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Clinical Image

Disseminated Sporotrichosis as the Initial Presentation of AIDS

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CLINICAL IMAGE

A 38-year-old man was admitted to our hospital with 3-month history of fever, asthenia and profound weight loss. In addition, he complained of multiple skin lesions, which started initially as papules and progress to ulcers. He reported a history of cat bite in his arm. Physical examination was notable for numerous skin nodular lesions; the majority of them ulcerated, throughout his body, especially on trunk, back and lower limbs (Figure 1 and 2). Nasal inspection revealed septum ulcer and partial destruction.

Laboratory exams showed positive reaction to HIV (CD4⁺ count and viral load were 50 cells/ul and 281.994 copies, respectively). Subsequently, combination antiretroviral therapy



Figure 1 Multipleulcero-crusted round lesions on trunk.



Figure 2 Two ulcers in the inner aspect of left lower leg; the largest measure 5x8 cm.

Clinical Research in HIV/ AIDS

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Figure 3 Suppurative granuloma filled with plasma cells, epitheloid cells and lymphocytes (H&E stain, 100x).



Figure 4 Numerous rounded and cigar shaped budding yeasts (GomoriGrocott stain, 20x).

was started with Tenofovir, Lamivudine and Efavirenz. A 4-mm abdomen skin's punch biopsy was obtained and demonstrated diffuse suppurative granulomatous dermatitis with giant cells, epitheliod cells, plasma cells and lymphocytes (Figure 3). PAS and Gomori-Grocott stains revealed rounded and elongated cigarshaped elliptical yeast structures (Figure 4 and 5). Biopsy of nasal septum ulcer grew *Sporothrixschenckii* on Sabouraud dextrose agar medium, confirming the diagnosis of sporotrichosis.

Amphotericin Bdeoxycholate (2.5 g, total dose) was initiated for 2-weeks, followed by Itraconazol (200 mg/day) for 6 months with clinical improvement. Maintenance therapy with Itraconazol was planned until patient immunological status improved (i.e. CD4> 200 cells/ul).

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Sporothrichosis is the mostprevalent mycosis in South America, caused by the dimorphic fungus –*Sporothrix* complex –which included four distinct species: *S. globosa, S. brasiliensis, S. Mexicana and S. schenckii.* [1]. Although it is classically described as associated with traumatic inoculation from soil, vegetables and organic matter contaminated with *S.* species, zoonotic transmission has also been reported [2]. Since 1998, a cat-transmitted Sporothrichosis epidemic has emerged in Rio de Janeiro, Brazil [3]. Remarkably, the majority of HIVinfected patients presented with disseminated form, involving skin, mucosa, bone or meninges [4]. In endemic countries, Sporothrichosis should be considered as an opportunistic infection, requiring the inclusion of this disease in differential diagnosis of skin lesions in AIDS patients.

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