**INTRODUCTION**

*Sporothrix schenckii* is a widespread dimorphic fungus that often causes a localized subacute to chronic lymphocutaneous infection. In immunocompromised individuals, however, *S. schenckii* can cause disseminated disease. In this clinical vignette, we present a case of an immunocompetent man who presented with diffuse ulcerative cutaneous lesions and bone pain who was ultimately diagnosed with disseminated sporotrichosis.

**THE CASE**

**History of Present Illness**

A 59-year-old man with hepatitis C presented with diffuse skin nodules. He reported two months of painful nodular lesions on his chest and upper extremities, which spread to his head, trunk and lower extremities. He also complained of fevers and left ankle pain.

**Physical Exam**

Temp 100.8 BP 140/80 HR 110

Skin: >80 polymorphic nodules ranging from subtly erythematous to violaceous, suppurative and centrally ulcerated.

MSK: Left ankle and elbow were edematous and tender.

**Social History**

Prior alcohol and tobacco use. No prior IV drug use. MRSA exposure. Multiple sexual partners.

**Clinical Course**

Day 1: Patient presents with multiple nodules (Figure A).

Day 9: MRI showed osteomyelitis of tibia and fibula (Figure B).

Day 10: Biopsy of right arm and chin nodules unrevealing.

Day 12: Bone scan shows multiple foci of increased uptake.

Day 14: Biopsy of left ankle pain.

Day 15: Nodules not improving. Repeat skin biopsy performed.

Day 19: Bone biopsy unrevealing.

Day 38: Final culture results confirm *Sporothrix schenckii*. (Figure E and F).

On further exploration of patient’s social history, patient admitted to trauma from blackberry bush thorns.

**DISCUSSION**

- *Sporothrix schenckii* is known for a paucity of organisms on microscopy and may take persistence to diagnose, particularly in the absence of a recognizable sporotrichott pattern.

- Disseminated cutaneous sporotrichosis is rare, most often occurring in immunocompromised patients, however it may afflict immunocompetent patients and should remain in the differential diagnosis of disseminated nodular lesions.

- While skin culture is the gold standard for diagnosis, cutaneous histopathology can serve as a valuable resource for accelerated diagnosis and prompt treatment.

- This case demonstrates the importance re-evaluating a patient who is not improving on current therapy and continues to have new clinical exam findings. Daily skin exams and revisiting social history in this patient proved to be fruitful.

- High suspicion by the physician and re-biopsying lesions was integral in making a definitive diagnosis.

**FOLLOW UP**

- Nodules have largely resolved although patient continues to have bone and joint pain.

- Patient continues on itraconazole therapy and may require lifelong suppressive therapy.

**REFERENCES**


**FIGURES**

- Figure A. Centrally ulcerated nodule.
- Figure B. MRI showing lytic lesions of tibia
- Figure C. Subcutaneous nodules in a linear pattern.
- Figure D. Asteroid body
- Figure E. Elongated conidophore with inflated tip bearing ovoid micrconidia
- Figure F. Classic “cigar shape” budding yeast