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A rare case of fungal liver abscess in an immunocompetent patient from India

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Poster session 2, September 22, 2022, 12:30 PM - 1:30 PM

**Objectives:** To report a case of hepatic abscess caused by Candida albicans, which is a low common cause of hepatic abscesses in a non-auto-hematologic population. Fungal infections represent <2% of the total isolates in pus from hepatic abscess in patients without onco-hematologic malignancies.

**Methods:** A 68-year-old male diabetic patient came with complaints of fever with chills and rigor and right upper abdominal pain and yellowish discoloration of eyes and urine. His LFT, PT-INR, SOFa were deranged. CECT report shows ascites and peritonitis. His CECT showed irregular multilobulated hypodense lesions in segment V, VI, VII of liver. Direct and mycological and bacteriological culture examination was performed.

**Results:** Direct examination of pus sample showed budding酵母 cells with pseudohyphae and in SDA culture at 37°C it showed white puffy colonies. The species was identified by VITEK 2 system as C. albicans. The MBC obtained of antifungals were (ug/mL): fluconazole (≥0.5×MIC), voriconazole (≥0.12), amphotericin B (≥0.5×MIC), miconazole (≥0.06), amphotericin B (3), flucytosine (≤5). The patient was started on caspofungin and improved symptomatically. Then oral fluconazole was started and continued until the resolution of lesions on imaging during the follow-up.

**Discussion:** Colonization of the gastrointestinal tract is thought to be the main origin of the dissemination of Candida neoformans facilitates the spread of Candida from the gastrointestinal tract to the liver. The likely source of infection is GIT in this case.

**Conclusion:** We describe a case of fungal liver abscess in an immunocompetent patient caused by Candida albicans which was successfully treated with caspofungin.

**P233**  
Features of Cryptococcosis in Human Immunodeficiency Virus-negative patients, France 1985-2020

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**Objectives:** HIV-negative individuals make up an increasing proportion of cases of cryptococcosis in France, but the features of disease and outcomes in this population have yet to be characterized. We describe the presentations and outcomes according to host factors underlying cryptococcosis in HIV-negative individuals in France.

**Methods:** The French National Reference Centre for Invasive Mycoses and Antifungals has implemented nationwide surveillance of cryptococcosis since 1985 with the democratization of the infecting antigen. We analyzed the characteristics of infection in HIV-negative patients diagnosed up to 2020. We also compared the demographic characteristics, presenting features, treatment regimen, and outcomes according to host factor and infecting serotype in patients diagnosed since 2005.

**Results:** The mean age of patients was 56.5 years, 60.5% were male, and 60.3% were born in Europe. Only 26 cases were due to Cryptococcus gattii, all others were caused by C. neoformans. Of the 1031 cases, 389 occurred in patients with malignancy (37.2%), including 168 patients with hematological malignancy, 63% of whom had lymphoid neoplasms, 201 occurred in solid-organ transplant (SOT) recipients (19.7%, including 147 kidney and 27 liver), and 298 occurred in patients with ‘other’ underlying factors (28.4%), including auto-immune disease (n = 86), end-stage liver or kidney disease (n = 47), sarcoidosis (n = 42), chronic pulmonary disease (n = 22), and diabetes mellitus (n = 16). A total of 19% of patients (n = 189) had no apparent underlying risk factor.

Among 612 patients diagnosed since 2005, there were significant differences according to the four major categories of risk factors (malignancy, SOT, others, and none) in terms of age, diagnostic methods, proportion of patients with positive cryptococcal antigen (CAG), antigen titers, disease localization, treatment regimen, and 90-day mortality. In the diagnostic workup, a lumbar puncture and blood cultures were performed for 94% and 42.2% of patients, respectively, more frequently for immunocompromised patients than those with no underlying host factor (P = 0.05 and P < 0.001, respectively). SOT patients had more frequent central nervous system involvement (P < 0.001) and positive serum CAG detection with antigen titers ≥1:512 (P < 0.001). Patients with malignancy were significantly older (P = 0.001) with more frequent meningitis (P = 0.007). Isolated lung infections (P = 0.002) and isolated skin lesions (P < 0.001) were more frequent in patients with ‘other’ conditions and in those with no underlying factor, respectively. Immunocompromised patients were more likely to receive combination antifungals including fluconazole (44.7%, 45.4%, and 42.2% for SOT, malignancies, and ‘other’ conditions, respectively) compared with patients with no underlying factor (33.3%, P < 0.001). Overall, all cause 90-day mortality was 27.0% (95% CI 23.3-30.8%). Patients with malignancy had the highest 90-day mortality (37.5%, P = 0.001), compared with SOT recipients (23.7%), those with ‘other’ conditions (24.7%), and those without underlying conditions (13.5%). Compared with patients with serotype D infections, those infected with serotype A were significantly younger (P = 0.004), more likely to be born in Africa (P < 0.001), to have isolated pulmonary disease (P < 0.001), and less likely to have isolated skin infections (P < 0.001).

Conclusions: HIV-seronegative patients with cryptococcosis are a heterogeneous group of patients encompassing different disease characteristics and outcomes. Management of cryptococcosis in HIV-negative patients should be tailored to underlying host factors, disease localization, and infecting serotype.

**P234**  
Clinical and microbiological spectrum of invasive trichosporonosis from a tertiary care institute in India

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**Introduction:** Trichosporonosis has emerged as an opportunistic pathogen causing invasive infections in immunocompromised patients. Invasive trichosporonosis can involve any organ of the human body. Trichosporon spp. can colonize many parts of our body and hence it is important to differentiate between colonization and infection for appropriate management of the patients.

**Objectives:** To understand the clinical and epidemiological features of infections caused by Trichosporon spp.

**Methods:** All patients with clinically significant isolation of Trichosporon spp from various samples during a period of one year from January 2018–December 2019 were included in the study. In the present retrospective study demographic data, risk factors, clinical features, microbiological data, treatment, and the outcome of patients with invasive trichosporonosis were analyzed.

**Results:** There were 14 cases of trichosporonosis during the study period. The predominant age group was 10-70 years and the male:female ratio is 4:5:1.
The underlying condition of the patient at admission was accidental trauma in 4/14 (28.6%) chronic kidney disease in 2/14 (14.3%), hematological malignancy in 2/14 (14.3%), pneumonitis in 1/14 (7.1%), renal disease in 1/14 (7.1%), acute fibrinolysis in 1/14 (7.1%). The risk factors for acquisition of infection with Trichosporon species in the 14 patients were administration of broad-spectrum antibiotics in 15 (92.8%), urinary catheterization in 11 (78.5%), central venous catheterization, and prolonged ICU stay in 8 (57.1%) each, previous antifungal therapy in 6 (42.9%). The other risk factors were chemotherapy, severe sepsis, and neutropenia.

The clinical presentations were cutaneous tract infections in 10/14 (71.4%) patients (9 were catheter-associated UTIs), fungemia in 2/14 (14.3%), and wound infections in 1/14 (7.1%) patients.

Trichosporon auditis is the predominant species isolated in 12/14 (85.7%) patients. Other Trichosporon spp. isolated include T. orientis and T. gehea. All the isolates were correctly identified by VITEK 2 except one which was identified as T. inkin in VITEK 2 and T. dolbareae by MALDI-TOF.

All the isolates were susceptible to voriconazole and amphotericin B. 9/14 (64.2%) of the isolates were susceptible to itraconazole. Trichosporon spp. is inherently resistant to echinocandins. A total of 7 patients (50%) were successfully treated with voriconazole for a period of 14 days with advice to follow up and discharged. In all, 9 patients (64.3%) died due to underlying disease before treatment could be started.

Conclusion: Upper tract infection, mostly CA-UTI was the commonest clinical presentation of Trichosporon infection in our study followed by bloodstream infection and wound infection. The commonest risk factor was prolonged broad-spectrum antibiotic therapy followed by urinary catheterization. The growth of Trichosporon spp. from various samples has to be interpreted with caution as the organism can also exist as a colonizer in different body sites. Voriconazole was effective in the treatment of trichosporoniasis.

Fungal Face Incognito: a clinical, dermoscopic, and mycological study

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Objectives: Fungal face incognito (FFI) occurring on the face is the most frequently misdiagnosed cutaneous fungal infection; however, very limited information is available on fungal FFI. This study aimed to characterize the clinical, dermoscopic, and mycological features of FFI.

Methods: We retrospectively evaluated 38 patients with mycologically proven facial FFI at a single institution in Korea between July 2014 and July 2021.

Results: The patients had a mean age of 59.6 ± 20.4 years and showed a slight female predominance (male-to-female ratio, 1:1.5). The most common clinical presentation was an acniform-like pattern (47.4%), followed by a macule-like (31.6%), pseudocyst-like (9.5%), coccoid-like (7.9%), and folliculocyst-like (7.9%) pattern. The mean duration from disease onset to diagnostic confirmation was 3.4 months. Overall, 78.9% of the patients had accompanying chronic systemic diseases and 37.5% had concurrent mycoses on other skin sites, mainly on the face and trunk. Among the 23 (60.5%) cultured specimens, Trichophyton rubrum was the most frequently detected causative species, followed by Microsporum (18%) and T. mentagrophytes and T. verrucosum were also isolated from one case each. On dermoscopy, scales (91.1%) and dilated vascular patterns (arteriolar vessels and telangiectasia, 76.3% and 65.2%) were commonly observed in glabrous skin, with follicular patterns such as black dots, broken hairs, and empty follicles. The characteristic trichoscopy features were comma hairs, corrugated hairs, Morse code-like hairs, and translucent hairs.

Conclusion: The clinical characteristics and distinct dermoscopic features described in this article can aid in the differential diagnosis of facial FFI while reducing diagnostic delays and unnecessary treatments.

A rare case of co-infection with Nigrospora oryzae with mucormycosis in an immunocompromised post-COVID-19 patient

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Objective: A rare case of co-infection of Nigrospora oryzae with mucormycosis in an immunocompromised post-COVID-19 patient.

Methods: A 44-year-old male diabetic patient, with sub-optimal glycemic control, contracted COVID-19 infection and was managed with high-dose steroids. A month after recovery from COVID-19 infection, he developed severe headache with sudden onset right-sided facial swelling. A contrast-enhanced magnetic resonance imaging was done which was suggestive of infective/inflammatory rhinocerebral sinusitis with intracranial extension with a possibility of fungal etiology. Functional nasal endoscopic sinus surgery was performed and tissue was sent for microbiological processing. On KOH mount, broad paecilomyces fungal hyphae were seen. Fungal growth was obtained on SDA at 24°C and 37°C within 4 days of inoculation. It was confirmed as Rhizopus arhizus both phenotypically as well as by MALDI-TOF. Patient was put on antifungal therapy in form of In liposomal Amphotericin B 500 mgid. However, patient had persistent headache, vomiting, and low-grade fever post procedure. A repeat CE-MRI was performed which was suggestive of necrotic brain tissue/abscess and was planned for frontal lobe abscess drainage. Pas was inoculated on routine mycological media. On KOH mount, broad paecilomyces hyphae along with narrow septate hyphae were seen. Fungal growth was obtained on SDA at 24°C within 5 days of inoculation, which on L.PCR were identified as Nigrospora spp. The identity of the isolate was confirmed by Next generation sequencing as Nigrospora oryzae.

Post-2 weeks of treatment and strict glycemic control, patient started improving. The headache and swelling subsided. He was further started on oral hydroxycloroquine and was asked to follow up after a month.

Results: COVID-19 epidemic that emerged by the end of 2019 has been associated with a huge number of deaths globally. Acute invasive fungal rhinosinusitis is a potentially fatal infection in immunocompromised patients post COVID-19. Various studies reveal that invasive fungal infections have been the leading cause of death in 25%-73.7% of patients. Among these invasive fungal infections, Mucor spp. were detected in 77.8% patients. Pseudallescheria fumigatus in 31.6% while 8.3% showed mixed infection with both the fungi. Along with the established pathogenicity of Mucorales in causing invasive fungal infections, other fungal co-infections are also being observed. These invasive fungal infections in an immunocompromised host bear a high mortality and morbidity rate (18%-80%). Therefore, early diagnosis, followed by aggressive medical care, surgical debulking, and control of underlying disease is of utmost importance.

Conclusion: Acute invasive fungal rhinosinusitis saw a spurt in incidence during the widespread COVID-19 pandemic. Diagnosis of invasive fungal infection is based on the clinical setting and characteristic presentation, supported by radiological and mycological evidence. Prompt diagnosis and treatment are the need of the hour.