References


Phaeoacremonium parasiticum Infective Endocarditis Following Liver Transplantation

Phaeoacremonium species, formerly known as Phialophora species, are distributed worldwide, and infection usually occurs through traumatic inoculation. P. parasiticum has a predilection for infecting immunocompromised hosts [2], but infection in apparently immunocompetent hosts has been described [3, 4]. The clinical manifestations of P. parasiticum infection include subcutaneous abscesses and acute or chronic arthritis; there has been one case of disseminated infection [3–5]. Infective endocarditis and fungemia due to P. parasiticum have not yet been described. We report what we believe to be the first case of P. parasiticum (formerly Phialophora parasitica [1]) endocarditis and fungemia in the literature.

A 45-year-old man with liver failure secondary to alcohol abuse underwent orthotopic liver transplantation (OLT) in July 1995. Posttransplantation complications included respiratory failure, renal failure, venous thrombosis, wound dehiscence with ascitic fluid leakage, and bilateral pleural effusions. The immunosuppressive regimen included cyclosporine, azathioprine, and prednisolone. Infective complications included Klebsiella oxytoca bacteremia, Staphylococcus epidermidis bacteremia, and a pleural space Candida humicola empyema.

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Clinical Infectious Diseases 1997;25:1251–2
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A second OLT was performed on day 55 of hospitalization because of allograft failure. Cytomegalovirus viremia was detected the next day and was treated with ganciclovir. On day 57, a lesion with a central brown-black eschar and surrounding induration was noted in the web space between the thumb and index finger of the left hand (figure 1). Microscopic examination of the fluid showed phaeoid fungal elements. A cottony-white mold grew on Sabouraud dextrose agar; this mold darkened with age. The colony texture was velvety-to-funiculose with a yellow-brown-olivaceous obverse and a blackish reverse. Hyphae encrusted and were initially hyaline but later turned brown.

Figure 1. Lesion between the thumb and index finger of the left hand of a patient with Phaeoacremonium parasiticum infective endocarditis following liver transplantation. Note the central pigmentation with associated induration.
The phialides were brown, thick-walled, and acicular. They were autopsy specimens revealed fungal myocarditis, fungal pneumonitis, and fungal microabscesses in the kidneys.

The optimal therapy for \textit{P. parasiticum} infection is unknown, but complete surgical resection of small localized cutaneous lesions is probably the treatment of choice. Antifungal agents that have been used to treat \textit{P. parasiticum} infection, with variable success, include amphotericin B, 5-flucytosine, ketoconazole, and terbinafine [5].

In summary, we present a case of \textit{P. parasiticum} endocarditis, fungemia, and disseminated infection following liver transplantation. As there are increasing numbers of immunosuppressed patients, the incidence of invasive fungal diseases—including infections with phaeo fungi—will likely increase.

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References

Invasive Cryptococcosis in a Family with Epidermodysplasia Verruciformis and Idiopathic CD4 Cell Depletion

Epidermodysplasia verruciformis (EV) is a rare autosomal recessive disease that was first described in 1922 [1]. Patients with EV present with extensive flat and pityriasis-like warts in sun-exposed areas such as the face and hands [1, 2]. The onset of EV usually occurs in young adulthood, and the disease is associated with depressed cell-mediated immunity and a propensity for transformation of the warty lesions to squamous cell carcinoma [3–5]. Several human papilloma viruses have been associated with EV [2–4]. Other opportunistic infections have not been reported in patients with EV. We describe a consanguineous family with seven children in which two of three siblings who had EV developed disseminated cryptococcosis.

A 25-year-old woman was admitted to the hospital because of a 6-week history of headaches and intermittent fever. Her medical history was unremarkable except for multiple warts of different sizes that had appeared on her face, hands, and forearms over the 3 years before admission. Physical examination revealed a fever (temperature of 38.8°C), skin lesions, and bilateral papilledema. Lumbar puncture yielded CSF with a WBC count of 87/mm³; the CSF cryptococcal antigen titer was 1:1,024. Cultures of blood and CSF yielded \textit{Cryptococcus neoformans} variety \textit{neoformans} serotype A. The patient was treated with iv amphotericin B. After 2 weeks, her treatment was changed to oral fluconazole (400 mg/d), but all her symptoms, including papilledema, recurred. The patient was cured only after receiving another 6-week course of amphotericin B and several more weeks of oral fluconazole therapy.

The patient’s older brother had been admitted to the hospital 9 years earlier (at age 23) because of a 2-week history of headaches. A CT scan of the brain revealed a posterior fossa mass. His medical history was also significant for multiple flat warts of various sizes that covered his forehead and arms. Cultures of brain tissue and CSF yielded \textit{C. neoformans} variety \textit{neoformans} serotype A. The patient received a 6-week course of amphotericin B therapy and completely recovered; he has been well ever since. Papillomavirus type 3 and 10 were detected by PCR of biopsy material from skin lesions.