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

**P136**
A rare presentation of subcutaneous Entomophthoramycosis

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Poster session 2, September 22, 2022, 12:10 PM - 1:30 PM

Entomophthoramycosis is a chronic granulomatous type of subcutaneous infection seen mainly in immunocompromised individuals. The usual focus of Ceiulphthoramycosis infection in an rhinocentrumophthoramycosis, characterized by chronic inflammation and localization of the lesions, paranasal tissue, sinuses, orbits, and upper lips and it subsequently affects the lower extremities.

We report a case of subcutaneous Entomophthoramycosis in a 21-year-old male with an allergic history of asthma to left foot by a woods stake 4 months back. Primary treatment of the wound was done at a local hospital. A total of 4 months post-trauma he developed multiple paraspinal discharging sinus on the dorsolateral aspect 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 acute unceasing discharge. He underwent wound debridement under spiral anesthesia and tissue was sent for fungal culture, histopathological examination.

Aerobic culture of the wound swab revealed moderate growth of Methyllic-racem inhibitors fungemia an sensitive to clindamycin, gentamicin, andloxil. 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 glabrous colonies adherent to surface with pale reverse. Lactophenol cotton blue preparation revealed broad, sparsely septate hyphae with primary conidiophores which are glabrous approx. 40 μm in diameter, produced singly. They have a characteristic protruding papilla on one side. The fungal isolate was identified as Entomophthora species. Sequencing results are awaited for species identification and confirmation.

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

Entomophthora 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 entomophthoramycosis of the foot, in a 49-year-old female from Venezuela. To the best of our knowledge, we report the first case of subcutaneous entomophthoramycosis of the lower extremity in India and the second case in the world.

**P137**
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 areas, especially in frequency and clinical aspects of infantile PCM forms (I-JF). In this work, we have reviewed and analyzed 10 years of paracoccidioidomycosis (PCM) forms (I-JF) in both zones using data in both clinical and laboratory results of I-JF cases were recorded on standardized protocols entered into a database that helped consolidate the information.

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

In NWA, 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 6 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.

NWA: 70% hepatosplonitisum with peritonitis and acros, 35% gastrointestinal symptoms including diarrhea. Adenomegaly (70% cervical, 15% mediastinal).

Serology (I-JF) nonreactive: 32%.

NWA: 42% sinusitis, 35% hepatosplonitisum, 25% osteoarthropathy, 21% pulmonary nodules, 25% pericardial effusion, 21% mucocutaneous. Adenomegaly (75% cervical, 42% mediastinal-retroperitoneal).

Serology (I-JF) nonreactive: 12.5%.

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

Are differing the different epidemiological characteristics observed? Predominantly hepatosplonitisum and intestinal forms in NWA, hepatitis having local material the first sample where Paracoccidioides is detected in many cases. In contrast, more diverse clinical manifestations are observed in NEA. Most cases with concomitant sinusitis and/or recent osteoarthropathy.

Serology results of both populations suggest recent to use a single antigen preparation for serological tests and include aminoglycoside isolation.

Our group reported clinical and anthropogenic effects influencing the appearance of I-JF outbreaks in the NEA, a region where the observation of these cases was historically very rare. Probably, NWA provides a different ecological niche for Paracoccidioides, which favors its constant appearance over time. We have already started a molecular epidemiological study, probably including soil studies of NWA would be important to try to better understand this scenario.

**P196**
Persistent Fusemia with Candida auris in a patient with enterocontucaeous 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 standard methods, multi-drug resistance, and case of spread in healthcare settings. Here, we report a case of Persistent C. auris fungemia (2 months) in a patient with enterocontucaeous fistula.

Methods: A 77-year-old man without any comorbidities underwent surgery for diverticulitis perforation which was complicated by intra-abdominal abscess, anastomotic leak, and multi-drug-resistant bacteria 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 cephalosporin (in the absence of sensitivity breakpoint). Patient continued to grow C. auris in the blood so flucytosine was added as a part of combination antifungal therapy. On dual antifungal therapy for 28 days there was a transient clearance of fungemia. Work up for endocarditis, intrathoracic collections, and subduralphaptia was negative. But Patient was continued on total parenteral nutrition via central line in view of enterocontucaeous fistula. Patient developed a recurrence of fungemia after 4 days of stopping antifungal treatment. Patient was started on injection of meticillin and gentamicin (in view of on-resistance to flucytosine), on which cultures turned sterile and patient improved. Plan was made to give total 6 weeks of parenteral combination antifungal therapy.

Results: C. auris management complexities exist 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 (unpublished 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.

Table 1.

| Candida auris | drugs | MIC ≤ 1 | MIC ≤ 0.25 | MIC > 4 | MIC > 16 | Sterile |
|--------------|-------|---------|------------|--------|----------|--------|
| Candida auris | Flucytosine | 32      | 32         | 256    | 256      | 256    |
| Candida auris | Voriconazole | 32      | 32         | 256    | 256      | 256    |
| Candida auris | Fluconazole | 32      | 32         | 256    | 256      | 256    |

Poster Presentations