Mycetoma

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A twenty years old male from tribal community accompanied with father, enter in outpatient department with limping gait. He complained chronic pain, unable to flex and eversion of right foot since last 14 years. Progressive increased in swelling over dorsum of foot and around the right ankle, with multiple nodules and recurrent discharging sinuses. He recollected that long days ago before this swelling he had severe pain at right heel due to un-notice prick of big acacia thorn. He removed the thorn. One week of thorn prick he noticed small small nodule over closed to site of prick there was painless gradually nodules are increased in number, many of them are conglomerated together. Gradually edema of around ankle is increased with restriction of movement at ankle. He applied some herbal remedies and quack tried to puncture the nodules resulted in infection, throbbing pain and non-healing discharging yellow, blackly granules sinuses. He was examined by many quacks, ayurvedic, unanani, homeopath and mantrak, applied varies ointment, powders and oral antibiotic. There was transient improvement and relapse. He denied history chronic febrile illness except local pain and restriction movement at ankle joint, anorexia, and weight loss. He was non diabetic, non-smoker but alcoholic and tobacco chewer. Investigations showed hemoglobin 12.8 mg/dl, white cells count was 6100,HIV negative.

Fig. 1A: Multiple nodules and black crusts over healing sinuses

Fig. 1C: Complete healed sinuses with fibrosis

Fig. 1B: Multiple bursting sinuses with reddish yellow granules

Fig. 1D: Gram stained actinomycesis hype and buds

On examination there were multiple nodular tumors with black crust (Figure 1A), inversion, eversion, flexion and extension movements at right ankle were restricted. There was woody, non tender, non pitting swelling around the right ankle and dorsum of foot. X-ray right foot did not show any bony lesion. He denied to further investigations such as MRI, ultrasonography, culture and sensitivity due to lack of funds.

He was prescribed oral doxycycline 100 mg twice and itroconazole 200mg twice for 30days and follow up after one month. He improved within 15 days and stop taking treatment due to lack of money. We repeatedly call him on phone but failed to respond, lastly author (HSB) visited his resident 60 KM from Mahad. There were multiple sinuses, tender swelling, and yellow, blackish color pus was draining from multiple sinuses (Figure 1B). He was unable to walk and had febrile illness. We gave him three months course of doxycycline 100 mg twice a day and itroconazole 100 mg twice day. At the end of three months there was complete cure of lesion with fibrosis, loss of edema and movements at ankle joints were no more restricted and he walk without limp (Figure 2C). He was followed for every six month for next 18 months without any recurrence. Pus was examined under microscope showed multiple fungus hype and budding of actinomycesis (Figure 1D).

Mycetoma was recognized by the WHO as neglected tropical disease. Mycetoma or Madura foot was first described by Vandyke carter in 1860 in Madurai, India.

Mycetoma is a potentially serious, devastating, chronic inflammatory disease cause by microaerobic actinomycetic bacteria (actinomycetoma or fungus (eumycetoma) Heavy rainfall, high humid and hot climate flourished the organism responsible for mycetoma in coastal region of Maharashtra.

“Mycetoma belt” runs from India to Yemen and goes through sudan, Senegal and onto south America and Mexico. Mycetoma caused by actinimycetoma microaerophilic bacteria responds to antibiotic and eumycetoma fungal infection responds to anti fungal agents. Surgical intervention s is only done if there is bone involvement. With continuation of drug therapy till there is complete improvement (Figure 1C). Madura foot is not a contagious disease. If neglected May result in life time disability due to amputation of affected part usually foot.

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