Deep-Seated Trichosporonosis in an Immunocompetent Patient: A Case Report of Uterine Trichosporonosis

We report an unusual case of endometritis caused by Trichosporon beigelii in an elderly woman who had no clinically obvious immunosuppression nor even clinically obvious skin disease. No evidence of predisposing factors for deep trichosporonosis was identified in this patient, who apparently is of normal immune status.

Minor skin pathogens can, on occasion, be the cause of deep or systemic infections. The fungus Trichosporon beigelii is associated with a number of clinically minor skin infections, yet, in a few cases, it can also cause more-serious deep infections, usually in an immunocompromised host. In this article, we report a case of Trichosporon endometritis in a clinically immunocompetent elderly woman.

The patient, a 74-year-old woman, was assessed for abnormal vaginal discharge. She had atherosclerotic heart disease and a history of chronic obstructive lung disease. The patient was not diabetic and was not receiving any immunosuppressive drugs. She complained of postmenopausal vaginal bleeding, which occurred intermittently for several weeks. At the time the patient underwent uterine curettage, the gynecologist noted a significant amount of purulent discharge.

The uterine curettage specimens were fixed in formalin and processed on a Fischer Histomatic 266 tissue processor (Fischer Scientific, Pittsburgh, PA). Histology slides were made and stained with standard hematoxylin and Gomori methenamine silver methods. Specimens for fungal culture were inoculated on Sabouraud dextrose agar (Becton Dickinson Microbiology Systems, Sparks, MD) and brain-heart infusion agar. The yeast isolates were identified by the API 20C (Bio Merieux, Marcy l’Etoile, France). On microscopic examination, a background of amorphous necrotic matter was seen, along with a thick neutrophilic exudate. Many groups of fungal hyphae were present; these were septate and showed acute angle branching. The hyphae showed the expected positive staining reaction with the Gomori stain (figure 1). The culture specimens grew an organism that was identified as T. beigelii on the basis of urease production and a compatible biochemical profile on the API 20C.

T. beigelii is most commonly associated with superficial skin infections, such as white piedra and onychomycosis, and with various forms of papulovesicular, papulopustular, and purpuric lesions [1, 2]. Deep infections and fungemia are usually associated with an immunosuppressed state [1–3].

To our knowledge, this is the first case of T. beigelii endometritis to appear in the literature; the literature search we undertook consisted of an examination of the computer files of MEDLINE, Excerpta Medica, and Biological Abstracts, as well as a search of the paper records (dating back to 1879) of Index Medicus at the University of British Columbia. This case is most unusual in that the patient had no clinically obvious immunosuppression nor even obvious clinical skin disease.

Deep systemic Trichosporon infection has been noted in the background of systemic immune suppression caused by such factors as hematologic malignancy, immunosuppressive therapy, and diminished immune function of various causes. It can present in a number of deep sites, and it can be present as a fungemia. No evidence of predisposing factors for deep trichosporonosis were identified in this case, and the patient was clinically cured after curettage and a course of amphotericin B and itraconazole.

The presentation of a deep infection in this patient of apparently normal immune status is most interesting.

Robert M. T. Chan, Patrick Lee, and Julius Wroblewski
Mount Saint Joseph Hospital, Vancouver, British Columbia, Canada

References