at that time (Figure 2A). Since it seemed difficult to heal the lesion completely with only antibiotics, she was given surgical debridement on day 20. The ulcer had a necrotic bed, with the Achilles tendon and the calcaneal bone exposed (Figure 2B). We started NPWT with V.A.C. Therapy System (Kinetics Concepts Inc [KCI]) as a pretreatment for skin grafting on day 42. The vacuum suction was maintained at 125 mm Hg, and the wound dressings were changed every third day for 24 days. By day 69, good granulation tissue covered the ulcer bed (Figure 2C). A mesh skin graft was successfully engrafted on day 78. By day 127, the ulcer was completely healed, and she was able to walk again by herself (Figure 2D). Treatment with antibiotics was continued throughout the 4-month treatment course.

Discussion | Buruli ulcer should be considered in patients who present with chronic refractory ulcers or atypical cellulitis unresponsive to standard treatment. Its diagnosis relies primarily on PCR methods, and PCR targeting of IS2404 is a highly sensitive and specific diagnostic test (sensitivity and specificity >90%).

In this case, although the lesion extended deeply and required radical debridement, we were able to avoid amputation and achieve good wound healing by wound bed preparation with NPWT, which increases wound blood flow and granulation tissue growth and decreases local edema and bacterial flora at the wound site. Portable NPWT treatment devices are adaptable for outpatients and also can be used in developing countries. This treatment outcome suggests that NPWT might be appropriate for treatment of advanced BU cases.

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Primary Cutaneous Trichosporonosis Responsive to Voriconazole

Primary cutaneous trichosporonosis in immunocompetent individuals is very rare.

Report of a Case | A woman in her 20s presented with a large erythematous indurated plaque involving the face and neck that had been first noted at age 2 years. The plaque progressively increased in size, and similar plaques developed over the back, right dorsal surface of the hand, suprapubic area (Figure 1A), and right thigh over the last 4 years. Scarring developed in the plaques over the face and hand during the course of the disease and led to flexion contracture of the hand with limita-
There were no constitutional symptoms. There was no history of trauma preceding these lesions. She had received multiple modalities of treatments, including antileprosy therapy for 1.5 years, antitubercular therapy for 2 months, antileishmanial therapy with amphotericin B for 3 months, and anti-fungal therapy with itraconazole for 3 months, without any significant improvement.

Results of routine hematological and biochemical investigations and chest radiography were normal. A Mantoux test showed an induration of 2 × 1 mm at 48 hours. Direct potassium hydroxide preparation of the skin tissue showed multiple budding yeast cells and arthrospores (Figure 2A). Skin biopsy showed a granulomatous infiltrate composed of giant cells, lymphocytes, and histiocytes admixed with neutrophils and eosinophils. There were some hyaline hyphae branching at acute angles with multiple spores and budding yeasts. These structures stained with silver methenamine and periodic acid-Schiff stains (Figure 2B). Cultured skin biopsy specimens on 2 different occasions grew Trichosporon species identified by standard mycology laboratory procedures, including morphologic characteristics identified on cornmeal Tween-80 agar (Thermo Fisher Scientific Inc), color reduction on triphenyltetrazolium chloride medium, hydrolysis of urea, and sugar assimilation tests (Figure 2C). Using the molecular techniques of polymerase chain reaction analysis and DNA sequencing of internal transcribed spacer and intergenic spacer regions, the fungus species was identified as Trichosporon mycotoxinivorans.

Since there was no clinical and laboratory evidence of involvement of other organ systems, we made a diagnosis of primary cutaneous trichosporonosis. We treated the patient with itraconazole, 200 mg, twice daily, which was followed by moderate healing on the hand and face. However, after 5 months, she developed a skin-colored, soft, 8 × 12-cm swelling over the left elbow. Radiography showed no bony involvement. Fine-needle aspiration biopsy from the swelling revealed septate hyphae with some spores suggestive of a trichosporonic abscess.

Drug susceptibility results showed that the fungus was sensitive to voriconazole but resistant to other antifungal drugs. Minimum inhibitory concentrations for fluconazole, caspofungin, and flucytosine were greater than 64 μg/mL, and for itraconazole, amphotericin, and micafungin, they were greater than 32 μg/mL. Itraconazole treatment was discontinued, and voriconazole, 200 mg, twice daily was administered. Over the next 6 months, the patient had almost complete clearance of all her lesions with postinflammatory pigmentation and significant improvement in quality of life (Figure 1B). Voriconazole treatment was discontinued after 6 months, and at last follow-up 3 months later, there had been no recurrence.

**Discussion** | Trichosporonosis most commonly presents as white piedra, a superficial infection of the hair shaft. Invasive trichosporonosis is known to develop in immunosuppressed patients and presents as a severe systemic illness. The least common manifestation is primary invasive cutaneous infections by *Trichosporon* species.1-5
**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 lymphohistiocytotic infiltrate extending into the upper and mid-dermal 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-κ 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 biphosphonate, 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, distinctly 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](https://www.jamanetwork.com/)

The erythematous plaque shows a slight trailing scale.