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 the overall non-fermentable C. parapsilosis is very high and poses a threat to rational 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 Entomophthoromycosis

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

Entomophthoromycosis is a chronic granulomatous type of subcutaneous infection seen mainly in immunocompetent individuals. The usual focus of Conidiphilobolus infection is in rhinocentrophilomyces, characterized by chronic, indolent, and localized swelling of the nose, paranasal sinuses, rhinostoma, and upper lips and it subsequently affects the lower extremities.

We report a case of subcutaneous Conidiobolus in a 21-year-old male with an allergic history of asthma to dust. He was discharging by a wooden stick 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 dorsolateral plantar 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 sinusogangrenous discharge. He underwent wound debridement under spinal anesthesia and tissue was sent for fungal cultures, histopathological examination.

Aerobic culture of the wound swab revealed moderate growth of Methyllose-resistant Fusarium species suggestive to conidiaform, gomortega, and lusor. Histopathological examination of the tissue showed a resolving abscess with granulation tissue. Direct microscopic examination of the nose 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 gale nema. Lactophenol cotton blue preparation revealed broad, sparsely septate hyphae with primary conidia 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 Conidiobolus 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 nystatin 400 mg twice daily, tablet imidazole 400 mg twice daily for 1 week, followed by 400 mg once daily for 6 months.

Conidiobolus is a soil saprophyte, found in degrading vegetation in moist warm climates in tropical countries. There has been only one published case report of subcutaneous entomophthoromycosis 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.

**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 paracoccidioidomycosis PCM form (I-JF). In this work, we have reviewed the accumulated 10 years of paracoccidioidomycosis PCM form (I-JF) in both areas during 15 years in adults and children.

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 most 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 Northeast of the country (NRA).

In NRA, 32 IJF 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 IJF 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

NRA: 70% hepatopneumonitis with parotitis and axilla, 35% gastrointestinal symptoms including diarrhea. Adenomegaly (70% cervical, 15% mediastinal).

Serology (I-JF) test: positive: 32%.

NRA: 42% cutaneous, 37% hepatopneumonitis, 25% otorhinolaryngitis, 25% peripheral edema, 25% rhinocentrophilomyces. Adenomegaly (75% cervical, 15% mediastinal-oentamopthoramycosis).

Serology (I-JF) test: positive: 12.5%.

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

Are the different epidemiological characteristics observed? Predominantly hepatopneumonitis and intestinal forms in NEA, being with local material the first form where Paracoccidioides is detected in many cases. In contrast, more diverse clinical manifestations are observed in NEA. Most cases with continuous subcutaneous lesions and the presence of pulmonary and pericardial forms characterized I-JF in this zone.

Considering serological tests important in the PCM diagnosis and to follow up the treatment success, no reactive tests obtained (32% in NRA, 12.5% in NEA) show a serious diagnostic problem emphasized the need to work on more sensitive tools to reduce the high mortality of this clinical form. The variable expression of glabrous species can affect tests to use a single antigen preparation for serological test and include rhinocentrophilomyces.

A group reported climate and anthropogenic changes influencing the appearance of I-JF outbreaks in the NEA, a region where the observation of these cases was historically very rare. Probably, NEA provides a different ecological niche for Para- coccidioides, which favors its constant appearance over time. We have already started a multicenter molecular epidemiological study to include soil studies of NRA would be important to try to better understand this situation.

**P308**

Persistent Pseudemphomyces Candida auris in a patient with enterocutaneous fistula

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Objective: Candida auris (C. auris) is a major emerging threat to the healthcare sector in view of the difficulty in early identification by standardized methods, multhead resistance, and case of spread in healthcare settings. Here, we report a case of persistent C. auris fungemia (2+ months) in a patient with enterocutaneous 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 ILU stay. Patient was admitted to our center with sepsis and blood culture grew C. auris. Patient was managed with injection of cefazolin (in the absence of unifocal breakpoint). Patient continued to grow C. auris in the blood so fluconazole 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 collection, and subdural bulging was negative. But Patient was continued on total parenteral nutrition via central line in view of enterocutaneous fistula. Patient developed recurrence of fungemia after 4 days of stopping antifungal treatment. Patient was started on injection of miconazole and voriconazole (in view of on-treatment resistance to fluconazole), on which cultures turned sterile and patient improved. Plan was made to give total 6 weeks of parental combination antifungal therapy.

Results: C. auris management complexities come 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 (empiricidal from other Candida spp.) Upon completion antifungal treatment might be the answer till further studies.

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

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**Table 1.**

| Candida auris | drugs | ≤ 3 | ≤ 5 | ≤ 6 | ≥ 7 | ≥ 8 | Sterile |
|---------------|------|-----|-----|-----|-----|-----|--------|
| Candida parapsilosis | ≤ 2 | ≥ 3 | ≤ 4 | ≤ 5 | ≥ 6 | ≥ 7 | Sterile |
| Candida tropicalis | ≤ 3 | ≤ 4 | ≤ 5 | ≥ 6 | ≥ 7 | Sterile |

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**Poster Presentations**

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