

IMAGES IN DERMATOLOGY

Mini-mycetoma, an Indicator of Broader Disease

Mini-micetoma, indicio de un problema mayor



A. Robles-Tenorio^a, L. Vera-Cabrera^b, V.M. Tarango-Martínez^{c,*}

^a Escuela de Medicina y Ciencias de la Salud, Tecnológico de Monterrey, Mexico

^b Facultad de Medicina, Universidad Autónoma de Nuevo León México, Mexico

^c Instituto Dermatológico de Jalisco "Dr. José Barba Rubio", Secretaría de Salud Jalisco, Guadalajara, Mexico

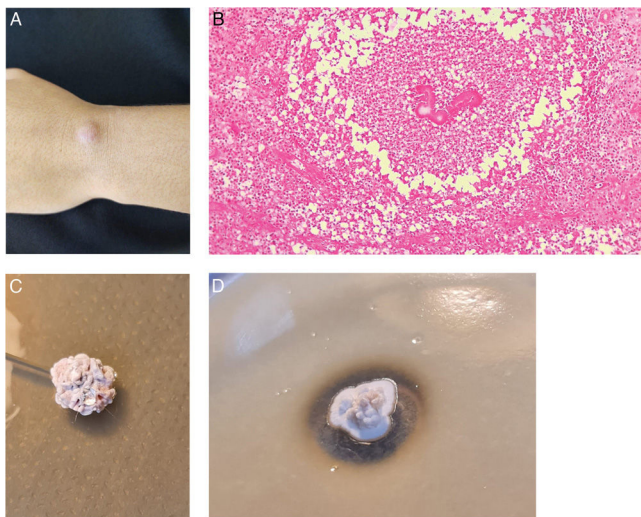


Figure 1

An 18-year-old woman presented with a 10-month history of a 1 cm nodule on her left hand (Fig. 1A). The lesion was surgically excised considering a clinical diag-

nosis of pilomatrixoma vs dermatofibroma. At the time of suture removal, the wound showed purulent discharge. Histopathology showed lobulated grains, a mixed inflammatory infiltrate, and the Splendore-Hoeppli phenomenon (Fig. 1B). Whitish, wrinkled colonies grew in Sabouraud culture from the discharge (Fig. 1C). Negative hypoxanthine and positive casein hydrolysis tests confirmed *Nocardia brasiliensis* infection (Fig. 1D). Treatment involved a 6-month regimen of trimethoprim-sulfamethoxazole (SXT) 800/160 mg BID and amoxicillin-clavulanic acid (AMC) 875/125 mg BID, resulting in both mycological and clinical cure.

Mini-mycetomas are small, non-invasive, localized forms of actinomycetomas caused by *N. brasiliensis*, primarily affecting children and adolescents. A robust immune system or infection with less virulent strains likely explain this localized form, as opposed to typical actinomycetomas and eumycetomas. While there are no established treatment guidelines, anecdotal evidence suggests a minimum 6-month regimen with AMC and SXT. Since mini-mycetomas have an unremarkable presentation, clinicians should become aware of this condition in endemic areas or in patients who migrate from affected regions.

* Corresponding author.

E-mail address: drtarangovic@gmail.com (V.M. Tarango-Martínez).