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# Images in Clinical Tropical Medicine

## Buruli Ulcer

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A 34-year-old Peruvian female, 34 weeks pregnant, had burning pain and edema in the right thigh. A 1-cm asymptomatic nodular lesion preceded this complaint by 1 year. Treatment with dicloxacillin was followed by the lesion becoming red, swollen, and hot, accompanied by oozing. Despite additional dicloxacillin and clindamycin treatment, the lesion progressed, with the development of necrotic borders and, 2 months later, the appearance of four additional nodules on the same leg. Microscopic analysis of a skin biopsy showed acid-fast organisms; culture on Lowenstein Jensen medium initially grew colonies suggestive of *Mycobacterium ulcerans* but was finally reported as negative. Tissue polymerase chain reaction confirmed the identification of the organism.[1] After delivery of a healthy baby, the patient was treated with streptomycin and rifampin for 8 weeks, and the open wound was treated with local surgery, resulting in complete cure (Figure 1).

Buruli ulcer is the third most common mycobacterial disease,[2] usually acquired in tropical and subtropical regions of the Americas, Asia, Africa, and Australia. Typical manifestations are lower limb lesions, which may or may not ulcerate. These lesions are minimally painful but progress and lead to functional deficits and stigmatization.[1–3] Treatment with rifampin and an aminoglycoside is usually curative.[3] Treatment is often delayed because of lack of diagnostic suspicion or cost.

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## REFERENCES

1. Guerra H, Palomino JC, Bravo F, Donaires N, Van Marck E, 2008. *Mycobacterium ulcerans* disease, Peru. *Emerg Infect Dis 14:* March. Available at: http://www.cdc.gov/EID/content/14/3/373.htm.
2. Caro F, Llerena G, 2006. Buruli ulcer in Tumbes. A case report and literature review. *Folia Dermatol Peru 17:* 76–81.
3. World Health Organization, 2004. *Provisional Guidance on the Role of Specific Antibiotics in the Management of Mycobacterium ulcerans Disease (Buruli Ulcer).* Geneva: World Health Organization.

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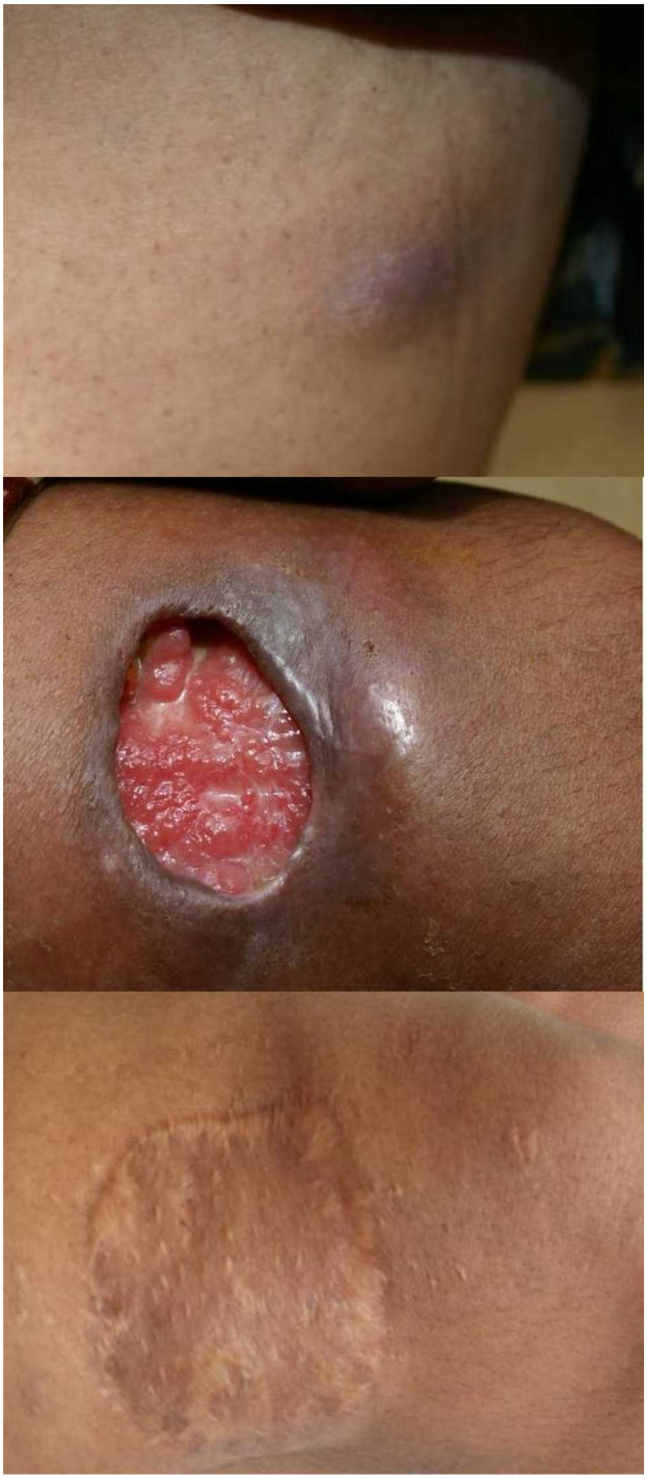

FIGURE 1. Buruli ulcer. **Top**, Early nodular lesion. **Center/bottom**, Deep and undermined ulcerative lesion with necrotic borders, before and after medical treatment plus local surgery including skin grafting. This figure appears in color at www.ajtmh.org.