introduction: The ventral ophthalmoscopy can be prognostic (bacterial), non-prognostic (granulomatous (tuberculous, brucel- losis, fungal infections). Fungal infections are the most common causes for 0.7%-7% of all blood infections. Tubercular ventral ophthalmoscopy have a high prevalence in developing countries like India. Co-infection of the spine by both fungal and tuberculosis organisms is rare, there is only one case that has been reported till now in our literature review. The case A-42 was admitted with complaints of lower back pain for 3 months and fever with chills for 1 month. He had done multiple O/D visits at other centers for his lower back pain in the past 2 months, while a whole spine MRI was done which was suggestive of pyogenic intradural, due to multiple spinaudum lumbar 4/5 causing fixatra- tion of nerve roots for which he was given days of IV and followed by 15 days of oral methylprednisolone. On admission, patient developed fever and lower back pain for which he was admitted. Repeat MRI spine revealed kuruona stri- a partial spinaudal. At the point, he was referred to our center for further management and was admitted. He was a known case of diabetes and underwent bilateral DJ stent in nephrectomy 3 months before. On post-operative day 4, he had developed low back pain. He was trivially sick but feasible, stable to sit or walk without support. He also had guarding and tenderness in the right lower quadrant. On clinical and laboratory studies showed no increase. He was done, CINNAAT was suggestive, while culture revealed growth of Candida albicans. He was started on injection of fluconazole 400 mg loading dose and 200 mg/day for 5 days. After 6 days, the patient was asymptomatic and low back pain was peremptory. Hence a repeat ventral biopsy was planned. Surprisingly, CINNAAT of the biopsy sample detected very few Mtb and contra- rium in situ reaction space, following which the patient was initiated on weight-based EBCF regimen along with fluconazole. Currently, patient is active and his lower limb weakness has improved with lower limb muscle power 0/5 to 3/5 on follow-up after a month.

Conclusion: Non-prognostic ventral ophthalmoscopy due to tuberculosis is common in a high TB burden country like India. Even though Candida is a rare causative agent, but should always be considered as a differential in patients having risk factors for our patient. Glucose, thirty week, DIS and MDR could have precluded for developing Candida ventral ophthalmoscopy. The positivity of fungal ventral biopsy should not be ignored in patients with high-risk factors, especially, if deep groin with clinical and radiological signs bolting its high presence. High suspicion and tissue diagnosis remains crucial factors for early diagnosis and aids in better clinical outcome.

P264 A rare case of post coid bilateral renal mucormycosis Mane Sheshani Cure Infectious Disease Clinic, Ahmadabad, India

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

Objective: The most commonly reported sites of Candida-associated mucormycosis till now have been rhino- cerebral-sinusoidal.

Method: A 40-year-old male was presented with low-grade fever and increased CRP. He had a known history of diabetes, hypertension, and ischaemic heart disease since 2007. On examination, he was tachypneic and pale, blood pressure and oxygen saturation were within normal limits. He was also double vaccinated. Also had a history of moderate COVID (Unimicron) in January 2022. His CT score was 18/25. He was on for insulin for 4 years and was never on dialysis, anticoagulants, and statins.

Later on, patient developed fatigue, anorexia, abdominal discomfort, and pain in lower back. Also vomiting and nausea for 3 months. Both hands numbness and weakness, 5 days before admission with no improvement. On examination, patient was not able to lift his left side, 1 gcs for 5 days followed by, tabletorfanic acid 200 mg each for 3 weeks followed by, tablenilformic acid 100 mg bid.

Ultrasonography remains the first line of investigation and can show the dilated echogenic kidney with hypo- or abnormalities of the renal parenchyma. The curve of the kidneys is an indirect sign of impaired blood flow. The thickness of cortical appears normal with normal cortical echogenicity. A computed tomography (CT) of his abdomen and pelvis was performed and suggested mild increase of radiodensity changes suggestive of vasculitis. He was diagnosed with a diagnosis of focal segmental glomerulosclerosis, and he was started on prednisolone 15 mg/day and antihypertensive medications. Physical examination was normal, with no signs of cardiac intrasural pressure use of CANS infection. Basic investigations revealed no abnormalities, and the white cell count was 7.5 to 10.5 and the CRP was 8 ng.

He was maintained on clopidogrel to prevent the risk of small vessel disease in the right frontal lobe indolently. Therefore, she was treated with paraxial antibiotics for a bacteriological infection and was discharged.

Conclusion: The case described here is a case of post-coid bilateral renal mucormycosis. This patient presented with a known history of Cushing’s syndrome and was diagnosed with a diffuse parenchymal infection with high-risk factors for developing mucormycosis. The importance of early diagnosis and the potential for a good outcome cannot be overstated. The case described here was able to prevent an increase in the size of the lesion in the right frontal lobe and the possibility of a cerebral tumor was suggested. A diagnostic biopsy was performed, and the surgeon was studied for fungal aspergillosis. The case demonstrated the potential for a good outcome with the use of antifungal therapies.

She was started on intravenous amphotericin B, followed by oral voriconazole. Her headache gradually subsided with antifungal therapy. The duration of therapy was guided by serial radiological imaging, and the patient achieved a complete recovery at the end of 1 year of treatment. She remains asymptomatic to date, 2 years after treatment.

Discussion: Immunosuppressed patients with cerebral aspergillosis may present with minimal clinical and symptoms and obtaining a proper specimen for laboratory testing to viral or arterial to arrive at a definitive diagnosis. Radiological investigations may play an important role in the diagnosis as well as during the follow-up of a patient with cerebral aspergillosis. Appropriate antifungal treatment for a prolonged duration, with or without immunosuppressive intervention and reduction or induction of immunosuppressive therapy leads to a good prognosis.

P268 Rhinosporidial mucormycosis due to Sakazakia avitale in a Sri Lankan patient: A rare fungal infection Lijayange Shanthi Madumali Sigeera1, O.D.K.S.T. Rosa2, M.A. Mahamithi3, P.J. Jayasunderan3, P.L. Jayawardana3

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

Background: Sakazakia avitale is a well-known agent of naso-oral mucormycosis. However, we report an unusual case of rhinosporidial mucormycosis due to S. avitale in a Sri Lankan patient with diabetes mellitus.

Case Report: A 69-year-old female with diabetes mellitus was admitted with frontal headache, right-sided facial neuralgia, and right-sided facial swelling. Examination revealed frontal edema, mandibular sinus tenderness, and a right patch over the hard palate. Thick pus in postnasal space, growth in posterior tongue base, inflamed palate, and epiglottis, were revealed by endoscopy (Figs. 1A and 1B). She was treated with amphotericin B 1 mg/kg/day and voriconazole. The patient was discharged after 3 weeks of discharge. She was treated with topical voriconazole. She was discharged after 2 weeks of treatment.

Discussion: Immunocompromised patients with cerebral mucormycosis may present with minimal clinical and symptoms and obtaining a proper specimen for laboratory testing to viral or arterial to arrive at a definitive diagnosis. Radiological investigations may play an important role in the diagnosis as well as during the follow-up of a patient with cerebral aspergillosis. Appropriate antifungal treatment for a prolonged duration, with or without immunosuppressive intervention and reduction or induction of immunosuppressive therapy leads to a good prognosis.