

consider that the onychomycoses and clinically mild pityriases in patients of African origin are the principal form of introduction of *T. soudanense* into Europe (5).

Illegal immigration from North and Sub-Saharan Africa is becoming increasingly frequent in Spain. Another possible route of importation of *T. soudanense* is via the aid programmes organized by a number of organizations, under which children from regions affected by war or famine visit European families for short periods, often with the specific aim of obtaining medical attention.

The four cases of *T. soudanense* infection detected in Spanish patients showed markedly inflammatory lesions. However, in no case did we obtain any evidence of contact with African immigrants, suggesting that this pathogen is already more or less widespread in the general population of Spain. This should be borne in mind by the physicians of all countries in the European community with African immigrants.

ACKNOWLEDGEMENT

This study was partly supported by grant XUGA20819B96 from the Local Government of Galicia, Spain.

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Sporotrichoid Spread of *Mycobacterium Chelonae* in a Presumably Immunocompetent Patient

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Accepted January 15, 2002.

Sir,

Mycobacterium chelonae is an unusual human pathogen. Cutaneous dissemination with a sporotrichoid pattern has been described mainly in immunocompromised patients. We present here a case of infection by *Mycobacterium chelonae* with a linear cutaneous distribution in a healthy immunocompetent woman. Minocycline was an effective treatment.

CASE REPORT

A 42-year-old, healthy woman presented with one-month old erythematous-violet papular lesions on her left arm. Initially, only one lesion was present, on the proximal phalanx of the fourth finger (Fig. 1a). Over the next few days, new lesions developed on the dorsum of the hand (Fig. 1b) and forearm, in a linear distribu-

tion. Occasionally, some of these lesions ulcerated and drained. The patient did not have a history of trauma in this area. A small axillary adenopathy was present.

Haemogram, biochemical screening, immunoglobulin levels, human immunodeficiency virus serology and chest X-ray were all normal. A skin biopsy showed suppurative granulomas without evidence of microorganism (negative PAS and Ziehl-Neelsen techniques). Because of the sporotrichoid spread of the lesions, our initial clinical suspicion was lymphocutaneous syndrome by *Sporothrix schenckii*, so potassium iodide treatment was started. *Mycobacterium* sp. grew on a tissue culture. Thus, infection by *Mycobacterium marinum* was considered and the previous treatment was changed to minocycline (200 mg/day). Later, *Mycobacterium chelonae* was identified. The lesions healed satisfactorily and the treatment was continued for 2 months until the lesions disappeared.

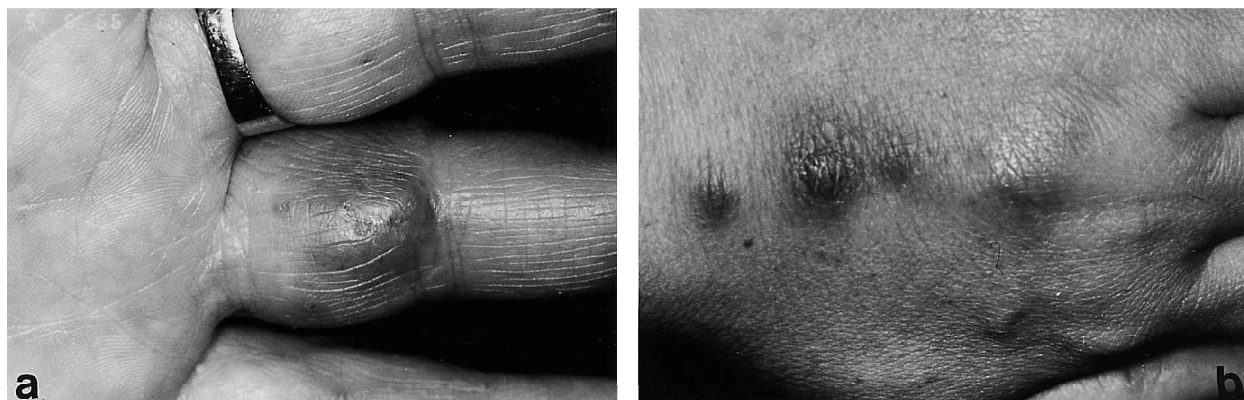


Fig. 1. The first lesion located on the proximal phalanx of the fourth finger (a) and linear distribution of the lesions on the dorsum of the hand (b).

DISCUSSION

Frequently, immunocompromised individuals present clinical patterns that are different from those of immunocompetent patients. Sporotrichoid distribution of the lesions of *Mycobacterium chelonae* infection is an uncommon finding, even in immunocompetent individuals. To our knowledge, previous reports refer to immunocompromised patients (1–7), with the exception of the case reported by Greer et al. (8), who also presented a presumably immunocompetent patient. In their case, there was a possible relationship between previous surgery and the mycobacterium infection. Clinical history, physical examination and complementary studies suggest that our patient is presumably immunocompetent. However, in addition to the sporotrichoid distribution, our case has other similarities with lesions described in immunocompromised patients, such as no history of previous trauma and ulceration and drainage in the evolution of the lesions (6).

Linear distribution of inflammatory lesions suggests first sporotrichosis, but other organisms can be the cause of this pattern as well. *Mycobacterium marinum* is the most common of these (9). Considering this fact, when a culture shows the presence of mycobacteria, we prescribed minocycline. Although *Mycobacterium chelonae* is a rapidly growing strain, culture media may not show growth until after 14 weeks. In our case, once the *Mycobacterium chelonae* was diagnosed, the lesions began to show improvement. Therefore, although clarithromycin may be the drug of choice for cutaneous disease induced by this organism (10), minocycline treatment was maintained, and healing occurred in a few weeks.

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