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Cutaneous Botryomycosis in an Immunocompromised Patient

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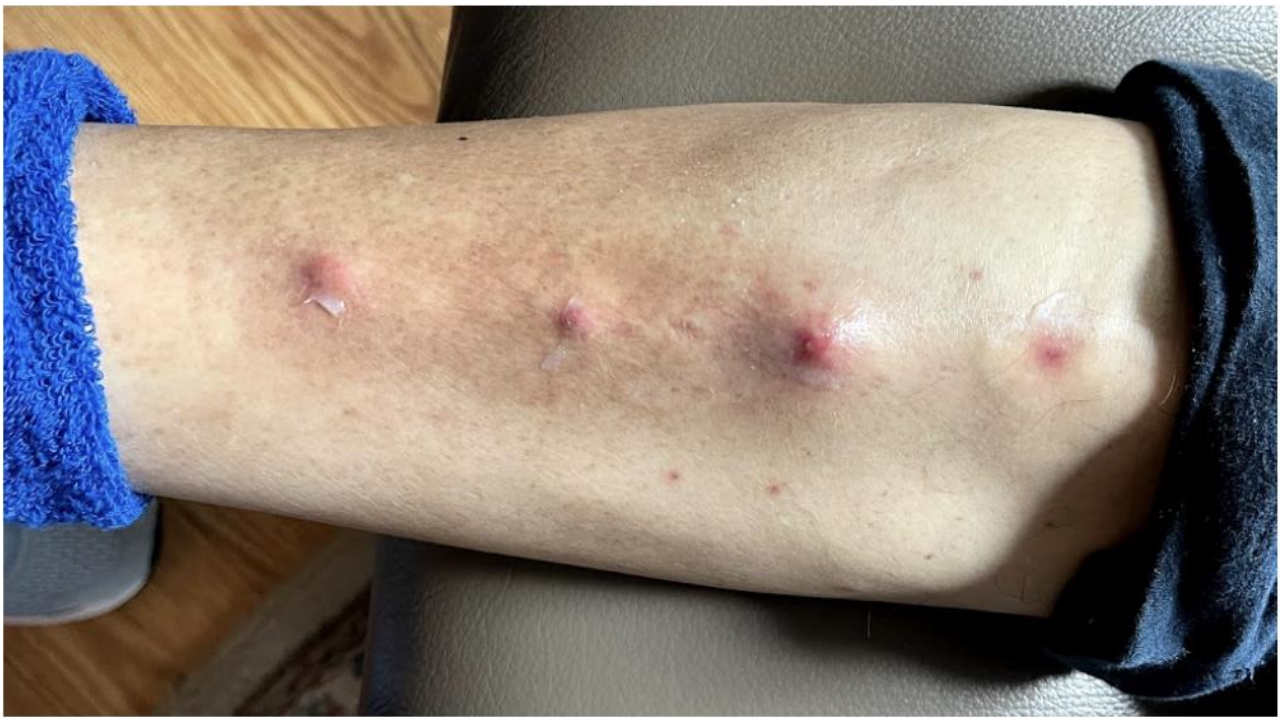
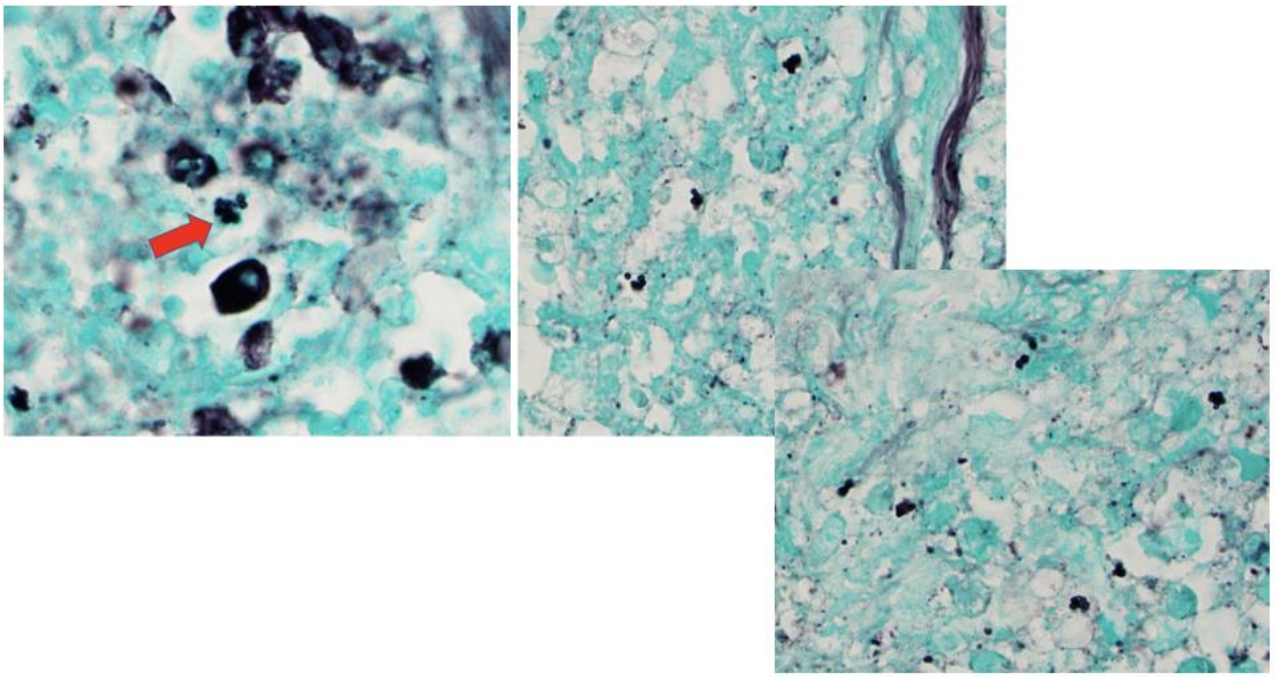


Panel A: Four tender nodules on the anterior Right shin.



Panel B: Gomori's Methenamine Silver (GMS) stain: Red arrow points to round structures that were initially thought to be questionable focal yeast like organisms, but not seen on PAS or acid-fast stains.

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A 76-year-old man with a history of orthotopic liver transplant presented with a 3-week history of erythematous, violaceous nodules on his anterior and posterior right leg (Panel A). Biopsies showed questionable yeast-like organisms on GMS stain, but not on PAS, Giemsa, or acid-fast stains (Panel B). A tissue biopsy sample grew methicillin-resistant Staphylococcus aureus, and the diagnosis of cutaneous botryomycosis was made by histopathology.

Botryomycosis presents as single to multiple nonpainful, firm nodules with or without draining fistulae that develop slowly and are typically caused by Staphylococcus species. The slow growth is thought to be due to a balance between the host's immune system and the bacteria's decreased pathogenicity. In addition to fungal and mycobacterial infections, botryomycosis should be considered in the differential diagnosis for immunocompromised patients presenting with cutaneous nodules. A 4-week course of doxycycline and local wound care led to complete resolution of the patient's lesions.