Sporotrichosis (Rose Gardener’s Disease) and Classification of Mycosis

Mycosis is a fungal infection, affecting all animals, including human beings. It is subacute or chronic infection caused by saprophytic dimorphic fungus *sporothrixschenckii*. In addition to the pathophysiological state of the body, the environmental factors are equally contributing to the development of mycosis. The fungal infection usually begins either with the inhalation of the spores or through direct cutaneous invasion of the organism.

Risk Factors for Developing Mycosis

- Antibiotic therapy
- Steroids or chemotherapy
- Diabetes
- Immunocompromized state as in HIV
- Extreme age groups, i.e., very young or very old
Classification of Mycosis

Based upon the level of tissue invasion, mycoses may be divided into the following types:

Superficial mycosis

This infection is limited to the superficial layer of the skin and hair, e.g., Tinea versicolor.

Cutaneous mycosis

Cutaneous mycosis not only invades deeper into the epidermis of the skin but also involves the hair and nails of the body. The organisms causing such infection are called dermatophytes, often limited to the keratinized layer of skin, hair and nails. The host immune system may be activated causing local inflammatory changes. Examples include ringworm infection.

Subcutaneous mycosis

Subcutaneous mycosis occurs as a result of piercing trauma to the skin, thus causing the organism to invade the skin, subcutaneous fats, fascia and muscles. Such infections require debridement and treatment with antifungal drugs.

Systemic mycosis

Systemic mycosis can be either due to primary pathogens or opportunistic organisms that are already residing inside the body. In the former case, they are usually inhaled and spread to the local tissues and lymphatic stream causing systemic infection. Opportunistic infections mostly occur in immunocompromized individuals. Examples of the latter include candidiasis, aspergillosis and cryptococcosis.

Sporotrichosis

Image: “This photomicrograph reveals the conidiophores and conidia of the fungus Sporothrix schenckii. Sporotrichosis, caused by the etiologic pathogen Sporothrix schenckii, is a skin infection involving the subcutaneous layer. It manifests itself in the formation of large ulcerations; however, the disease can become systemically disseminated,” by http://phil.cdc.gov/phil_images/20030721/16/PHIL_4208_lores.jpg. License: Public Domain
Sporotrichosis, also known as Rose Gardener’s disease, is a fungal infection caused by the species Sporothrix schenckii shown in the figure. The most common form of sporotrichosis is the cutaneous infection. Pulmonary and disseminated infections, although rare, have also been reported.

Epidemiology

Sporotrichosis occurs worldwide. It is endemic in China. Epidemics have been reported in South Africa, Australia and Brazil. In Peru, incidence is 1 case in 1000 people. The prognosis of the disease is very good.

Morbidity is associated with pulmonary sporotrichosis, specifically in patients with chronic obstructive pulmonary disease (COPD) or osteomyelitis developed as a result of dissemination. The mortality rate is significant in immunocompromized patients.

Sporotrichosis is common in males than females and it affects adults most.

Pathophysiology

The common mode of transmission of sporotrichosis is through skin inoculation. The dimorphic organism is found in the soil and enters the skin via cuts, wounds, animal bites or scratches.

The initial reddish, necrotic papule of cutaneous sporotrichosis appears after 1-10 weeks of skin injury. A granuloma is formed by the neutrophils, histiocytes and giant cells, along with local necrotic tissue. This suppurative area is then surrounded by the lymphocytes and the plasma cells.

The fungal infection spreads via the lymphatic stream, direct invasion of local tissues and rarely through the bloodstream. Hematogenous dissemination, if it occurs, causes severe visceral infections, including meningitis. The common extracutaneous sites of infection are the bones, joints, tendons and bursae.

A rare form of sporotrichosis occurs after inhalation of the organism, which causes pneumonia specifically in patients with COPD or alcoholism. Such infections are clinically and radiographically indistinguishable from tuberculosis or histoplasmosis. It may affect sinuses, kidney, subglottic region, and retina.

Clinical presentation

The clinical presentation depends upon the immune status of the host and site of the infection. Patients usually present with a primary lesion in the distal extremities. A small red, painless nodule may appear in 1 to 12 weeks of contact with the fungus usually in arm, finger and hand. Initially, it is a small nodule that enlarges and becomes pustular and later ulcerates. It is very slow to heal. The lesion is mildly painful with no signs of systemic illness such as fever.

Later on, new lesions begin to appear along the line of lymphatic tracts of the body. The fixed cutaneous lesions of sporotrichosis should be considered if they fail to heal spontaneously or with antibiotics. Hypersensitivity reactions such as erythema nodosum or erythema multiforme are also associated with the disease.

The clinical features of pulmonary sporotrichosis are usually nonspecific and only give clue towards underlying respiratory pathology. Symptoms include cough, shortness of breath, chest pain and fever. The disseminated infection is common
in immunocompromized individuals. In such cases, the signs and symptoms depend upon the organ involved.

Disseminated sporotrichosis exhibit symptoms depending on the body part involved such as joint pain caused by infection in the joint and difficulty in thinking, headache and seizures caused by infection in the central nervous system.

**Diagnosis**

Sporotrichosis needs to be differentiated from other bacterial and fungal infections of the lungs and joints. The differential diagnosis includes:

- Bacterial pneumonia
- Blastomycosis
- Histoplasmosis
- Leprosy
- Sarcoidosis
- Tuberculosis
- Tularemia
- Syphilis

The diagnosis of the sporotrichosis can be done by culturing the organisms from specimen such as pus, skin biopsy, CSF and synovial fluid. Periodic acid-Schiff, Gomori methenamine-silver or immunohistochemical staining methods are often used to visualize the organism.

The ratio of CSF to serum antibody against sporotrichosis suggests of meningeal involvement. Similarly, X-ray and CT scan of the chest point towards respiratory pathology; however, they do not provide a definitive diagnosis.

**Treatment**

1. Medical approach includes antifungal treatment for all forms of sporotrichosis.
   - Itraconazole per oral is most commonly used for a period of 3-6 months.
   - Supersaturated potassium iodide (SSKI) is also effective against cutaneous sporotrichosis; however, it should be avoided in pregnant females.
In severe cases, intravenous amphotericin B is recommended for disseminated sporotrichosis, followed by itraconazole therapy for 1 year.

2. **Topical heat application** may also be beneficial as the organism grows better at 35 °C. Patients can perform their routine activity as feasible.

3. **Surgical care** involves appropriate drainage of affected joints in case of osteoarticularsporotrichosis. Debridement may be done if required. In case of pulmonary sporotrichosis, surgical removal of the affected lung or specific part may be done.

Prevention and follow-up

There is no vaccine for prevention of sporotrichosis. Sporotrichosis can be prevented with the use of gloves and long sleeves while doing outdoor activities such as gardening. Ideally, animals should also be handled while wearing gloves to avoid zoonotic transmission. Animals that have skin lesions can easily transmit the disease to humans. Last but not the least, **patient education** is required regarding the mode of transmission and the adverse effects of antifungal therapy.

References

[Sporotrichosis](http://cdc.gov) via cdc.gov

[Sporotrichosis](http://medscape.com) via medscape.com

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