Chromoblastomycosis caused by Rhinocladiella aquaspersa

González, G.M.; Rojas, O.C.; González, J.G.; Kang, Y.; de Hoog, G.S.

DOI
10.1016/j.mmcr.2013.08.001

Publication date
2013

Document Version
Final published version

Published in
Medical Mycology Case Reports

Citation for published version (APA):
Chromoblastomycosis caused by Rhinocladiella aquaspersa

Gloria M. González a, O. Carolina Rojas a, José G. González b, Yingqian Kang c,d, G.S. de Hoog e,f,g,h,i,j,a

a Departamento de Microbiología, Facultad de Medicina, Universidad Autónoma de Nuevo León, Monterrey, Nuevo León, México
b Hospital Universitario Dr. José Eleuterio González, Facultad de Medicina, Universidad Autónoma de Nuevo León, Monterrey, Nuevo León, México
c CBS-KNAW Fungal Biodiversity Centre, Utrecht, The Netherlands
d Department of Microbiology, Guiyang Medical College, Guiyang, China
e Institute for Biodiversity and Ecosystem Dynamics, University of Amsterdam, The Netherlands
f Peking University Health Science Center, Research Center for Medical Mycology, Beijing, China
g Sun Yat-Sen Memorial Hospital, Sun Yat-Sen University, Guangzhou, China
h Shanghai Institute of Medical Mycology, Changzheng Hospital, Second Military Medical University, Shanghai, China
i Basic Pathology Department, Federal University of Paraná State, Curitiba, Paraná, Brazil
j King Abdulassiz University, Jeddah, Saudi Arabia

ARTICLE INFO

Article history:
Received 3 June 2013
Received in revised form 15 August 2013
Accepted 21 August 2013

Keywords:
Chromoblastomycosis
Rhinocladiella aquaspersa
Itraconazole

1. Introduction

Chromoblastomycosis is a chronic granulomatous fungal infection that causes hyperproliferation of cutaneous and subcutaneous tissues and is histologically characterized by the presence of muriform cells. Infection originates after the etiologic agent gains entrance via percutaneous trauma [1]. Main agents responsible for its etiology are Fonsecaea pedrosoi, Fonsecaea monophora, Cladophialophora carrioni, Phialophora verrucosa, and Rhinocladiella aquaspersa. The disease is found in tropical and subtropical areas [2–4], with the vicarious agents [5] of Fonsecaea and Phialophora occurring under hot and humid conditions [6], and Cladophialophora being restricted to arid climates [7–10]. R. aquaspersa is an uncommon cause of chromoblastomycosis, with most cases having been reported from the American continent [11–14]. The present paper presents a further case from Venezuela and summarizes the climatic conditions of the areas where R. aquaspersa is endemic.

2. Case report

A 63-year-old male construction worker, native and resident of a rural area in Siquisique (Caserío La Unión), Lara State, Venezuela, presented with an asymptomatic, localized lesion affecting the dorsal surface of the left hand, involving the knuckles and proximal interphalangeal joints of the third and fourth fingers. The dermatosis produced retraction of the fifth finger. Examination of the skin disclosed a scaly, crusted, dull-red plaque, friable with hemorrhagic dots. The lesion was almost flat and eroded. According to the patient, the lesion had developed over an 18-month period and trauma or inoculation was not recalled. There were no lymphatic commitments. He has never been outside Siquisique city. The patient denied other problems but was in poor health and nutritional conditions. To recover the etiologic agent, the area was soaked with alcohol and recover the etiologic agent, the area was soaked with alcohol and then eroded. Direct KOH examination of the crusts of the lesions revealed numerous thick-walled, globose or ovoidal, dark-brown muriform cells approximately 6–8 μm in diameter, either singly or arranged in groups.

Microscopic examination of a biopsy specimen from the lesion stained with periodic acid Schiff showed pseudoepitheliomatous hyperplasia and a mixed cell granulomatous infiltrate consisted of lymphocytes, histiocytes, giant cells, and neutrophils. Muriform cells were observed in the granulomatous tissue. These results...
The isolate assimilated \( \text{d}-\text{glucose}, \text{glycerol}, \text{2-k-\text{d}-\text{gluconate}}, \text{L-arabinose}, \text{\text{d}-xyllose}, \text{adonitol}, \text{n-\text{galactose}, inositol, \text{d}-\text{sorbitol, methyl-\text{d}-\text{glucopiranoside, N-acetyl-\text{glucosamine, d}-\text{cellobiose, d-maltose, d-saccharose, d-trehalose, d-melezitose, d-raffinose.}}}} \) In contrast, \( \text{d}-\text{lactose and xylitol were not assimilated. Urea hydrolysis was positive, growth on Mycosel agar was not inhibited by cycloheximide, and liquefaction of gelatin was absent. The isolate grew at 30 °C, had limited growth at 37 °C, and failed to grow at 40 °C. Growth in malt extract agar with all sodium chloride concentrations tested was negative.} \)

For molecular identification, approximately \( 1 \text{ cm}^2 \) mycelium from 2-week-old cultures was transferred to 2 ml Eppendorf tubes containing 200 \( \mu\text{l} \) of enzymatic lyses buffer \([20 \text{mM Tris–HCl (pH 8), 2 mM EDTA, 1.2% Triton X-100, 20 mg/ml lysozyme}, \) which were then incubated at 37 °C for 2 h with agitation. Afterwards, 390 \( \mu\text{l} \) TE 1 \( \times \) with 1% SDS and 4 \( \mu\text{l} \) (10 mg/ml) proteinase K were added and cells were incubated for 1 h at 55 °C. After, 100 \( \mu\text{l} \) 5 M NaCl and 80 \( \mu\text{l} \) of 10% CTAB/4.1% NaCl were added and the mixture was vortexed and incubated for 10 min at 65 °C. DNA was extracted twice with 1 vol of phenol–chloroform–isoamyl alcohol \((25:24:1)\), precipitated with absolute ethanol, washed with 70% ethanol, air dried, and resuspended in 200 \( \mu\text{l} \) of Tris–EDTA buffer \([19]\). Ribosomal DNA ITS domains were amplified using primers ITS-4 \((5\'\text{-TCTCCGCGTTATGATGC-3')}\) and ITS-5 \((5\'\text{GAAGATTAAGTGTGACTTAAACAAGG-3')}\) [20]. Amplifications were performed in a final volume of 25 \( \mu\text{l} \) containing 1 \( \times \) PCR buffer, 2 mM MgCl\(_2\), 0.2 mM of each dNTP, 200 nM of each primer, 1 U of AmpliFi polymerase (Bioline, Randolph, MA, U.S.A.), and 100 ng DNA. The thermocycling conditions were: 94 °C for 4 min, followed by 30 cycles of 94 °C for 60 s, 55 °C for 90 s, and 72 °C for 90 s, with final extension at 72 °C for 5 min. The final products were electrophoresed in 1.5% agarose gel and stained with ethidium bromide. Hyper Ladder I (Bioline) was used as a molecular weight marker for size determinations. The pattern of amplified bands was photographed and analyzed with the UVP Biolimaging System, EpiChemi III Darkroom. PCR products were purified using the commercial Wizard PCR Preps DNA purification system (Promega, Madison, WI, U.S.A.). Sequencing was performed in both directions at the Instituto de Biotecnología, Universidad Nacional Autónoma de México. DNA sequence fragments were compared to NCBI GenBank sequence entries using the BLAST algorithm and to a research database on black fungi at CBS-KNAW Fungal Biodiversity Centre, Utrecht, The Netherlands. The sequence was deposited in GenBank with accession number GU177853 as species of order Chaetothyriales. Later, the isolate was identified at CBS as \( R. \text{aquaspera.} \) The culture was deposited in the CBS reference collection as CBS 132913.

2.2. Antifungal susceptibility

Amphotericin B (AMB) (Bristol-Myers Squibb, Princeton, NJ, U.S.A.), itraconazole (ITZ) (Janssen Pharmaceutica, Beerse, Belgium), voriconazole (VRZ) (Pfizer, Inc., New York, NY, U.S.A.), posaconazole (PSZ) (Scherer-Plough, Kenilworth,NJ, U.S.A.), and terbinafine (TBF) (Novartis, Mexico) were obtained in reagent-grade powder form from their respective manufacturers. Isolates were evaluated by using Clinical and Laboratory Standard Institute broth macrodilution approved standard reference method M38-A2 [21]. After adequate sporulation occurred on PDA, the mycelium was overlaid with sterile distilled water, and suspensions were made by softly scraping the colonies with wooden applicators. Heavy fragments were allowed to settle, and the upper, homogeneous supernatant was transferred to sterile tubes. Inocula suspension of \( 10^6 \text{ CFU/ml} \) were prepared by hemacytometer counts and then diluted in RPMI 1640 medium with glutamine and morpholinopropanesulfonic acid buffer at a concentration of 0.165 M (Angus, Niagara Falls, NY, U.S.A.) to obtain a final organism concentration of 0.1, 1, and 10 µg/ml. The MIC was determined after 7 days incubation at 37 °C.

2.1. Mycology

The mold was subcultured on SGA and on potato dextrose agar (PDA) on culture plates \((20 \text{ mm diam.}) \) incubated at 30 °C. After 2 weeks velvety colonies developed which were dark olive with an olivaceous black reverse. Slide cultures were performed on PDA blocks. After 2 weeks slides were stained with lactophenol cotton blue and evaluated in a Nikon Eclipse 50i microscope. Isolates from different clinical sources were single-celled, smooth, ellipsoidal to clavate, 4.0–6.6 \( \mu\text{m} \) long, light brown. The mold was tentatively identified by morphological and molecular identification. The patient was treated with oral itraconazole (100 mg/day). The lesions improved after 2 months, with significant healing, desquamation having disappeared, and culture became negative. No side effects were noted by the patient during the course of treatment. Unfortunately, the patient could not be contacted for further follow-up.
was verified by plating 10 μL onto PDA, incubating the plates at 35 °C, and counting the number of colonies. Serial dilution of the drugs was made following the CLSI guidelines in order to obtain final concentrations of the drugs ranging from 0.015 to 8 mg/L for all antifungal compounds. Candida krusei ATCC 6258 and Paecilomyces variotii ATCC MYA3630 were used for quality control.

Results of susceptibility testing were: AMB ¼ 0.06 μg/mL, ITZ ¼ 1 μg/mL, VRCZ ¼ 1 μg/mL, and PSZ ¼ 0.25 μg/mL, respectively.

3. Discussion

R. aquaspersa is a rare agent of human chromoblastomycosis. An overview of clinical cases is presented in Table 1; several reports provided only very scant information. Most cases report the presence of mirmiform cells in tissue, but in Case 3 these were absent. The clinical appearance of the disease is highly diverse [23].

The optimal conditions for propagation of the species are in Cladophialophora and Fonsecaea and are restricted to arid and tropical climates, respectively [5,9], but environmental data of cases of R. aquaspersa do not show any consistency (Table 1). Caserio La Unión of the present case is located in the northernmost part of the state, between 600 and 700 m above mean sea level. This area presents temperatures between 23 and 28 °C, its annual precipitation varies between 950 and 1400 mm, and its annual evaporation rates range from 1400 to 2400 mm. The predominance of semi-deciduous vegetation is associated to the aforementioned climatic conditions. The global distribution of R. aquaspersa is (sub)tropical. The species has thus far not been recovered from the environment, but Badali et al. [14] mentioned a case acquired by from a cactus thorn suggesting a natural habitat on living or dead plants. Marques et al. [13] reported a case secondary to an insect bite.

The species is susceptible to commonly used azoles, and in our case treatment of the infection with itraconazole led to healing within two months.

Conflict of interest statement

We declare that we have no conflict of interest.

Acknowledgments

Please acknowledge anyone who contributed towards the study by making substantial contributions to conception, design, acquisition of data, or analysis and interpretation of data, or who was involved in drafting the manuscript or revising it critically for important intellectual content, but who does not meet the criteria for authorship.

Table 1

Published cases of Rhinocladiella aquaspersa.

<table>
<thead>
<tr>
<th>Case</th>
<th>Strain</th>
<th>Patient, age</th>
<th>Site, duration</th>
<th>Geography</th>
<th>Therapy</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CBS 313.73</td>
<td>Male 56</td>
<td>Hand, 15 yr</td>
<td>Alpupeca, Mexico, 1000 m alt, arid</td>
<td>Terbinafin 6 mo (500 mg/d), cured</td>
<td>[24]</td>
</tr>
<tr>
<td>2</td>
<td>CBS 122635</td>
<td>Male 56</td>
<td>Ear, 5 yr</td>
<td>Solanena, Paraiba, Brazil, 600 m alt, tropical dry</td>
<td>Electrocauterization, itraconazole (200 mg/d), cured</td>
<td>[14]</td>
</tr>
<tr>
<td>3</td>
<td>FMR 7699</td>
<td>Female 62</td>
<td>Foot, cactus puncture, 20 yr</td>
<td>Medellin, Colombia, 1400 m alt, temperate dry</td>
<td>Itraconazole 7 mo (200 mg/d), cured</td>
<td>[11]</td>
</tr>
<tr>
<td>4</td>
<td>60</td>
<td>Female 52</td>
<td>Abdomen</td>
<td>South Korea</td>
<td>Itraconazole 4 mo (200 mg/d), surgery; cured</td>
<td>[25]</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>Male 52</td>
<td>Arm, leg, forehead, 2 y, insect bite</td>
<td>Maranhão, Brazil, 300 m alt, tropical</td>
<td>Itraconazole; failure</td>
<td>[13]</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>Male 5</td>
<td>Upper limb, 2 yr</td>
<td>Santa Cruz de Bucaral, Falcon state, Venezuela, 800 m, arid</td>
<td>Ketoconazole; failure</td>
<td>[12]</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>Male 5</td>
<td>Abdomen</td>
<td>Minas Gerais, Brazil, 300 m alt, tropical</td>
<td>Itraconazole; failure</td>
<td>[26]</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>Male 56</td>
<td>Hand, 18 mo</td>
<td>Costa Rica, tropical</td>
<td>Itraconazole 2 mo (100 mg/day); cured</td>
<td>[12]</td>
</tr>
<tr>
<td>9</td>
<td>No data</td>
<td>Male 56</td>
<td>Abdomen</td>
<td>Siquisique, Lara State, Venezuela, 600 m alt, tropical</td>
<td>Present case</td>
<td></td>
</tr>
</tbody>
</table>

References


