Trichosporon mycotoxivorans was commonly used in various textile, agriculture, cosmetic, and pharmaceutical industries for its ability to detoxify mycotoxins such as ochratoxin A and zearalenone. In recent years, it has been isolated as a respiratory pathogen causing pneumonia in some cases of cystic fibrosis, but to our knowledge, a cutaneous manifestation has not been previously described. We could not establish a route of exposure in our patient.

Azoles have proven to be the most effective treatment options for other Trichosporon infections. Our patient showed significant improvement of skin lesions with voriconazole.

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Interstitial Granulomatous Dermatitis as the Initial Manifestation of Myeloma

Interstitial granulomatous dermatitis (IGD) has been associated with pharmacotherapy, various autoimmune conditions, and hematologic malignant conditions. Herein, we report a patient in whom IGD was the initial manifestation of a previously undiagnosed myeloma.

Report of a Case | A man in his 50s presented with a 1-year history of an asymptomatic symmetric eruption involving his upper back, arms, forearms, and hands. His medical history was significant for arthritis, diabetes mellitus, hypertension, and a retroperitoneal schwannoma that was excised with negative margins 1 month prior to presentation. His medications included metformin, telmisartan, naproxen, and vitamin B6.

On physical examination, he had erythematous to violaceous patches and plaques, some with a slight trailing scale (Figure 1). One of the lesions on his right forearm was infiltrated and had an annular border. Multiple punch biopsy specimens were obtained for further investigation and revealed an interstitial lymphohistiocytic infiltrate extending into the upper and mid-reticular dermis (Figure 2) with some associated elastophagocytosis. A CD68 immunostain revealed histiocytes intercalated among the collagen bundles. An increase in mucin was not appreciated, and there was no associated necrobiosis. A diagnosis of IGD was made, and further workup to determine an underlying cause was performed.

Results of a complete blood cell count, comprehensive metabolic panel, and urinalysis were unremarkable. He tested negative for antinuclear antibodies, anti-Ro/SS-A, anti-La/SS-B, p-ANCA, c-ANCA, and rheumatoid factor. An immunofixation electrophoresis (IFE) revealed an increased IgA level and M-spike with an IgA-k reading too small to be quantified.

The patient was referred to hematology, and a bone-marrow biopsy was performed. His marrow was infiltrated with 20% to 25% of IgA-restricted plasma cells, and the patient was subsequently diagnosed with stage I myeloma. He began treatment with bisphosphonate, and his skin disease resolved shortly after presentation without recurrence. His myeloma progressed over the course of 3 years, and he underwent bone-marrow transplantation.

Discussion | Interstitial granulomatous dermatitis usually presents between ages 50 and 60 years, with a female predominance. Clinically, there are multiple asymptomatic papules and plaques on the proximal limbs and trunk, and in a few patients, cordlike lesions can be seen, distinctively known as the “rope sign.” Histologically, IGD is characterized by an interstitial arrangement of histiocytes in the reticular dermis often surrounding foci of degenerated collagen. Extracutaneous manifestations may precede, occur simultaneously, or

Figure 1. Clinical Image of the Patient’s Upper Back

The erythematous plaque shows a slight trailing scale.

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follow the development of the skin lesions. Interstitial granulomatous dermatitis has been associated with various hematologic malignant conditions including myelodysplastic syndrome, leukemia, and lymphoma. The prognosis of IGD is favorable, with two-thirds of patients maintaining complete remission after 3 months to 3 years, and therapy does not seem to alter the disease course.

This is the first case, to our knowledge, of IGD as the initial presentation of myeloma. This case highlights the importance of a thorough systemic workup to detect not only an autoimmune disease but also an underlying hematologic malignant condition in patients who present with IGD. As part of the routine workup in these patients, we advocate the use of the more sensitive IFE testing to detect an underlying paraproteinemia.

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COMMENT & RESPONSE

Patient Contribution to Reconstructive Decision: The Purse-String Closure

To the Editor Cutaneous reconstructive choices reflect a decision-requiring algorithm that should permit input from the patient as well as the surgeon. While some parameters considered may be objectively determined by quantitative analysis, others may be subjective, subtle, even emotional, and not so easily evaluated. The excellent study by Joo et al1 and the thoughtful commentary by Maher et al2 compare the efficacy of the purse-string closure vs secondary healing for wounds on the trunk and extremities. Although it is of interest that no statistical difference emerged in scar quality, aesthetic outcome is usually of lesser importance to patients in these locations. What might be of greater concern is healing time and emotional reaction. Healing time is not so simple to evaluate when comparing a wound closed by sutures with a wound allowed to heal by granulation. A granulating wound is considered healed when the defect has completely epithelialized, but when is a sutured wound healed? Rather than comparing healing time, it would be simpler to compare “care time” by the patient. Whether the sutures in a closed wound (as illustrated in Figure, C1) are removed in 1 or 2 weeks, the patient care time involved to complete secondary-intent healing is clearly greater. Furthermore, from an emotional perspective, many patients would prefer to deal with a smaller or a completely closed defect rather than the original size wound from the tumor removal.

Sadly, they are a number a precepts that we continue to blindly accept based on hearsay or “authoritative” pronouncements until they are shown to be untrue by careful study—the emperor truly has no clothes. The analysis by Joo et al1 has demonstrated that certain assumed and accepted consequences of purse-string closure do not stand up to analysis. However, I am sure they would agree that thought-

Figure 2. Hematoxylin-Eosin-Stained Punch Biopsy Specimens From the Right Forearm

A, Normal epidermis overlying a subtle, low-density, interstitial, histiocytic dermal infiltrate and mild perivascular lymphoid inflammation (original magnification ×110). B, Low-density dermal infiltrate of CD68+ histiocytes intercalate interstitially among collagen bundles (original magnification ×660).