

FUNGAL OSTEOMYELITIS OVER CUNEIFORM AND NAVICULAR BONE, A RARE OCCURANCE

¹Tan HK; ¹Teo A; ¹Akmal R, ¹Lye JX; ¹Saiful A;

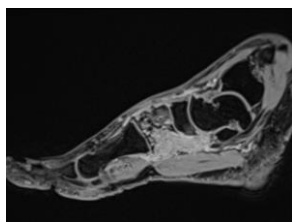
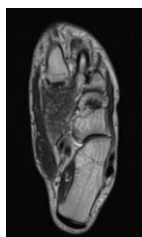
¹Orthopaedic Department, Hospital Sultan Haji Ahmad Shah, Temerloh, Malaysia

INTRODUCTION:

Fungal osteomyelitis is rare and difficult to be diagnosed. It mimics other pathologies, and usually happens in immunocompromised patient. We report a case on fungal osteomyelitis of cuneiform and navicular bone.

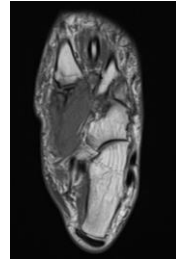
CASE REPORT

A 62 year-old healthy gentleman, presented with 1month history of left midfoot pain and swelling. No precedent trauma or wound over left foot. X ray noted mixed lytic and sclerotic changes over medial and intermediate cuneiform with raised inflammatory markers, and negative tuberculosis screening. CT showed multiple well defined with narrow zones, expansile mixed lytic and sclerotic, inconclusive of infection, bone cyst, or metastases.



MRI reported osteomyelitis changes and multiple small rim enhancing collections over cuneiforms, navicular, base of the 1st and 2nd metatarsal. Incisional biopsy of bone and soft tissue had fungal culture positive with *Acremonium* species. Patient completed 2 weeks Iv Amphotericin B, followed by 4 weeks oral Fluconazole as recommended by infectious disease physician. Subsequent MRI

showed resolved rim-enhancing collections with no evolving changes of osteomyelitis. Patient was monitored under foot and ankle team.



DISCUSSIONS:

Fungal osteomyelitis is difficult to diagnose as no distinguish clinical or radiological features compared to other cause of osteomyelitis. Biopsy is the only test that can diagnosed fungal bone infection. Infectious Diseases Society of America (IDSA) recommended Amphotericin B based combination treatment with flucytosine as induction therapy (at least two non-contiguous sites involvement) followed by maintenance therapy with fluconazole, for two to four weeks. Debridement is required if persistent or refractory osteomyelitis, but is rarely needed. Some studies recommended that antifungal should continue for at least six to twelve months.

CONCLUSION:

Detailed evaluation of bone pain in patients at risk of fungal infection. Early bone biopsy, and aggressive debridement with combination antifungal therapy can improve disease outcome.

REFERENCES:

Perfect JR, Dismukes WE, et al. Clinical practice guidelines for the management of cryptococcal disease: 2010 updated by the Infectious Diseases Society of America, Clin Infect Dis, 2010, vol. 50 (pg. 291-322)