of invasive aspergillosis was considered in patients who had at least one clinical and one mycological EORTC criteria. Galactomannan in different samples was measured via FluoMent™ ELISA. The efficacy of different antifungals and outcomes were analyzed.

Results: Total 57 patients with TB underwent evaluation for invasive aspergillosis. Among them, five patients were diagnosed with concurrent TB and invasive aspergillosis, and 12% of them had multiple TB lesions and two or more concurrent pulmonary infections. The average age was 31 ± 12 years with a female preponderance (40%). Two patients were diagnosed with HIV among non-HIV patients. The median CD4 T-cell count was 264 (17-1700) cells/mm^3. Invasive aspergillosis is aClinicol factor. Bacteriologically, most common pulmonary lesions were purulent consolidation with indurated nodules in tuens in bad appearance, while CNS lesions showed multiple ring-enhancing lesions. All the patients had CRNSAAT positive, two were from BAL samples, one from CSF, and one from the lung biopsy. In all, except one who had esophageal fistula. Of those, three were severe invasive aspergillosis satisfying the host, mycological and clinical criteria as per the EORTC/MSG 2021 guidelines. The treatment of co-infection is challenging due to the interaction of rifampicin with which is the drug of choice for invasive aspergillosis. Here, 3 patients were treated with line amphotericin B, while the other 2 patients were started on voriconazole with rifampicin sparing regime for TB. Of the 5 patients, 4 patients showed good response to the treatment, with one failure.

Condition: The possibility of concurrent TB and invasive aspergillosis in non-neutropenic hosts should be considered to avoid devastating outcomes. The lack of clinical suspicion may result in misdiagnosis, and most importantly, the chronology of TB makes it non-indistinguishable from invasive aspergillosis.

P146 Co-infections due to Aspergillus and Mucorales: Case series from a superspecialty medical center in India

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Objectives: To present details of a case series of fungal co-infections (aspergillosis and mucormycosis) including clinical course, laboratory diagnosis, treatment, and outcome.

Methods: Clinical features of 7 cases of fungal co-infections (3 pulmonary, 4 rhino-orbito-cerebral or sino-nasal) were evaluated, and reports of samples were considered for the microbiology laboratory for direct microscopy and fungal culture were retrieved from laboratory records. Presence of septate and hyphae histophagia in direct microscopy of clinical samples and growth of Aspergillus and Mucorales in culture was considered as evidence of probable mucormycosis and aspergillosis (as per EORTC guidelines).

Results: Mechanical neutropenia, cavitary lung disease, and nasal and GI tract involvement as severe risk factors observed in patients with fungal co-infection, while use of systemic corticosteroids for treatment of ARDS/COVID-19 infection was common in rhino-orbito-cerebral (ROC) or sino-nasal (SN) co-infection. Diabetes mellitus was a common risk factor for both groups of cases.

Concert, cough, shortness, and absence of breath were the most common features in pulmonary fungal co-infection cases, while headache, facial swelling and pain, nasal stricture, vision disturbance, and altered sensorium were the most common features in ROC/SN fungal co-infection.

Conclusions: Fungal co-infection with aspergillosis and mucormycosis is a serious condition requiring early intervention. This is facilitated by high sensitivity of direct microscopy in tissue samples used for diagnosis in ROC/SN co-infection, but histopathology is the gold-standard for mucormycosis. BAL samples used for diagnosis in pulmonary cases rather than lung biopsy. Robust clinical adjuvant services, early diagnosis, and combined surgical and pharmacological approaches are crucial to a favorable outcome.

P145 Penicillium-like mycoid: caught red-handed, but remained unidentified

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Objective: This case highlights the presence of a self-limited respiratory mycosis in an immunocompetent host and need for fungal sequencing in diagnosis of such rare cases.

Methods and Results: A 25-year-old, apparently healthy software engineer, had an overnight journey in an air-conditioned bus from Hyderabad to Pune. The next day, she developed throat irritation followed 3 days later by fever and cough without dyspnea or wheezing. Her chest X-ray was found to be normal. Three days later she was admitted to the hospital. Her chest X-ray showed bilateral hilar nodularity, which was referred to ID as a case of suspected tuberculosis, but her presenting symptom being sore throat, the acumen of symptoms, presence of nodular shadow changes which were absent in X-ray, was found on day 3 earlier were against the diagnosis of TB. Inhospitalinal tuberculosis was therefore considered.

Histobronchoscopy showed an intense inflammatory exudate, but GM staining did not reveal any fungal hyphae. BAL Galactomannan, Xpert MTB/RIF were negative. Both BAL and CT guided lung nodule biopsy samples grew a mold. Red pigment formation in culture and its morphological appearance on LPCR mount (Fig. 2) led to a diagnosis of Penicillium species infection. MALDI TOF MS, which had a low Penicillium spp in its 2018 database, failed to identify the organism, leading to the identification of a different Penicillium species.

Since the patient was showing clinical improvement, a self-limiting infection was thought of and therapy was withheld with caution. The patient was completely asymptomatic after 15 days and CT chest done 20 days later showed complete resolution of the lesion.

We believe that this illness was due to inhalation of spores from the air-conditioned room, alacting a minor inflammatory respiratory illness. The organism grown from pleural biopsy and lung nodule was found to be Penicillium, but it was not a common Penicillium species. Further, this organism is not a pulmonary isolate, but it was found to be in the cases of CNS infections and IPA as well.

Penicillium fungi are often isolated from poorly maintained air conditioning rooms. In this case, the Penicillium-like organisms failed to produce progressive disease in the immunocompetent host. If the same organism could be cultured from BAL and blood and use specific mycological analysis to confirm the diagnosis, this could be considered a useful clinical diagnostic tool.