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First case of Candida auris candidemia in Manipur, Northeast India
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Poster session 2, September 22, 2022, 12:30 PM - 1:30 PM

Objective: Candida auris is known as an emerging ‘superbug’ because of its intrinsic resistance to one or more, sometimes to all available antifungal drugs and spreading globally. It has the ability to cause devastating nosocomial infections. In India, C. auris infection is on the rise with reports from north, south, central and eastern India. Thus we present the first case of C. auris fungemia from a tertiary care hospital of Manipur in Northeast India.

Methods: A 13-year-old Muslim girl was referred from a private hospital to Regional Institute of Medical Sciences (RIMS) hospital on November 19, 2021 with a history of burning epigastrium, headache, loss of appetite, shortness of breath, dry cough, fever, and generalized weakness for last 3 days. At the time of admission she was cyanotic. Family gave history of congenital heart disease and frequent visits to hospital. Echocardiogram revealed congenital cyanotic heart disease (Tetralogy of Fallot) showing large perimembranous VSD with bidirectional shunt. A complete hemogram showed neutrophilic leukocytosis with shift to left with band form, absolute monocytosis, and increased RBC count with mild anisocytosis. On November 24, 2021, 1 day after admission, her condition deteriorated and she was shifted to ICU. However the condition of the patient deteriorated and she died on November 29, 2021 due to acute decompensated heart failure. Follow-up of other patients admitted in the same ward revealed no candidaemia in next few weeks.

Results: A single blood culture sent on November 29, 2021 was Incubated in an automated blood culture system, BacT Alert and showed growth of budding yeast cells. Growth in SDA revealed it to be Candida sp. and Gram-stained smear examination revealed presence of budding yeast cells but no pseudohyphae. Gram stain test was negative. On CHROM agar, it produces pale yellow colonies at 24 h which progresses to light purple colonies around the rim at 48 h. Further processing in VITEK 2 (Biomérieux) identified it as C. auris. The isolate was sent to National Culture Collection of Pathogenic fungi, WHO collaborating center, PUSMERI and the isolate was confirmed as Candida auris by MALDI-TOF MS assay.

Conclusion: Candida auris is spreading irrespective of the level of health care. Blood culture before administration of antibiotics and in febrile sick patients cannot be underestimated. Rapid and accurate identification methods for timely diagnosis and stringent infection control measures with an emphasis on hand hygiene are important to prevent and control C. auris outbreaks.

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A challenging case of pyrexia of unknown origin of adrenal mass
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A familiar dilemma in tropical countries is to consider the diagnosis of tuberculous (TB) in a patient with fever of unknown origin until proven otherwise. Often, in resource-limited settings, a response to a trial of empiric anti-tuberculosis therapy (ATT) is needed to prove TB. However, chronic granulomatous diseases such as invasive fungal infections and sarcoidosis have clinical features mimicking extrapulmonary TB. Thus, the workup for a definitive diagnosis is necessary.

A 53-year-old male presented with low grade, intermittent fever, loss of weight and appetite for a duration of 6 months and generalized abdominal pain for the last 2 months. He has lost about 16 kg in the past 6 months. He also reported a mild cough with scanty white mucoid sputum. There was no contact with a case of TB. He developed small orifically circular copper Color pancyte lesions in the trunk for the last 1 month (Fig. 1). The general examination of the patient was grossly normal except for hepatomegaly. Routine blood examination, renal and liver function test, and chest X-ray were normal and HIV ELISA was non-reactive.

With the strong suspicion of TB, the patient underwent CT-scanning of the chest and abdomen was done which showed bilateral heterogeneous adrenal mass with few hypodense areas within measuring right side 3.1 × 1.8 cm and left side 3.1 × 2.5 cm in suprarenal location and liver was enlarged size 19.5 cm with normal attenuation (Fig. 2). There were no clinical features to suggest pheochromocytoma or Cushing’s syndrome. The PET-CT revealed metabolically active disease involving bilateral adrenal gland, abdominal and retroperitoneal lymph node with diffuse hepatomegaly. Transabdominal ultrasonography guided FNA was done from adrenal lesions. The test for tuberculosis was negative and the cytology reported non-caseating granulomas with intracytoplasmic yeast cells suggestive of histoplasmosis. The adrenal endocrine profile was normal. From skin lesions, a biopsy was done. Direct KOH from skin lesions revealed budding yeast cells while the culture was not cultured. The patient was treated with 3 mg/kg liposomal amphotericin B for 2 weeks followed by daily trimiconazole for maintenance. The fever was resolved after 8 days of liposomal amphotericin B and skin lesions softened after 3 weeks of therapy.
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Subcutaneous phaeohyphomycosis by Phaeoacremonium species in a renal transplant recipient

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**Objective:** Phaeohyphomycosis refers to infections due to a large group of heterogeneous organisms called ‘chomatogeous’ or ‘indusiated’ fungi. The infection exhibits a wide spectrum of presentations such as deep local infections, pulmonary infections, central infections, and disseminated disease, which are associated with high mortality. The incidence of phaeohyphomycosis among solid organ transplant recipients is 0.7%. Hereby, we report a case of phaeohyphomycosis in a post renal transplant patient who presented with a subcutaneous swelling over the right elbow region.

**Method:** A detailed history was obtained from the patient after informed consent. The cystic fluid was subjected to microbiological including bacterial (Gram stain, culture on Blood agar incubated at 37°C) and fungal investigations (Calcofluor white stained agar (KOH) mount, culture on Sabouraud dextrose agar (SDA) incubated at 37°C and 25°C and brain heart infusion agar (BHI) incubated at 25°C). The identification of isolate was done phenotypically by preparing lactophenol cotton blue (LCB) mount from slide culture and molecular techniques using Sanger's sequencing.

**Result:** A 61-year-old diabetic and post renal transplant (7 years) male presented with complaints of swelling over the right elbow region for 1 month duration. Swelling was insidious in onset, gradually progressive, painless, cystic, non-palpable, non-tender, ∼8 × 7 cm in size, lobular in shape with irregular surface having normal overlying skin which minimally restricting the movement of the elbow. There was no history of trauma over the elbow region. Radial pulse was present. He was received for mycological investigation. Calcofluor white stained BHI mount demonstrated septate hyphae. Culture on SDA incubated at 37°C and 25°C grow cream-coloured colonies, turning grayish beige to olive-brown and developed colonies of aerial hyphae with reverse tan to brown in color after 2 weeks of incubation. LCB mount showed hyaline to brownish hyphae, cylindrical phialides growing along the hyphae with slightly tapering towards the apex, hyaline, oblong, conida, gathering in clusters at end of phialide. Phenotypically, the fungus was identified as Phaeoacremonium species and molecular identification and antifungal susceptibility are awaited. Patient was advised for surgical excision but he left against medical advice. Currently, he is not receiving any antifungal.

**Conclusion:** Phaeohyphomycosis is a rare and unique entry among fungal infections. Cutaneous phaeohyphomycosis predominantly occurs on the cutaneous with a localized solitary nodule or abscess. A high index of suspicion and the surgical approach including excision or debulking are mainly shown.