</table>
a central focus of acute inflammatory reaction surrounding grains in the subcutaneous tissue which was surrounded by histiocytes and a mixed inflammatory infiltrate comprising lymphocytes, plasma cells, eosinophils, macrophages and fibrosis along with thick club shaped structures and septate fungal hyphae.

Yellow to green velvety colonies appeared on SDA-C plates after 4 days. Microscopic morphology of the colony showed conidiophores with single phialides covering approximately the entire vesicle which was compatible with that of *Aspergillus flavus*. (Figure 6A & B). Repeatedly three different samples were tested and on each occasion *Aspergillus flavus* was isolated. Bacteriological cultures were sterile.

The antifungal susceptibility test done at Department of Medical Microbiology, Postgraduate Institute of Medical Education and Research, Chandigarh by CLSI M38-A2 protocol showed the MIC of amphotericin B, fluconazole, voriconazole, itraconazole, posaconazole, caspofungin, anidulofungin and micafungin to be 0.5µg/ml, 32 µg/ml, 0.06 µg/ml, 0.06 µg/ml, 32 µg/ml, 16 µg/ml and 16 µg/ml respectively.\(^5\) Surgical curettage and debridement were done along with treatment with itraconazole (5mg/kg/day) for 8 weeks. The patient responded to treatment with regression of swelling after two months without any discharge. No relapse was seen on subsequent follow up for 6 months. (Figure 7)

**DISCUSSION**

The reliable epidemiological information regarding eumycetoma is limited even though it was first reported from India in the middle of the 19th century. Eumycetoma usually affects adult males involving limbs and other exposed parts of the body. Children are the least affected group. The case presented here was an infant who presented with a rapidly progressive course of the disease which is an unusual presentation. There are very few reports on eumycetoma in children from India. (Table 1)\(^6\-\^9\)

**Fig. 1.** Multiple discharging sinuses in the left leg

**Fig. 2.** X-Ray of the affected limb showing soft tissue swelling

**Fig. 3.** White grains present in the discharge

**Fig. 4.** A-Fungal hyphae in discharge (×400); B-Fungal spores seen in discharge (×400)
Aspergillus species are uncommon cause of eumycetoma. Many antifungals showed higher MIC values against this isolate. Also, the development of the lesion was very fast which might lead to early involvement of bones if differentiation of the lesions was not done accurately for appropriate therapy.

The differential diagnosis for multiple discharging sinuses in children includes osteomyelitis and tuberculosis. Staphylococcal infection and mucormycosis, both are rapidly progressive in nature, and later is associated with necrosis of skin and subcutaneous tissue leading to eschar formation. Other diseases presenting as discharging sinuses in children are actinomycosis, botryomycosis, nocardiosis, and sporotrichosis. Sinuses of actinomycosis and nocardiosis usually discharge granules; botryomycosis is associated with subcutaneous nodules and large verrucous lesions; and in sporotrichosis, ascending chain of nodules develops along the skin lymphatic channels. Eumycotic and actinomycotic mycetoma are characterized by multiple punched out lytic lesions and both osteolytic and osteosclerotic lesions in bones respectively. In this regard, yaws and syphilis should also be considered. Differentiation between actinomycetoma and eumycetoma is important because of their differences in response to treatment. The colour of grains helps a great deal to make a presumptive diagnosis so that proper treatment of mycetoma can be started in time.

In conclusion, it is utmost necessary that, the clinicians become aware of the disease to suspect and investigate for fungal etiology, especially in the absence of response to antibacterial therapy.

ACKNOWLEDGEMENT

I express my sincere gratitude to Dr. Arunaloke Chakrabarti, Professor & Head, Dr. Shivaprakash M Rudramurthy, Professor, Mrs. Sunita Gupta, Senior Medical Technologist, Department of Medical Microbiology, Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, for doing antifungal susceptibility test of the isolate.

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