Condition. There is an increase in the absolute number of invasive infections by Candida auris observed over the past 2 years. At this moment, the percentage of fluorescent non-Aspergillus C. parapsilosis is very high and poses a threat to nostril patients and has a clinical impact on our hospital. Being able to identify and treat infections caused by this pathogen is important to prevent clinical outbreaks.

P156 A rare presentation of subcutaneous Entomophthoromycosis

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Entomophthoromycosis is a chronic granulomatous type of subcutaneous infection seen mainly in immunocompetent individuals. The usual cases of Condylactinomycosis infection is in rhinomycotusentorophoromycosis, characterized by chronic, indolent, and localized swelling of the nose, perinasal tissues, sinuses, cheeks, and upper lips which in itself affects the lower extremity.

We report a case of subcutaneous Condylactinion mycosis in a 23-year-old male with an alleged history of trauma to left foot by a wooden stake 6 months back. Primary treatment of the wound was done at a local hospital. A total of 4 months post-trauma he developed multiple pus discharging sinuses on the dorsum and plantar aspects of the left foot, for which local dressing was done in a nearby hospital. He presented to our hospital with non-healing multiple sinuses, with active unsympathetic discharge. He underwent wound debridement under spinal anesthesia and tissue was sent for fungal culture, histopathological examination.

Aerobic culture of the wound swab revealed moderate growth of Methylle-ruminant Fusiforms aureus sensitive to cindolmycin, gentamicin, and linezolid. Histopathological examination of the tissue showed a resolving abscess with granulation tissue. Direct microscopic examination of the tissue by KOH mount showed no fungal elements. It was inoculated into Sabouraud’s dextrose agar with and without cycloheximide and incubated at both 25°C and 37°C. Sabouraud’s dextrose agar without cycloheximide incubated at 37°C after 48 h of incubation grew cream-colored glistening colonies adherent to surface with pale reverse. Lactophenol cotton blue preparation revealed broad, sparsely septated hyphae with primary conidia which are glistening approx. 40 µm in diameter, produced singly. They have a characteristic protruding papilla on one side. The fungal isolate was identified as Conidiobolus species. Sequencing results were awaited for species identification and confirmation.

Serial wound dressings were done following strict infection control policies and he was started on tablet linezolid 400 mg twice daily tablet itraconazole 400 mg twice daily for 1 week, followed by 400 mg once daily for 6 months.

Condylactinomyces is a soil saprophyte, found in decaying vegetation in most warm climates in tropical countries. There has been only one published case report of subcutaneous Conidiobolomycosis of the foot, in a 49-year-old female from Venezuela. To the best of our knowledge, we report the first case of subcutaneous Entomophthoromycosis of the lower extremity in India and the second case in the world.

P157 Infant-juvenile paracoccidioidomycosis. Two Argentine endemic zones with different epidemiological and clinical aspects? What influences this situation?

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Argentina has two endemic areas of paracoccidioidomycosis (PCM): It is noteworthy that epidemiological characteristics differ in both regions, especially in frequency, and clinical aspects of infection PCM form (I-JF). In this work, we have reviewed and analyzed 10 years of paracoccidioidomycosis PCM (I-JF) in both regions in acute/intermediate and chronic cases. From January 2012 to December 2021 data of epidemiological characteristics, clinical history and laboratory results of I-JF cases were recorded on standardized protocols and entered into a database that helped consolidate the information.

Although the more extensive area of PCM historically with the highest incidence is located in Northeastern Argentina (NEA), the major number of I-JF was observed in the smaller PCM endemic area, located in the Northwest of the country (NRA).

In NRA, 12 I-JF were recorded including 20 cases of I-JF form in children from 1-13 years old. No outbreak was registered. Cases were equally distributed over the 10 years.

In NEA, 28 I-JF were recorded including 9 cases of I-JF form in children from 7-14 years old. Of these cases, 48% (7/15) presented as an outbreak in 2012. The rest were only registered in 2018-2020.

More frequent clinical manifestations of I-JF:

NRA: 75% hepatosplenomegaly with peritonitis and abscess, 15% gastrointestinal symptoms including diarrhea, Adenomycosis (70% cervical, 15% mediastinal).

Serology (I-JF) non-reactive: 32%.

NRA: 42% cutaneous, 37% hepatosplenicmycosis, 25% osteomyelitis, lesions, 21% pulmonary nodules, 24% pericardial effusion, 21% mucocutaneous. Adenomycosis (75% cervical, 42% mediastinal-occipital).

Serology (I-JF) non-reactive: 12.5%.

NRA records most cases of I-JF with a constant frequency and with a lower median age, NEA seems to only occur in outbreaks.

Are entitling the different epidemiological characteristics observed? Predominantly hepatosplenic and intestinal forms are observed in NRA, being with local material the first sample where Paracoccidioides is detected in most cases. In contrast, more diverse clinical manifestations are observed in NEA. Most cases with concomitaneous cutaneous lesions and the presence of pulmonary and pericardial forms characterized I-JF in this zone.

Considering epidemiological tests are important in the PCM diagnosis and to follow up the treatment success, reactive tests obtained (32% in NRA, 12.5% in NEA) show a serious diagnostic problem emphasized the need to work on more sensitive tests to reduce the high mortality of this clinical form. The variable expression of GP43 among isolates of Paracoccidioides species may suggest tests to use a single antigen preparation for serological tests and include autochthonous isolates.

Our group reported clinical and atmospheric changes influencing the appearance of I-JF outbreaks in the NEA, a region where the observation of these cases was historically very rare. Probably, NRA provides a different ecological niche for Para-

coccidioides, which favors its constant appearance over time. We have already started a multicenter molecular epidemiological, probably include soil studies of NRA would be important to try to better understand this situation.

P158 Persistent Fungemia with Candida auris in a patient with enterocutaneous fistula

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Objectives: Candida auris (C. auris) is a major emerging threat to the healthcare sector in view of the difficulty in early identification by standardized methods, multidrug resistance, and ease of spread in healthcare settings. Thus, we report a case of persistent C. auris fungemia (8–2 months) in a patient with enterocutaneous fistula.

Methods: A 77-year-old man without any comorbidities underwent surgery for diverticular perforation which was complicated by intra-abdominal abscesses, anastomotic leak, and multidrug-resistant bacteriuria requiring high antibiotics, total parenteral nutrition, and prolonged ICU stay. Patient was admitted to our center with sepsis and blood culture grew C. auris. Patient was managed with injection of capecitabine (in the absence of sutures breake). Patient continued to grow C. auris in the blood as fluconazole was added as a part of combination antifungal therapy. On dual antifungal therapy for 28 days there was a transient clearance of fungus. Work up for endocarditis, intrathoracic infection, and subduralabscesses was negative. But Patient continued on total parenteral nutrition via central line in view of enterocutaneous fistula. Patient developed a recurrence of fungemia after 4 days of stopping antifungal treatment. Patient was started on injection of capecitabine and voriconazole (in view of on-therapy resistance to fluconazole), on which cultures turned sterile and patient improved. Plan was made to give total 6 months of parenteral combination antifungal therapy.

Results: C. auris management complexities even from multiple factors. The above case emphasizes the urgent need for C. auris specific minimum inhibitory concentration breakpoints and standard guidelines for treatment. Currently, treatment is based on the Center for Disease Control’s proposed breakpoints (extrapolated from other Candida spp.). Upfront combination antifungal treatment might be the answer till further studies.

Conclusions: Management of invasive C. auris infection presents a major therapeutic challenge to clinicians and a major threat to healthcare sector even after timely identification.