Clinical presentation

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As mycetoma is painless, presentation is late in the majority . It presents as a slowly progressive, painless, subcutaneous swell ing commonly at the site of presumed trauma. The swelling is variable in its physical characteristics: firm and rounded, soft and lobulated, rarely cystic and often mobile . Multiple secondary nodules may evolve; they may suppurate and drain through multiple sinus tracts. The sinuses may close transiently after discharge during the active phase of the disease. Fresh adjacent sinuses may open while some of the old ones may heal completely . They coalesce and form abscesses, the discharge being serous, serosanguineous or purulent. During the active phase of the disease the sinuses discharge grains, the colour of which can be black, yellow , white or red depending upon the organism. Pain supervenes when there is secondary bacterial infection. The common sites a ff ected are those that come into contact with soil during daily activities: the foot in 70% (Figure 6.23 and the hand in 12% (Figure 6.24). In endemic areas the knee (Figure 6.25), arm, leg, head and neck (Figure 6.26 and perineum (Figure 6.27) can be involved. Rare sites are the chest, abdominal wall, facial bones, mandible, testes, paranasal sinuses and eye. In some patients there may be areas of local hyperhidrosis over the lesion. This may be due to sympathetic o veractivity or increased local temperature due to raised arterial blood flow caused by the chronic inflammation. In the majority of patients, the regional lymph nodes are small and shotty . Lymphadenopathy is common. This may be due to secondary bacterial infection, lymphatic spread of mycetoma or a local immune response to the disease. The condition remains localised; constitutional distur bances are a sign of secondary bacterial infection. Cachexia and anaemia from malnutrition and sepsis may be seen in late cases. It can be fatal, especially in cases of cranial mycetoma. - - - -)), thigh -

Figure 6.24 Mycetoma of the hand. Figure 6.25 Mycetoma of the knee. Figure 6.26 Actinomycetoma of the head and neck.

Figure 6.27 Extensive satellite inguinal actinomycetoma from a pri mary foot lesion involving the anterior abdominal wall and perineum.

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