

CJASN

Clinical Journal of the American Society of Nephrology

June 2020 • Vol. 15 • No. 6

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On the Cover

What is the diagnosis?

A 50-year-old male from Sudan, with a history of vitiligo and kidney failure secondary to hypertensive nephrosclerosis after a living unrelated donor kidney transplant 2 years prior, presented to the clinic for evaluation of a skin lesion. On examination, there was a smooth, multilobulated, pink, nontender nodule on the left fifth metatarsal head (left). A biopsy revealed phaeohyphomycosis caused by *Medicopsis romeroi*, as ascertained by culture. Two years later, he returned to the clinic reporting that his vitiligo had begun to spread to involve his upper back, head, and neck (center). A biopsy revealed keratinocytes with pale blue cytoplasm, multiple keratohyalin granules, and a thickened granular layer, features consistent with epidermodysplasia verruciformis (EDV) (right).

Key teaching points

Phaeohyphomycoses refer to cutaneous and subcutaneous infections caused by various groups of dematiaceous fungi (Revankar and Sutton 2010). Infection caused by *M. romeroi* in solid organ transplant recipients is rare but tends to affect people from West Africa and Asia. *M. romeroi* should be considered in immunosuppressed patients from these endemic areas and can be treated by surgical excision with or without coadjunctive antifungals (Los-Arcos *et al.* 2019).

EDV, caused by β -type human papilloma virus, can result in a generalized eruption of flat topped warts and areas of cutaneous change that can resemble tinea versicolor in morphology. Acquired EDV has been reported in persons with HIV / AIDS and recipients of solid organ transplants (Rogers *et al.* 2009; Ovits *et al.* 2017). In acquired EDV, it is hypothesized that depressed cell-mediated immunity results in increased susceptibility to otherwise nonpathogenic β -type human papilloma virus types (Rogers *et al.* 2009). Acquired EDV can be treated by de-escalating immunosuppressive therapy.

Left image: Phaeohyphomycosis. Smooth, multilobulated, pink nodule.

Center image: Epidermodysplasia verruciformis. Hypopigmented macules and flat-topped thin papules with overlying fine scale. Note the linear array on lesions on the scalp, consistent with the Koebner phenomenon. The patient gave his consent for photography and publication.

Right image: Histology of epidermodysplasia verruciformis. Keratinocytes with pale blue cytoplasm, multiple keratohyaline granules, and a thickened granular layer ($\times 20$ magnification).

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(Images and text provided by Vernon Joseph Forrester, Darren Guffey, Barrett Zlotoff, Mark Wick, and Mary Nolan, University of Virginia, Charlottesville, VA)