A 46-year-old male farmer born in Minas Gerais State, Brazil, presented with disseminated plaque-like, ulcerated skin lesions (Figure 1A–D). Laryngoscopy showed lesions on the pharyngeal, nasal, and laryngeal mucosa (Figure 1E). He was a heavy tobacco smoker and drank 1–2 L of rum daily.

The differential diagnosis included secondary syphilis, sporotrichosis, histoplasmosis, tuberculosis, chromomycosis, and leishmaniasis. The following serologies were negative: venereal disease research laboratory (VDRL), Chagas disease, hepatitis B surface antigen, hepatitis C antibodies, and human immunodeficiency virus (HIV). Biopsy showed granulomatous inflammation, and yeasts with birefringent walls and multiple buds with a rudder’s wheel aspect, characteristic of paracoccidioidomycosis (PCM), were seen (Figure 2A and B). Enzyme-linked immunosorbent assay (ELISA) for rPb27 and rPb40 (highly specific for Paracoccidioides brasilensis) was strongly positive.1

Treatment with itraconazole (200 mg/day) resulted in generalized swelling, necessitating cessation. Cetoconazole (200 mg/day) was started and used for 3 months without improvement.

PCM is the most prevalent deep mycosis in Latin America, and it is caused by dimorphic fungus Paracoccidioides brasilensis.2 It has different anatomoclinical forms (acute/subacute or chronic/multifocal), and it may affect any organ or system. The mucocutaneous involvement, seen in the present case, is most common in the chronic form of the disease. Prolonged treatment is necessary to control the mycosis, and use of traditional antibiotics such as sulfamethoxazole-trimethoprim is very effective.

Sulfamethoxazole-trimethoprim (800/160 mg two times per day) was added, and 60 days later, there was substantial improvement of the skin lesions; laryngeal lesions resolved after 6 months.

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