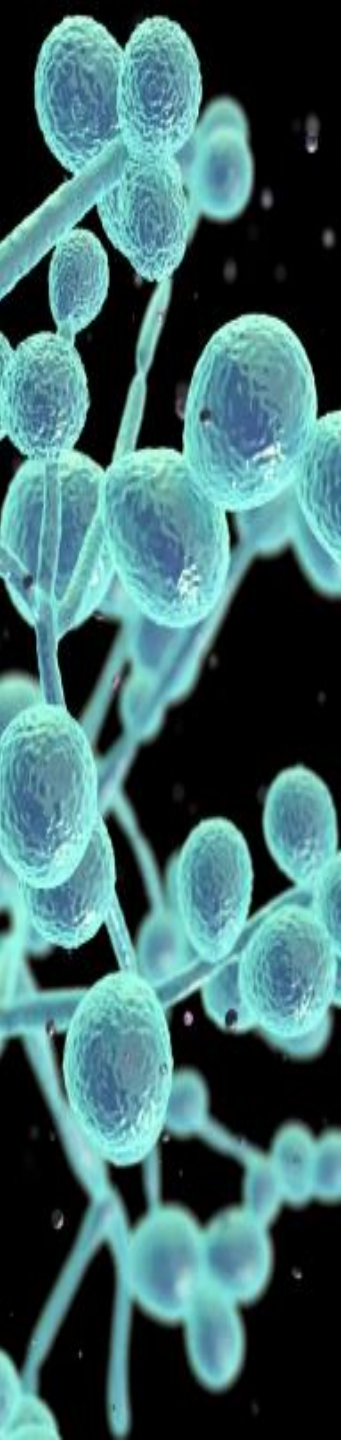


Silent Candida tenosynovitis and abscess formation in a patient with scleroderma

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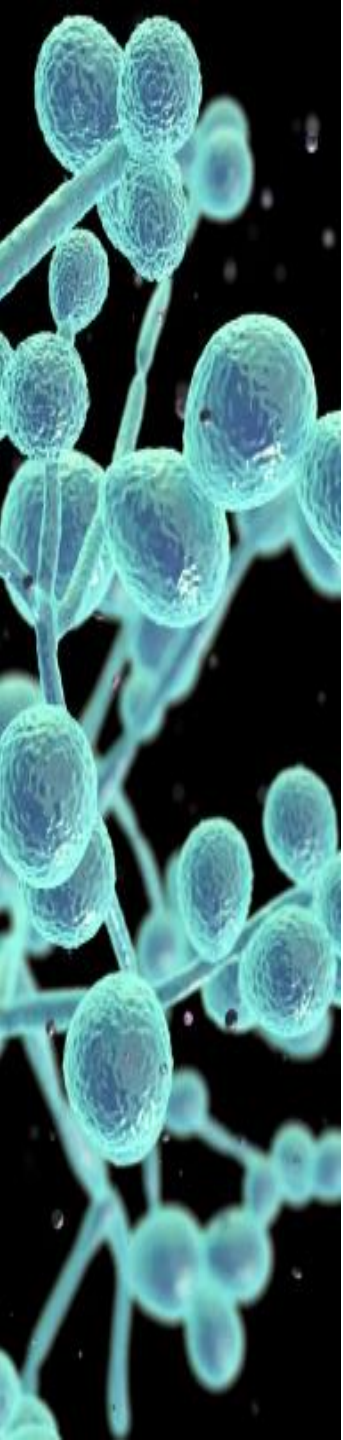
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Purpose:

Invasive candidal infections with osteoarticular involvement are especially seen in the presence of prostheses, immunosuppression due to genetics or glucocorticoid use, or after long-term antibiotic use. It is **extremely rare** to see it in the **hand**¹⁻³.



The most common species responsible for most of these fungal infections is ***C. albicans***. Most Candida osteomyelitis spreads **hematogenously** and can sometimes occur **after open fractures**. Tenosynovitis or costochondritis are available as case reports in the literature²⁻⁴ .

Here, we present a case in which silent Candida tenosynovitis and deep tissue abscesses developed after a closed trauma.

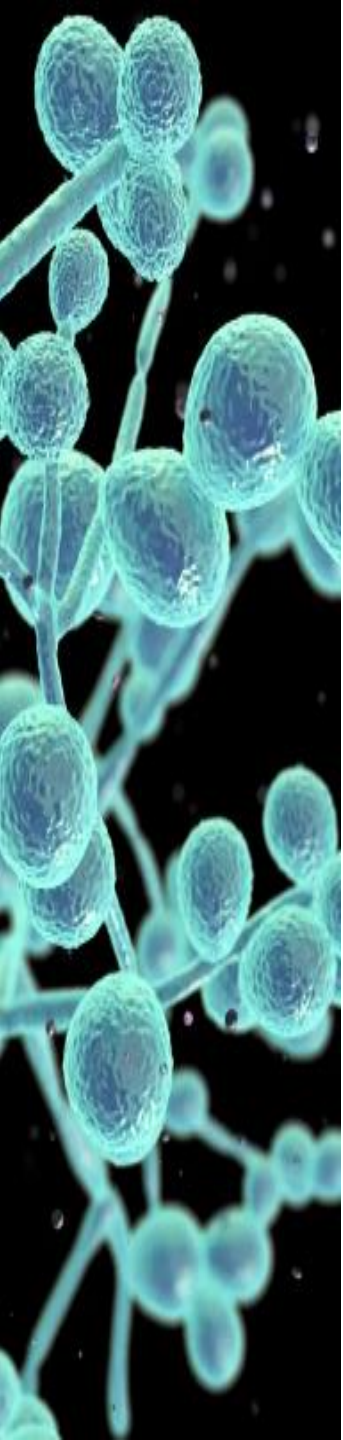


Case:

A 59-year-old woman with a diagnosis of **scleroderma** and a history of **steroid use** experienced a fall on her right arm 7-8 months ago and started to have discharge from her palm approximately 3-4 months later.

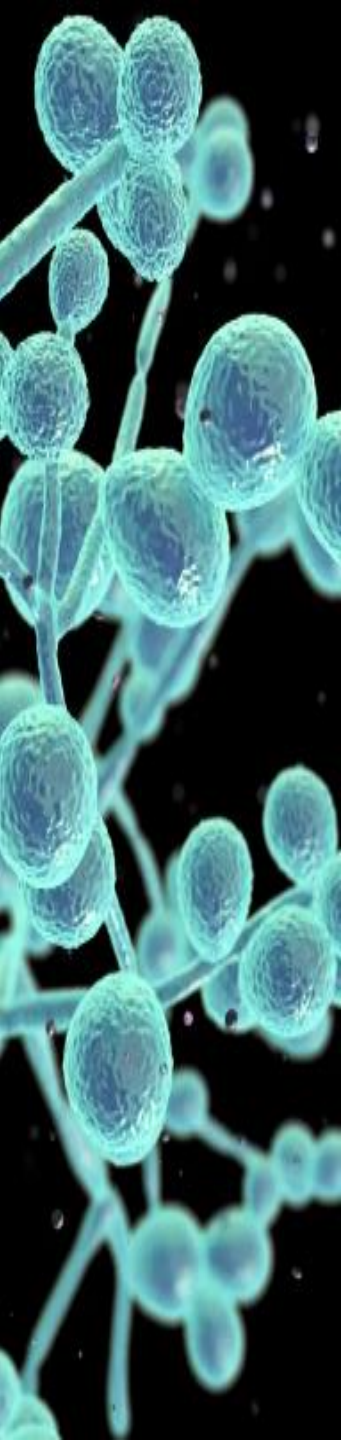
The patient was started on amoxicillin-clavulanate orally by the rheumatologist she was following, and when her complaints did not improve, she was referred to us.

In her medical history, she had a diagnosis of **DM, hypertension, thyroid dysfunction, and scleroderma**. The patient described having subfebrile fever.



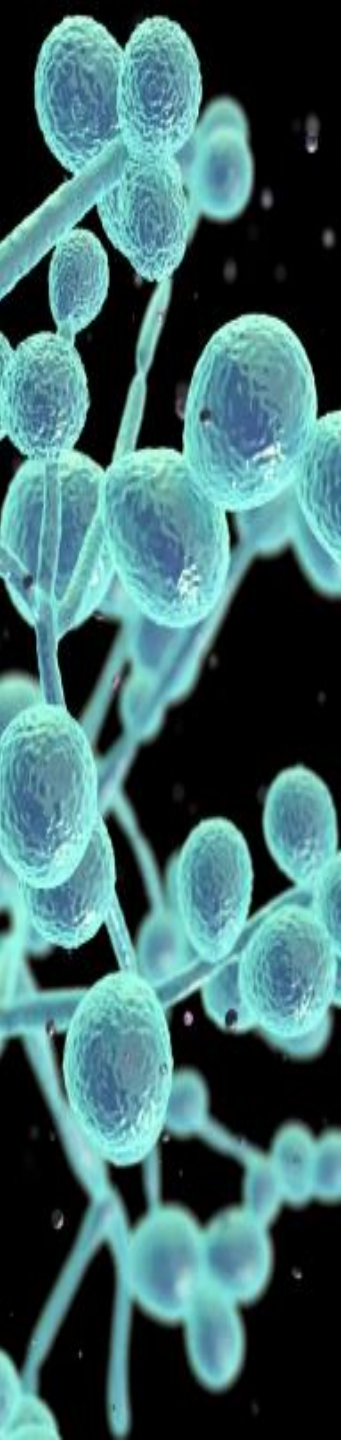
On physical examination,

Temperature was 37.4°C,
general condition was moderate,
weak right hand movements were
decreased,
there was slight swelling in the hand,
which **was not very noticeable** from the
outside,
and there was a dirty yellow purulent
discharge from the mouth of a 3 mm
fistula in the palm.



According to laboratory results,

white blood cell count was 12.9/ μ l,
hemoglobin was 11 g/dl,
sedimentation was 44 mm/h, and
C-reactive protein was 1.9 mg/L.

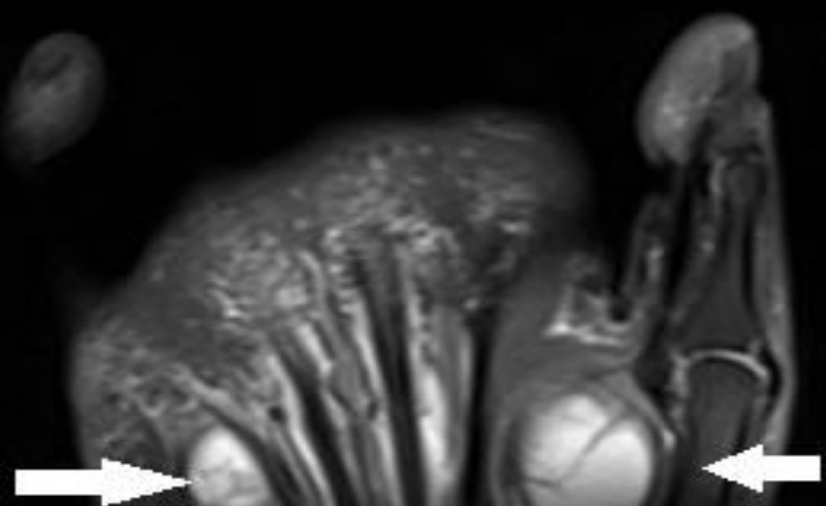


On MRI,

there was widespread tenosynovitis in the flexor tendons within the carpal tunnel and increased effusion in the tendon sheaths. Dense collection areas of **5x2.5 cm** adjacent to the 5th finger flexor, **4x2 cm** dorsal to the 1st finger flexor tendon, **1.5 cm** adjacent to the 4th finger, and **3.5x2 cm** adjacent to the 3rd flexor tendon at the palmar level were detected (Photo 1).

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DL%100 Vw%50
MagP:2.2 MagA%:24.6

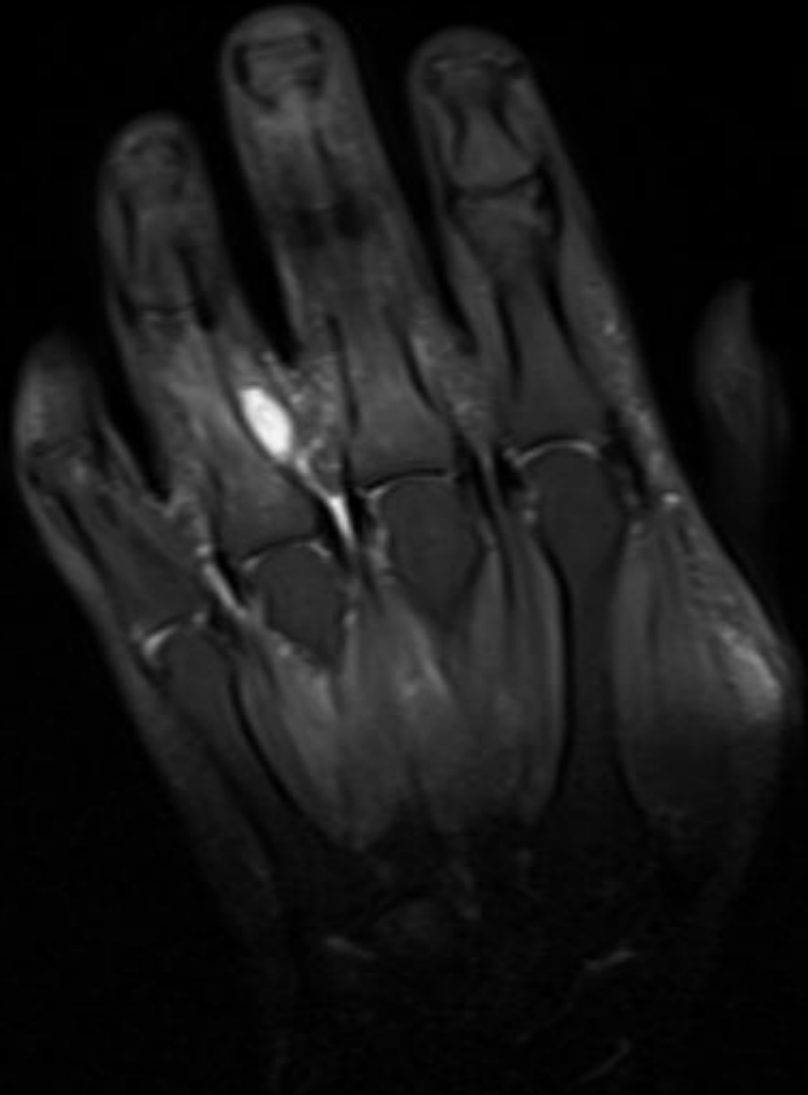


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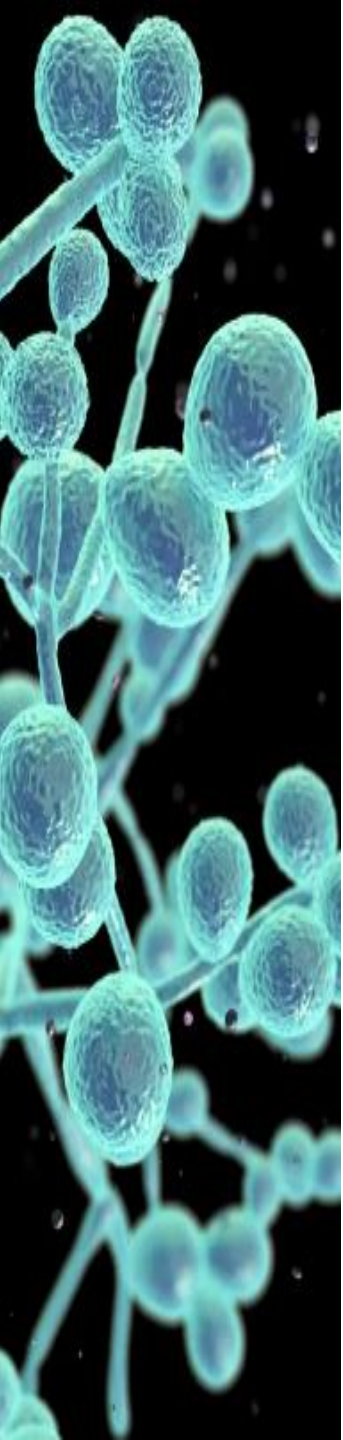


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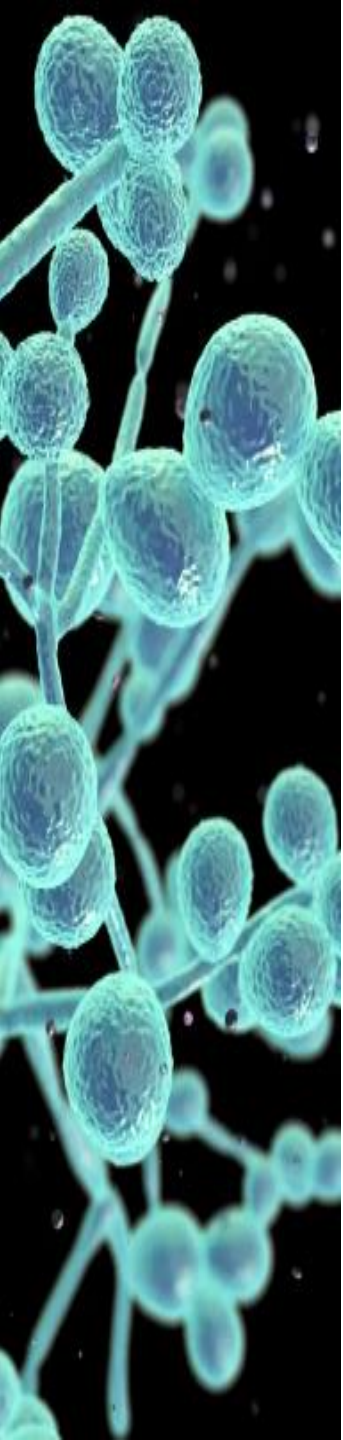


L R\F
DL%100 Vw%0
MagP:0.5 MagA%:42.6





- ***Candida albicans*** grew in the wound culture, and it was sensitive to fluconazole. The patient preferred treatment at an external center for further follow-up and was withdrawn from our follow-up.



Conclusion:

Although invasive candidal infections are very rare, with **2-14 cases per 100,000**, their **mortality** is quite high at **40-55%**⁵.

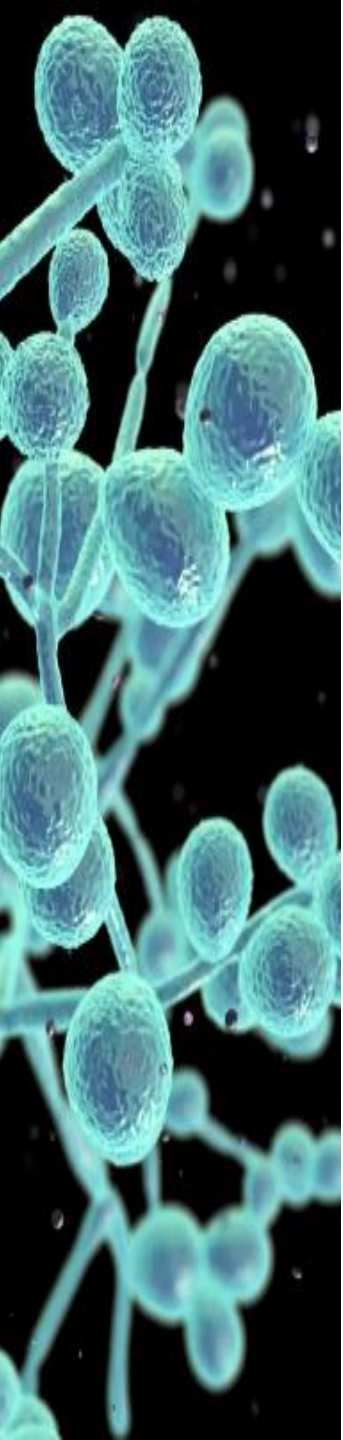
They are mostly seen in patients with multiple comorbidities who receive broad-spectrum antibiotics after long-term hospitalization in the intensive care unit.

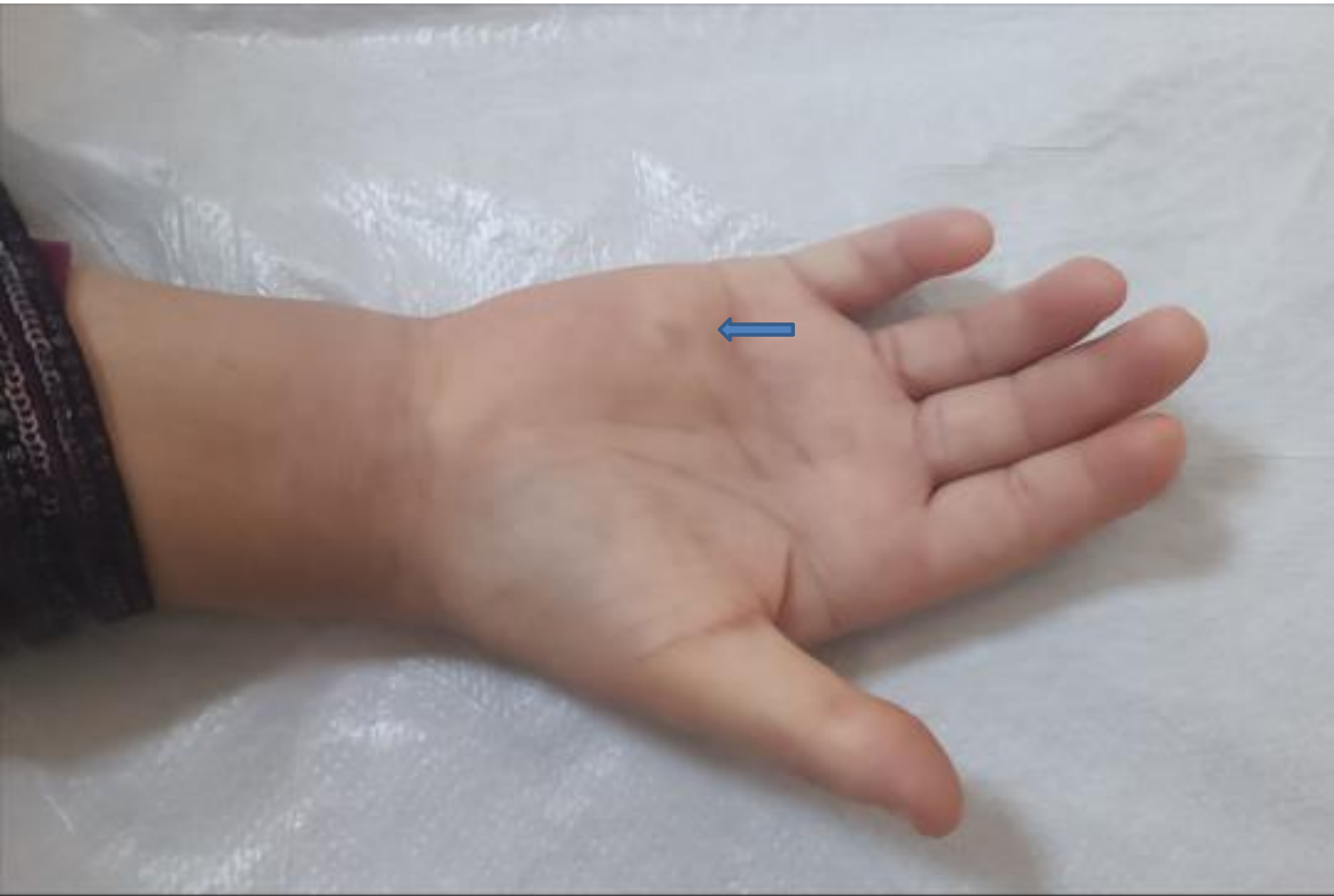
In Candida osteoarticular involvement, the intervertebral area and sternum are most commonly seen, while the incidence in **hands** and **feet** is only **around 3%**⁴.

Therefore, we found it appropriate to present this rare case.

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