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ALLOGENEIC TRANSPLANT

Mucormycosis in a patient post-Hematopoietic Stem Cells transplantation: successful therapy with amphotericin and posaconazole as consolidation

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Mucormycosis is a severe opportunistic infection caused by Mucorales fungi. It is more common in patients with poorly controlled diabetes, chemotherapy, undergoing corticosteroid therapy, solid organ and bone marrow post-transplant and large burns. The rhinocerebral form starts with the infection of the sinuses and progresses locally with up to central nervous system infiltration. It has a 40% mortality that can reach 65% in patients after hematopoietic stem cell transplantation (HSCT). Objective: To describe the case of a patient diagnosed with mucormycosis post-HSCT, with successful treatment with amphotericin lipid complex. Case: 18-year-old male patient, with a diagnosis of monocytic AML with central nervous system infiltration was submitted to Hematopoietic Stem Cell Transplantation (HSCT), haploidentical with the mother, on second complete remission on 08/28/2014. Conditioning was performed with fludarabine and TBI; GVHD prophylaxis included tacrolimus, mycophenolate and cyclophosphamide post-infusion. He received 3.96×10^6 CD34 cells/kg from bone marrow source, isogroup, and engraftment occurred on day +20. The patient developed skin and liver GVHD Grade II refractory to corticosteroids, requiring two infusions of antiCD25. Seven months after HSCT, he had a perianal infection, treated with vancomycin and meropenem. When assessing the infectious foci, he underwent facial sinus CT that showed mucosal thickening and positive serum galactomannan. He required nasal secretion drainage and fungal screening showed hyaline hyphae and growth of *Aspergillus flavus*, configuring a diagnosis of fungal rhinosinusitis by *Aspergillus*. He started treatment with voriconazole. Thirty days after the use of voriconazole, he had fever and CT scan showed lingular opacity measuring 1.5 cm. He underwent a bronchoalveolar lavage (BAL) that showed the presence of galactomannan antigen 5.03 and positive culture for *Cunninghamella spp.* (mucormycosis). We then chose to change the antifungal agent to Amphotericin lipid complex. Sensitivity testing was performed, showing MIC 1 for amphotericin and MIC for voriconazole above 16. He received amphotericin B lipid complex for 40 days and after that, switched to posaconazole as secondary prophylaxis, as well as gradual reduction in corticosteroids. The control CT scan showed complete resolution of the infection. The patient is currently receiving prophylactic posaconazole, as well as high-dose methylprednisolone for GVHD in the GIT. There was no fungal infection reactivation to date. Conclusion: Mucormycosis is a severe infection in HSCT, associated with high mortality and usually it does not show positive galactomannan; however, the case described above had high galactomannan in BAL and yet the culture was positive for *Cunninghamella*. The patient was receiving voriconazole and had good response to induction treatment with amphotericin lipid complex and consolidation with posaconazole.

Keywords: Transplantation, Stem Cells, Mucormycosis, Galactomannan, Amphotericin