Positive blood cultures in a patient recovering from febrile neutropenia

Keywords
Scedosporium prolificans; Febrile neutropenia; Immunosuppressed host; Fungemia.

Case summary
A 44-year-old male returned from India where he was hospitalized and diagnosed with Hemophagocytic Lymphohistiocytosis (HLH). He had been initiated on dexamethasone followed by a prednisone taper. On return to Canada, he presented with non-productive cough, fevers and pancytopenia and was admitted to the Intensive Care Unit (ICU) with sepsis. He underwent a bone marrow biopsy and the diagnosis of intravascular large B cell lymphoma with secondary HLH was made. He was started on a regimen of cyclophosphamide, doxorubicin, rituximab and etoposide along with filgrastim (G-CSF). He subsequently developed febrile neutropenia and his blood cultures initially grew OXA-48 carbapenemase-producing Escherichia coli along with filamentous fungi. He received combination therapy with high-dose IV imipenem-cilastin, IV piperacillin-tazobactam, IV colistin, IV tigecycline, and tazobactam, IV imipenem-cilastin. However, on further review it was determined that there were septate hyphae on the Gram stain from the blood cultures and a new organism was noted on his blood cultures (Fig. 1). What is your diagnosis?

Answer options
1. Candidaemia
2. Invasive Aspergillosis
3. Disseminated Scedosporium infection
4. Disseminated Fusarium infection

Discussion
Correct Answer: 3. Disseminated Scedosporium infection.

The two main species of the genus Scedosporium of human significance are Scedosporium prolificans and Scedosporium apiospermum (with teleomorph state of Pseudallescheria boydii) (Ortoneda et al., 2002). Both are ubiquitous filamentous fungi found in environmental sources such as soil and decaying vegetation (Husain et al., 2005). Their clinical manifestations range from colonization of respiratory tract, invasive localized disease to disseminated infections. Scedosporium prolificans is thought to be the more virulent species and is associated with disseminated infections in immunocompromised hosts such as patients with hematopoietic stem cell transplant and neutropenia (Ortoneda et al., 2002; Husain et al., 2005). Still Scedosporium fungemia is infrequently seen in blood cultures in clinical laboratories and the fungal conidia on blood culture Gram stain can be initially mistaken for oval yeast cells. However, the presence of truncated conidia along with septate hyphae is an important distinguishing feature from oval yeast cells with pseudohyphae. This initial distinction is important for antifungal choice as usual treatment of candidaemia differs significantly from that required in infections due to species of Scedosporium.

Furthermore, Scedosporium prolificans is the more resistant of the two species of Scedosporium and even though there are no validated interpretive breakpoints for determining resistance to antifungal agents, our isolate had MICs off-scale (highly resistant) to most antifungals tested and a voriconazole MIC of 16. This is comparable to other studies where a median voriconazole MIC of 4 (2–16) has been reported, a level well above the achievable free drug concentration in most

Abbreviation: BAL, bronchoalveolar lavage.
patients (Cuenca-Estrella et al., 1999; Carrillo & Guarro, 2001; Meletiadis et al., 2002; Cortez et al., 2008). This patient was started on voriconazole after the isolate was recovered from the BAL and while the resistance results were pending. Despite being on this treatment and recovery of his neutropenia, he developed disseminated infection with Scedosporium prolificans. Voriconazole therapeutic drug levels were checked and found to be sub-therapeutic at 0.7 (normal 1.0–5.5). The voriconazole dose was adjusted and high-dose terbinafine as well as miltefosine were added.

The European Society of Clinical Microbiology and Infectious Diseases (ESCMID) and the European Confederation of Medical Mycology (ECMM) joint guidelines advocate for treatment with voriconazole as a first line therapy for disseminated Scedosporium prolificans infection in immunocompromised patients (Tortorano et al., 2014). They also suggest therapeutic drug monitoring (TDM) of voriconazole as levels vary among individuals due to the differences in CYP3A4 metabolism. Combination of voriconazole with terbinafine is also listed as a treatment option as there is demonstration of in vitro synergy; however there is still a lack of clinical data and only case reports are published on utility of this combination (Meletiadis et al., 2003; Howden et al., 2003; Whyte et al., 2005). As our patient developed breakthrough scedosporiosis while on voriconazole, miltefosine was also added as salvage therapy based on clinical cases reports and in vitro data of its activity in combination with

voriconazole (Kesson et al., 2009; Trubiano et al., 2014; Compain et al., 2015). Without the recovery of normal immune function, mortality in disseminated Scedosporium prolificans infections has been reported to be up to 87.5% despite antifungal treatment (Rodriguez-Tudela et al., 2009). Unfortunately, our patient succumbed to a disseminated multi-drug resistant Scedosporium prolificans infection despite recovery of his counts and sterilization of his carbapenemase-producing bacteria.

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References


Fig. 1. (a) Gram stain of blood culture showing septate hyphae (thin arrow) and ovoid conidia with truncated base (thick arrow); magnification ×1000. (b) Growth of Scedosporium prolificans on Sabaroud Dextrose Agar (SDA) at 30°C for 4 days; surface of the colony. (c) Lactophenol blue stain of the fungus colony showing septate hyphae with conidiophores having swollen base and tapered ‘neck’ (thick red arrow) with conidia (thin red arrow); magnification ×400.


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