Mycetoma, an uncommon chronic infectious disease involving skin and subcutaneous tissue; commonly seen in tropical and subtropical countries. It is caused by true mycetes named eumycetoma and filamentous bacteria belonging to group actinomycetes. The incidence is more common in agricultural workers walking in bare foot. Foot is most commonly affected. Other less commonly affected sites includes hand, knee, chest and head and neck region. Both forms of mycetoma present as a progressive, subcutaneous multiple nodular swelling with discharging sinuses containing black colour granules. The treatment of these two etiologies is entirely different, a definite diagnosis after histopathological examination is mandatory. We here by present a case of eumycetoma affecting knee joint.

Keywords: Eumycetoma, Discharging Sinus, Knee.
Excisional biopsy was sent for histopathological examination. Grossly, a flap like irregular capsulated soft tissue specimen of size 9x6cm received. Cut surface shows multiple cystic spaces of size ranging from 0.2 to 0.4cm and filled with blackish material. Microscopic examination revealed club shaped organism surrounded by fibrous tissue [Figure 1a]. There were multiple branching septate fungal hyphae embedded in cement like material with secretion of brown black pigment and eosinophilic structure and adjacent areas of abscess formation [Figure 1b]. Special stain showed delineated 4-5μm thick fungal hyphae highlighted by special stains Periodic Acid Schiff (PAS) [Figure 2b] and Gomori Methenamine Silver (GMS) [Figure 3a]. Gram stain was negative [Figure 3b]. So Eumycetoma was considered according to histomorphological features. As the lesion was only in the subcutaneous tissue, not affecting the underlying bone, improvement of the wound was seen. Advice was given for culture of fungal organisms, but the wound was already healed.
3. Discussion

Mycetoma is endemics in dry tropics and sub-tropic region, although it can also be found in natives of Central and South America and the Middle East between latitudes 15°S and 30°N. It generally affects agricultural workers and people who walk Barefooted in dry and dusty environment. [6,7]. Pathogens are founds in the soil and are introduced through skin wounds during minor trauma. Infection presents as firm nodular swelling but it may be soft, lobulated and rarely cystic which grows in skin and subcutaneous tissue. The swelling can ruptures forming discharging sinus tracts exuding characteristic coloured grains [4]. The granules vary in size, colour and consistency depending on the etiological species. These grains are the hallmark of mycetoma [6].

The two main etiological groups of mycetoma - actinomycotic mycetoma and eumycotic mycetoma are caused by a number of species. Over 30 species have been identified to cause mycetoma [7,8].

Actinomycotic mycetoma is caused by aerobic species of actinomycetes belonging to the genera Nocardia, Streptomyces and Actinomadura. Eumycotic mycetoma is caused by a group of fungi with thick, septate hyphae, including Madurella mycetomi, Madurella grisea, Allescheria boydii and Acremonium species [6,9].

Dark (black) grains are found only among the eumycotic mycetoma. The pigment is a melanoprotein or related substance. The characteristic features of nodular soft tissue swelling of foot along with grain discharging from multiple sinuses can be used for rapid provisional identification of the etiological agent. Some sinuses heal with scarring with simultaneous appearance of fresh sinuses in the proximal areas. The incubation period varies from several weeks to months. Sinuses develop after 6-12 months and extend to involve the underlying fascia, muscle and bone is common. In eumycotic mycetoma, there may be multiple punched out lytic lesions in bones. Actinomycotic mycetoma is characterized by both osteolytic and osteosclerotic lesions [6,7,10].

Rarely there is lymphatic dissemination to regional lymph nodes [11]. Actinomycotic mycetomas expand faster, are more invasive and have more sinuses than eumycotic variants. Histopathological examination proves useful in differentiating actinomycetoma from eumycetoma.

In cases of Madura foot, biopsy material stained with Haematoxylin and Eosin shows grains or colonies with or without surrounding granulomatous reaction. Eumycotic colonies are frequently surrounded by fibrotic tissue [7,12]. A Gram stain is of considerable value in distinguishing between actinomycetoma and eumycetoma.

The granules of actinomycetoma consists of fine branching filaments, only about 1μm thick are gram positive, whereas the grains of eumycetoma are gram negative [10]. Eumycotic grains are composed of 4-5μm thick septate hyphae and are demonstrated by PAS (periodic acid-Schiff) and GMS (Gomori methenamine silver) stains [13].

Confirmation of diagnosis and exact identification of the species requires culture. Malt extract, Sabouraud’s and Glucose nutrient agars are the commonest types of media used in cultures of Mycetoma organisms. The culture technique is practically difficult and time consuming with chances of false negative [4, 14].

The common sero-diagnostic techniques in use are counter-immuno-pheresis and ELISA. These tests are tedious, need purified antigens and hence it is time consuming with cross reactivity between the different organisms commonly occurring [1,15].

Molecular detection and identification of the causative organism is important to understand the disease aetiology, and epidemiology. A specific PCR tests is not readily available at all centers [12]. Thus histology along with special stain has a beneficial role and remains the only option in culture negative cases. Imaging studies are useful in defining the extent of disease [7].

The main differential diagnosis in patients presenting with chronic discharging sinuses in extremities include are chronic bacterial osteomyelitis, tuberculosis, deep fungal infections like blastomycosis, coccidiodomycosis and also leishmaniasis, yaws and syphilis should be considered. Other differential diagnosis of mycetoma includes Kaposi’s sarcoma, malignant melanoma, Thorn and Foreign body granuloma [7,14,16].

Differentiation between actinomycetoma and eumycetoma is important because of the different responses to treatment. Surgery is indicated in mycetoma for small localized lesions, resistance to medical treatment or for better response to medical treatment in patients with massive disease. The surgical options range from wide local and debulking excisions to amputations. Surgical debridement, followed by appropriate combination of antibiotic therapy Amikacin Sulfate and Co-trimoxazole for several months is required for actinomycetoma, where as Many other drugs such as Amoxicillin-Clavulanic Acid, Rifampicin, dapsone, Sulphonamides, Gentamicin, and Kanamycin were tried as a second line of treatment for actinomycetoma in patients with resistant cases or who developed serious drug side effects [14].

Eumycetomas are only partially responsive to antifungal therapy but can be managed by Surgery in combination with azole groups (Ketoconazole/Itraconazole) for the duration of nine to twelve months treatment is the recommended .Amputation is indicated in advanced mycetoma with severe secondary bacterial infections not responding to medical treatment, emphasizing the importance of early and definite diagnosis [1,5,14,16].
4. Conclusion

Though Eumycetoma of knee is a rare site, it should always be considered in differential diagnosis of knee swelling with discharging sinuses containing black granules. The morbidity caused by mycetoma is massive and enormous resulting into deformities, septicemia and recurrences which subsequently necessitate amputation of the affected site. So, increased awareness and emphasis on correct diagnosis after clinical assessment and histological study with use of special stain is required.

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