P223

First case of Candida auris candidemia in Manipur, Northeast India

Ojita Konjemhang, Ranjana Khurjarajm, Phiyaxomi Ningthoujam, Aindhilla Acharjee, Hari Pressambika, Binita Thingam
Regional Institute of Medical Sciences, Imphal, India

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

Objective: Candida auris is known as an emerging ‘superbug’ because of its intrinsic resistance to one or more, sometimes to all available antifungal drugs and spreading globally. It has the ability to cause devastating nosocomial infections. In India, C. auris infection is on the rise with reports from south, south, central and eastern India. Thus we present the first case of C. auris fungemia from a tertiary care hospital of Manipur in Northeast India.

Methods: A 15-year-old Muslim girl was referred from a private hospital to Regional Institute of Medical Sciences (RIMS) hospital on November 19, 2021 with a history of burning epigastrium, headache, loss of appetite, shortness of breath, dry cough, fever, and generalized weakness for last 3 days. At the time of admission she was cyanotic. Family gave history of congenital heart disease and frequent visits to hospital. Echocardiogram revealed congenital cyanotic heart disease (Tetralogy of Fallot) showing large left-to-right shunt with bidirectional shunt. A complete blood count showed neutrophilic leukocytosis with shift to left with band form, absolute monocytosis, and increased RBC count with mild anisocytosis. On November 24, 2021, 5 days after admission, her conditions deteriorated and she was shifted to ICU. However, the condition of the patient deteriorated and she died on November 29, 2021 due to acute decompensated heart failure. Follow-up of either patient admitted in the same ward revealed no candidaemia in neat the few weeks.

Results: A single blood culture sent on November 29, 2021 was incubated in an automated blood culture system, BacT Alert and showed growth of budding yeast cells. Growth in SDA revealed it to be Candida sp. and Gram-stained smear examination revealed presence of budding yeast cells but no pseudohyphaes. Gram rest was negative. On CHROM agar, it produces pale yellow colonies at 24 h which progresses to light purple colonies around the rim at 48 h. Further processing in VITEK 2 Biometer confirmed it as C. auris. The isolate was sent to National Culture Collection of Pathogenic Fungi, WHO collaborating center, PULMER and the isolate was confirmed as Candida auris by MALDI-TOF MS assay.

Conclusion: Candida auris is spreading irrespective of the level of health care. Blood culture before administration of antibiotics and in febrile sick patients cannot be underestimated. Rapid and accurate identification methods for timely diagnosis and stringent infection control measures with an emphasis on hand hygiene are important to prevent and control C. auris outbreaks.

P224

A challenging case of pyelusia of unknown origin of adrenal mass

Arvind Kumar1, Ankesh Gupta2, Delbin Bhatia3, Neeraj Nitchha3, Navreet Wlig3
1AIIMS, New Delhi, India
2AIIMS, New Delhi, India
3AIIMS, New Delhi, India
4AIIMS, New Delhi, India

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

A familiar dictum in tropical countries is to consider the diagnosis of tuberculous (TB) in a patient with fever of unknown origin until proven otherwise. Often, in resource-limited settings, a response to a trial of empiric antibiotics is expected to prove TB. However, chronic granulomatous diseases such as invasive fungal infections and sarcoidosis have clinical features resembling extra-pulmonary TB. Thus, the workup for a definitive diagnosis is necessary.

A 53-year-old male presented with low-grade, intermittent fever, loss of weight and appetite for a duration of 4 months and generalized abdominal pain for the last 2 months. He has lost about 16 kg in the past 6 months. He also reported a mild cough with scanty white mucoid sputum. There was no contact with a case of TB. He developed small cutaneous nodule of color purple lesions in the trunk for the last 1 month (Fig. 1). The general examination of the patient was grossly normal except for hepatomegaly. Routine blood examination, renal and liver function test, and chest X-ray were normal and HIV ELISA was non-reactive.

With the strong suspicion of TB, the patient underwent CT scanning of the chest and abdomen was done which showed bilateral heterogeneous adrenal mass with few hypodense areas within measuring right side 3.1 x 1.8 cm and left side 3.1 x 2.5 cm in suprarenal location and liver is enlarged size 19.5 cm with normal attenuation (Fig. 2). There were no clinical features to suggest pheochromocytoma or Cushing's syndrome. The PET-CT revealed metabolically active disease involving bilateral adrenal gland, abdominal and retroperitoneal lymph node with diffuse hypermetabolism. Transabdominal ultrasound-guided FNA was done from adrenal lesion. The tests for tuberculosis were negative and the cytology reported necrotizing granulomas with intracytoplasmic yeast cells suggestive of histoplasmosis. The adrenal endocrine profile was normal. From skin lesions, a biopsy was done. Direct KOH from skin lesions revealed budding yeast cells while the cultures are awaited. The patient was treated with 3 mg/kg liposomal amphotericin B for 8 weeks followed by daily intramuscular for maintenance. The fever was resolved after 8 days of liposomal amphotericin B and skin lesions softened after 3 weeks of therapy.