Pulmonary mycetoma

A 60-year-old man, with a history of asymptomatic left upper lobe pulmonary mycetoma (*Figure 1*), presented with frank haemoptysis. Following haemodynamic stabilization he was referred for bronchial artery embolization therapy.

Pulmonary mycetoma, also known as a fungus ball or aspergilloma, usually comprise hyphae of *Aspergillus*, fibrin, mucus and cellular debris. Most are caused by *Aspergillus fumigatus*, although cases associated with *A. niger*, *A. flavus* and very occasionally *Candida* have been described. Predisposing factors include tuberculosis, bronchiectasis, cystic fibrosis, sarcoidosis and neoplasms. Mycetomas are often discovered incidentally on chest imaging but patients typically present with haemoptysis and productive cough. Weight loss, fever, dyspnoea and clubbing can form part of the clinical presentation.

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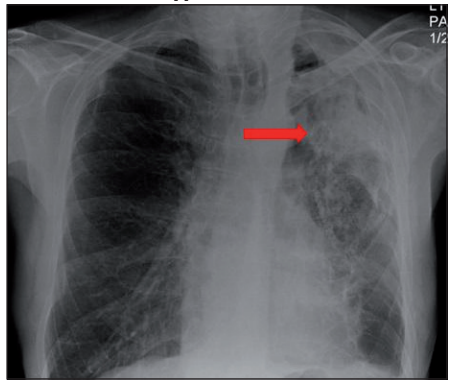
Figure 1. Chest radiograph showing a mass (red arrow) in the left upper lobe.



Radiologically, mycetoma are often seen in the upper lobe, typically as a mobile mass with an air crescent. Differential diagnoses of this radiological finding include neoplasm, abscess and haematoma. Up to 50% of sputum specimens reveal *Aspergillus* and serum IgG antibodies are positive in almost all cases (McCarthy and Pepys, 1973).

Treatment depends on symptoms – antifungals are of limited use (Pennington, 1980). Bronchial artery embolization should be considered in patients with significant haemoptysis and surgical excision is an option for recurrent haemoptysis, but causes significant mortality. Asymptomatic mycetoma usually do not need treatment. **BJHM**

McCarthy DS, Pepys J (1973) Pulmonary aspergilloma: clinical immunology. *Clin Allergy* **3**: 57–70

Pennington JE (1980) Aspergillus lung disease. *Med Clin North Am* **64**: 475–90

A man with facial changes

A 22-year-old man presented with a 3-month history of changes to his face. He had a history of chronic rhinitis and intermittent epistaxis. On physical examination, there was loss of eyelashes and lateral eyebrows, and thickening of the facial skin with exaggeration of natural lines of the forehead, perinasal and periorbital areas (*Figure 1*). Nasal cavity examination showed septal perforation and destruction of the nasal cartilages. Symmetric, poorly marginated multiple nodules on the patient's back and the extensor surface of his elbows were palpated. The ulnar and common peroneal nerves were enlarged on palpation with normal motor and sensory functions. Examination was otherwise normal.

The facial features were similar to 'leonine facies' or 'lion face'. Nasal biopsy and acid-fast Zeihl–Neelsen stain were compatible with a diagnosis of lepromatous leprosy.

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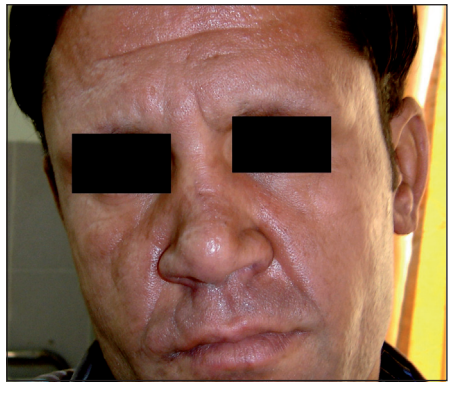
Figure 1. Loss of eyelashes and lateral eyebrows, and thickening of the facial skin with exaggeration of natural lines of the forehead.



Leprosy is an infection caused by *Mycobacterium leprae* with skin and peripheral nerve involvement. The transmission mode is not fully understood but it is probably spread by the respiratory route. Assessment of skin lesions (type and number) is important in disease classification. Advanced disease is characterized by body hair loss, especially of eyebrows and lashes. Invasion of the mucosa of the nose may mimic common cold. Septal perforation and/or collapse (saddle nose) may follow unless the condition is treated (Elinav et al, 2006). In addition to physical examination, skin biopsy and polymerase chain reaction play a major role in diagnosis. The patient was treated with dapsone, clofazemine, rifampin and clofazemine. After 2 months of treatment, the nasal septal perforation had healed. **BJHM**

Elinav H, Palladas L, Applbaum YH, Gilead L, Moses AE, Cohen-Poradosu R (2006) Plantar ulcers and eyebrow-hair paucity. *Clin Infect Dis* **42**(5): 684–5, 722–4 (doi: 10.1086/502983)