

CANDIDA OSTEOMYELITIS IN DIABETIC FOOT INFECTION: A CASE REPORT

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INTRODUCTION

Fungal osteomyelitis is relatively rare but is increasing in frequency due increased patient at risk. There is scarce literature discussing fungal osteomyelitis in diabetic foot infection. Here we discuss a case of Candida osteomyelitis in a patient with diabetic foot ulcer.

CASE REPORT

68 years old man, with underlying diabetes mellitus, presented with left big toe swelling, fever and pus discharge from left big toe for 3 days. On examination, the left big toe is swollen, warm, tender, with pus discharge. Blood investigations showed normal TWC ($7.49 \times 10^9/L$), raised in CRP (8.0 mg/L) and ESR (135mm/hr). Lytic lesion seen over left big toe metatarsal head, proximal and distal phalanx on x-ray (Figure 2a). We proceeded with Ray amputation of left big toe and bone biopsy. Sample was sent for culture & sensitivity(C&S). Bone C&S return as Candida albicans, thus patient treated with fluconazole for 2 weeks. 5 weeks post operation, wound is healing well. Repeated ESR reducing in trend to 60 mm/hr. Left foot x-ray shows no osteomyelitis. At 3 months post operation, wound healed and there is no signs of recurrence.

DISCUSSION

Candida albicans is the commonest pathogen isolated in fungal osteomyelitis. It usually affects the vertebra but may also occur at foot bones. Our patient the risk factor is immunocompromised state. Other risks factors include prolonged broad-spectrum antibacterial therapy, extended hospital stay, malignancy and surgical intervention. Systemic inflammatory

markers may be normal or slightly raised. As there is no distinctive clinical manifestation, bone biopsy is critical in diagnosis of Candida osteomyelitis. For treatment, combination of surgical debridement and antimicrobial therapy was recommended with fluconazole as the first line therapy. Studies showed that extended course of antifungal therapy of 6-12months results in a better cure rate. However, our patient who was treated with 2 weeks of fluconazole shows good outcome with no signs of recurrence at 3 months post Ray amputation.



Figure 1(A) left foot x-ray at presentation, (B) left foot x-ray 5 weeks post Ray amputation

CONCLUSION

As there is not much difference in clinical presentation between bacterial and fungal osteomyelitis, bone culture and sensitivity is crucial in diagnosis of fungal osteomyelitis. Appropriate antifungal regime with timely surgical debridement lead to improve outcome.

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