

Case Report

Giant eumycetoma gluteal region: excision and V-Y flap advancement

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ABSTRACT

Eumycetoma (“mycotic mycetoma”) is a chronic subcutaneous fungal infection of the skin and soft tissue, most often affecting the lower extremity (typically a single foot). Eumycetomas are usually confined to subcutaneous tissues but can involve fascia, bone, and regional lymph nodes via contiguous dissemination. We hereby report a case mycetoma of gluteal region, an unusual site of presentation.

Keywords: Eumycetoma, Gluteal region, Fungal infection

INTRODUCTION

Mycetoma or maduromycosis may be caused by true fungi or Actinomycetes. This infection result in a granulomatous inflammatory response in the deep dermis and subcutaneous tissue. Clinically it is characterized by formation of granules of causative organism which are discharged from skin by multiple sinuses. Eumycetoma is mainly caused by *P. boydii* (*S. apiospermum*) or *Madurella mycetomatis*. We hereby report a 55 years Hindu male patient presented with giant gluteal eumycetoma, treated with excision and V-Y flap advancement.

CASE REPORT

A 55 years Hindu farmer male is admitted in our institute with complaints of painless swelling of left gluteal region for last 4 years. There is no history of DM, HTN, TB or Immunodeficiency. On clinical examination swelling of around 10x12 cm is found left gluteal region. There is blackish discolouration, irregular surface and multiple discharging black granules over the swelling. Routine blood investigations including Hb and TLC were found to

be 12.5 gm/dl and 7400 respectively. Patient was operated and left gluteal swelling is excised. There was multiple sinus tracts with black coloured granules and dirty mud coloured fluid. A large tissue defect is created which is covered with V-Y flap Advancement. Patient was discharged postoperative day- 3. Postoperative stay was completely uneventful. Later on patient was followed after 1 weeks and 4 weeks. V-Y flap advancement is found successful. Histopathology report shows eumycetoma.



Figure 1: Showing multiple sinus with discharging granules.



Figure 2: Showing tissue specimen with fungal colony & gluteal fat.



Figure 3: Showing V-Y flap advancement.

DISCUSSION

Mycetoma is a chronic granulomatous, progressive, subcutaneous inflammatory infection. It is caused by true fungi or by bacteria, and hence, it is classified as eumycetoma or actinomycetoma, respectively. The triad of a painless subcutaneous mass, multiple sinuses, and seropurulent discharge containing grains is pathognomic of mycetoma. Mycetoma is a chronic progressive disease characterized by suppurative, swollen lesions and sinuses and can be caused by both bacteria and fungi. Based on the color of the grain, fungal mycetomata can be divided into two large groups: those causing black or white

grains. Black-grain mycetoma is mainly associated with *M. mycetomatis*, *Madurella grisea*, *Leptosphaeria senegalensis*, *Pyrenochaeta romeroi*, and *Exophiala jeanselmei*; white-grain mycetoma is usually caused by *Pseudallescheria boydii*, *Acremonium kiliense*, and other, occasional agents. As noted in most cases of mycetoma, it is difficult to explain how our patient acquired his infection. Since the patient is a farmer by occupation, he is in daily contact with soil, thorns, wood, and other trauma-causing objects; even minor trauma might have facilitated the introduction of the fungus into his foot. Hence surgical as well as medical management is an essential part of its treatment.

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REFERENCES

1. Ikai K, Tomono H, Watanabe S. Phaeohyphomycosis caused by *Phialophora richardsiae*. *J Am Acad Dermatol.* 1988;19:478-81.
2. Jacobs K, Bergdahl DR, Wingfield MJ, Halik S, Seifert KA, Bright DE, et al. *Leptographium wingfieldii* introduced into North America and found associated with exotic *Tomicus piniperda* and native bark beetles. *Mycol Res.* 2004;108:411-8.
3. Lieb DF, Smiddy WE, Miller D, Cooperman EW. Case report: fungal endophthalmitis caused by *Phialophora richardsiae*. *Retina.* 2003;23:406-7.
4. Mahgoub ES, Gumaa SA. Ketoconazole in the treatment of eumycetoma due to *Madurella mycetomii*. *Trans R Soc Trop Med Hyg.* 1984;78:376-9.
5. Meyers WM, Dooley JR, Kwon-Chung KJ. Mycotic granuloma caused by *Phialophora repens*. *Am J Clin Pathol.* 1975;64:549-55.
6. O'Donnell K, Cigelnik E. Two divergent intragenomic rDNA ITS2 types within a monophyletic lineage of the fungus *Fusarium* are nonorthologous. *Mol Phylogenet Evol.* 1997;7:103-16.

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