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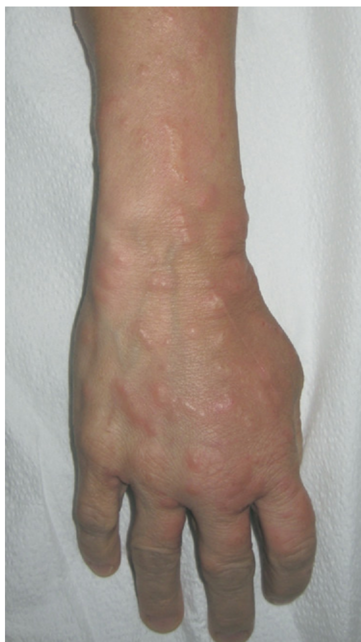

Figure 1. Upper extremity rash portraying progression along lymphatic channels.

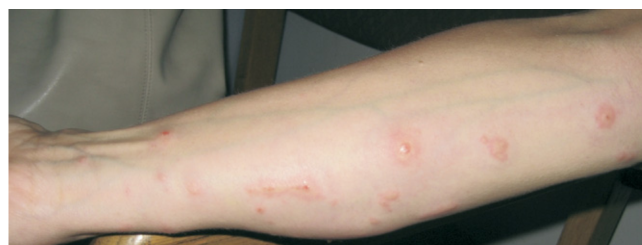

Figure 2. Upper extremity rash displaying distal, ulcerated lesions and proximal nodular lesions. Used with permission of Barry Hahn, MD, Department of Emergency Medicine, Staten Island University Hospital, Staten Island, NY.

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A 53-year-old healthy woman presented with a complaint of a painless pink nodule resembling an insect bite that started on her hand and progressed to the rest of her upper extremity (Figures 1 and 2). The symptoms started 3 weeks after gardening in her yard. She was treated with a 10-day course of antibiotics by her physician, without improvement. The patient began receiving antifungals, and a culture subsequently confirmed the diagnosis.

For the diagnosis and teaching points, see page 625.
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barotrauma and subcutaneous emphysema. Modulated pressure using a bag-valve-mask device provides the most reliable method for ensuring adequate pressure regulation, assuming the popoff valve is used appropriately. The big kiss, although an unmodulated technique, may be less likely to cause barotrauma, given the brevity of the procedure and the opportunity for the parent to self-regulate the amount of pressure generated. This common pediatric problem deserves low-risk treatment, and we have therefore ceased using the Beamsley Blaster in our ED.

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DIAGNOSIS:

Sporotrichosis. Sporotrichosis is a fungal infection caused by *Sporothrix schenckii*, which is naturally found in soil, hay, moss, and plants. It enters through small breaks in the skin, and symptoms will typically appear 1 to 12 weeks after the exposure. The first sign is a papule at the site of inoculation and commonly appears on the finger, hand, or arm. This is followed by additional nodules, which develop along lymphatic channels. Older, distal lesions ulcerate and drain, whereas more proximal lesions appear as nodules and undergo the same evolution. Pain is mild and systemic symptoms are typically absent. Infection usually involves cutaneous and subcutaneous tissues but can occur in other sites, predominantly in immunocompromised patients. Sporotrichosis can be confirmed by a culture of a freshly opened skin nodule or by serology.

Antifungals are the mainstay of therapy and should be continued for 2 to 4 weeks after all lesions have resolved. Complete recovery is the expected outcome in lymphocutaneous sporotrichosis if disease is treated appropriately.