Silent Candida tenosynovitis and abscess formation in a patient with scleroderma

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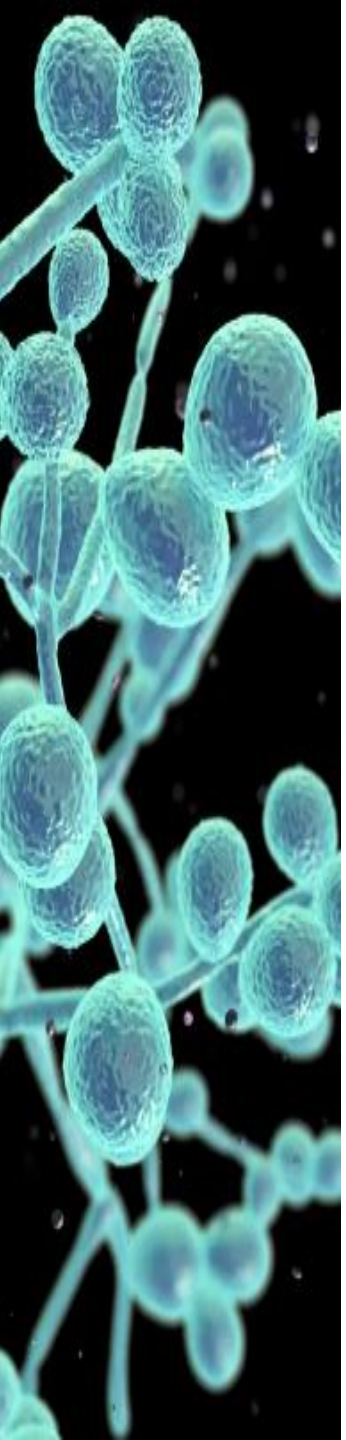
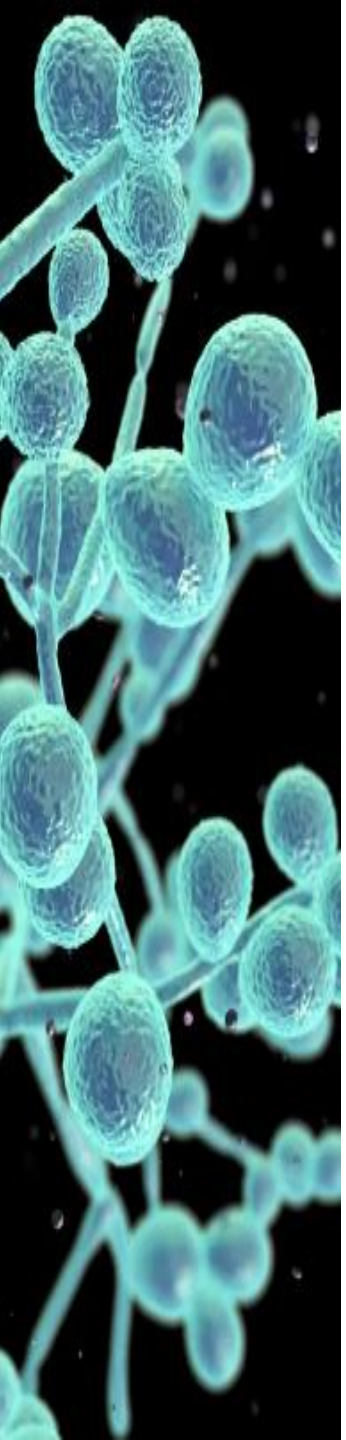


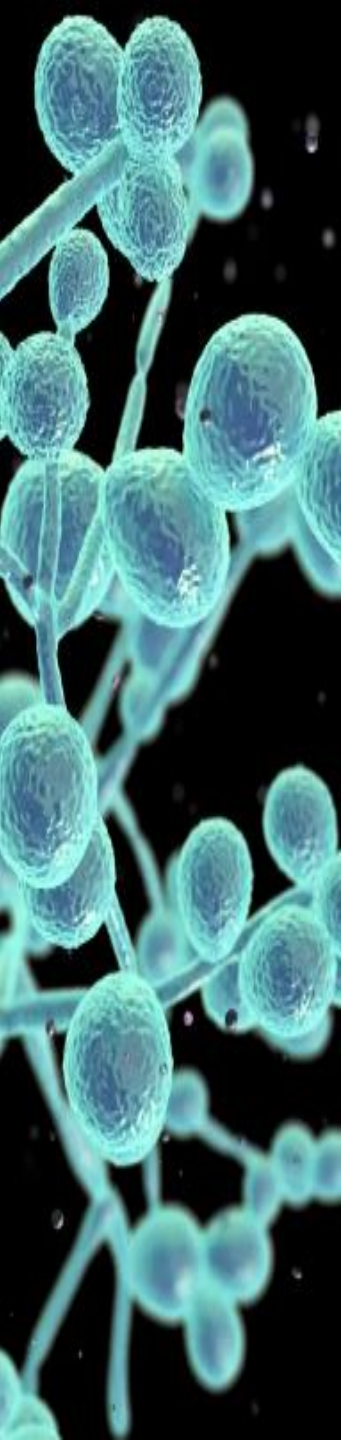
Purpose:

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 literature[2-4] .

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

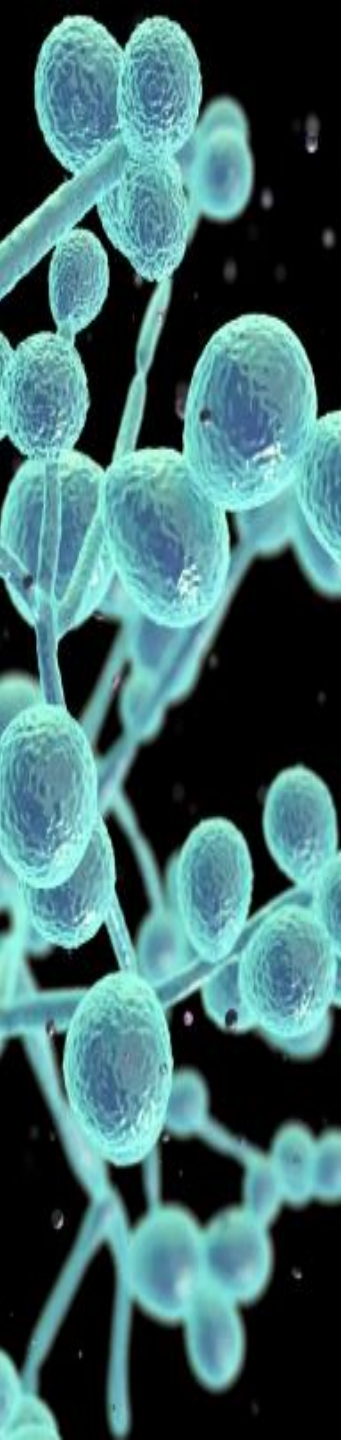


Case:

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,

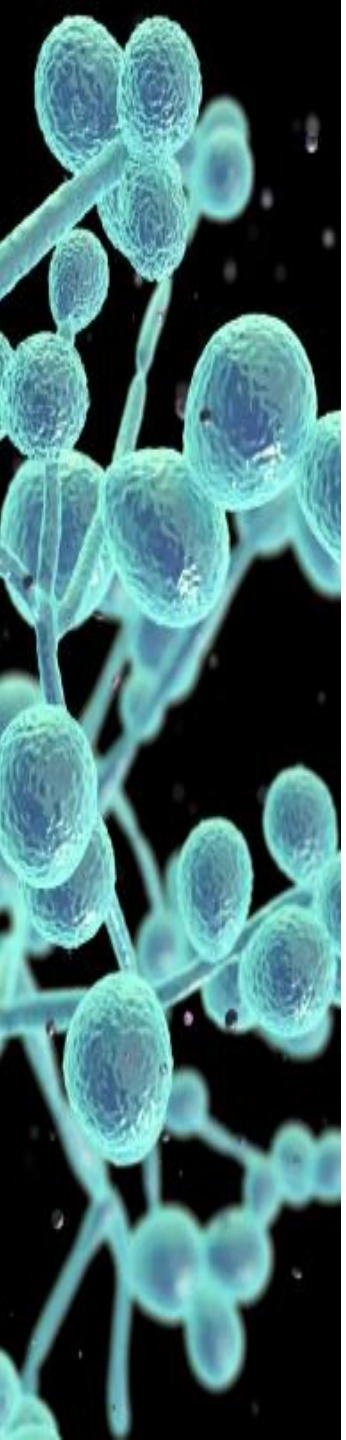
Temperature was 37.4°C,

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,

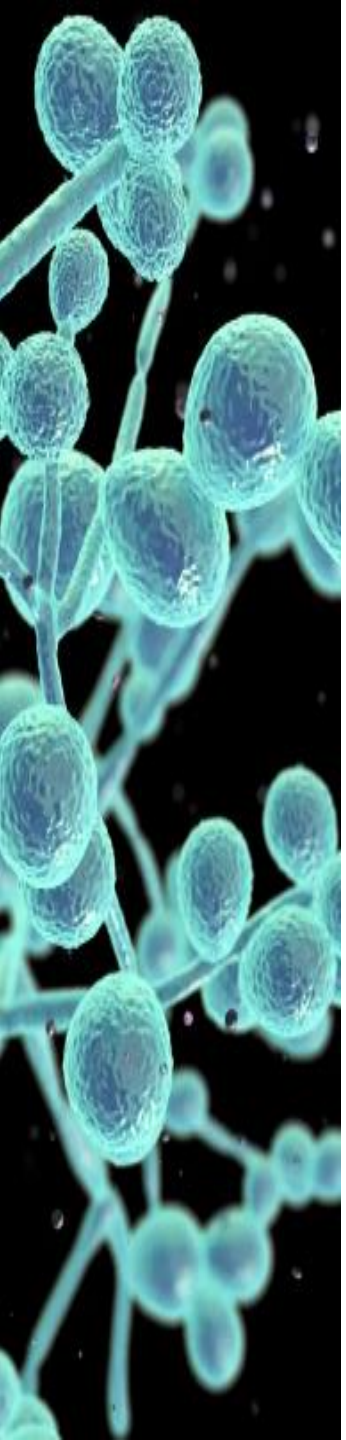
and there was a dirty yellow purulent discharge from the mouth of a 3 mm fistula in the palm.



According to laboratory results,

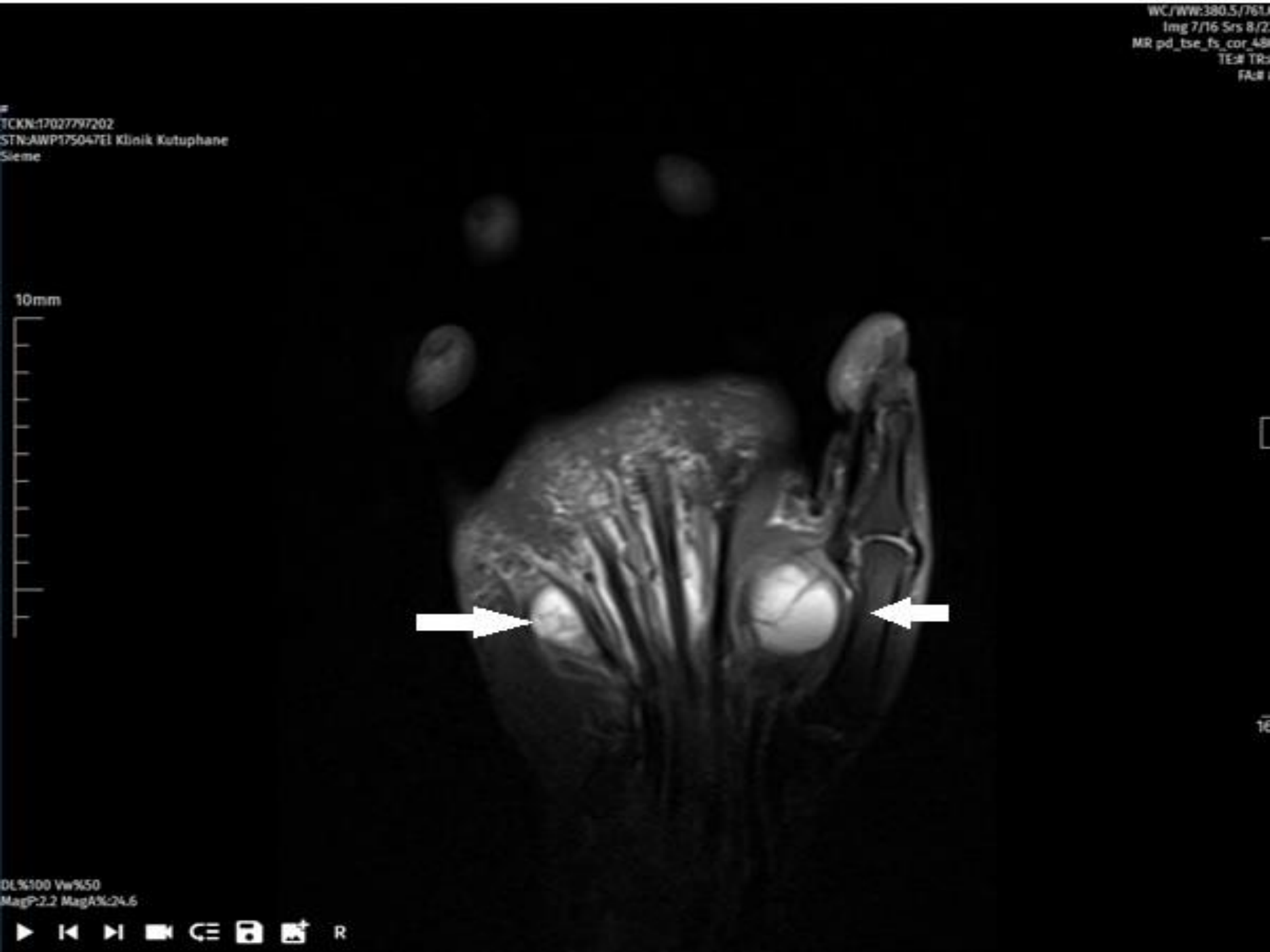
white blood cell count was 12.9/µl, hemoglobin was 11 g/dl, sedimentation was 44 mm/h, and

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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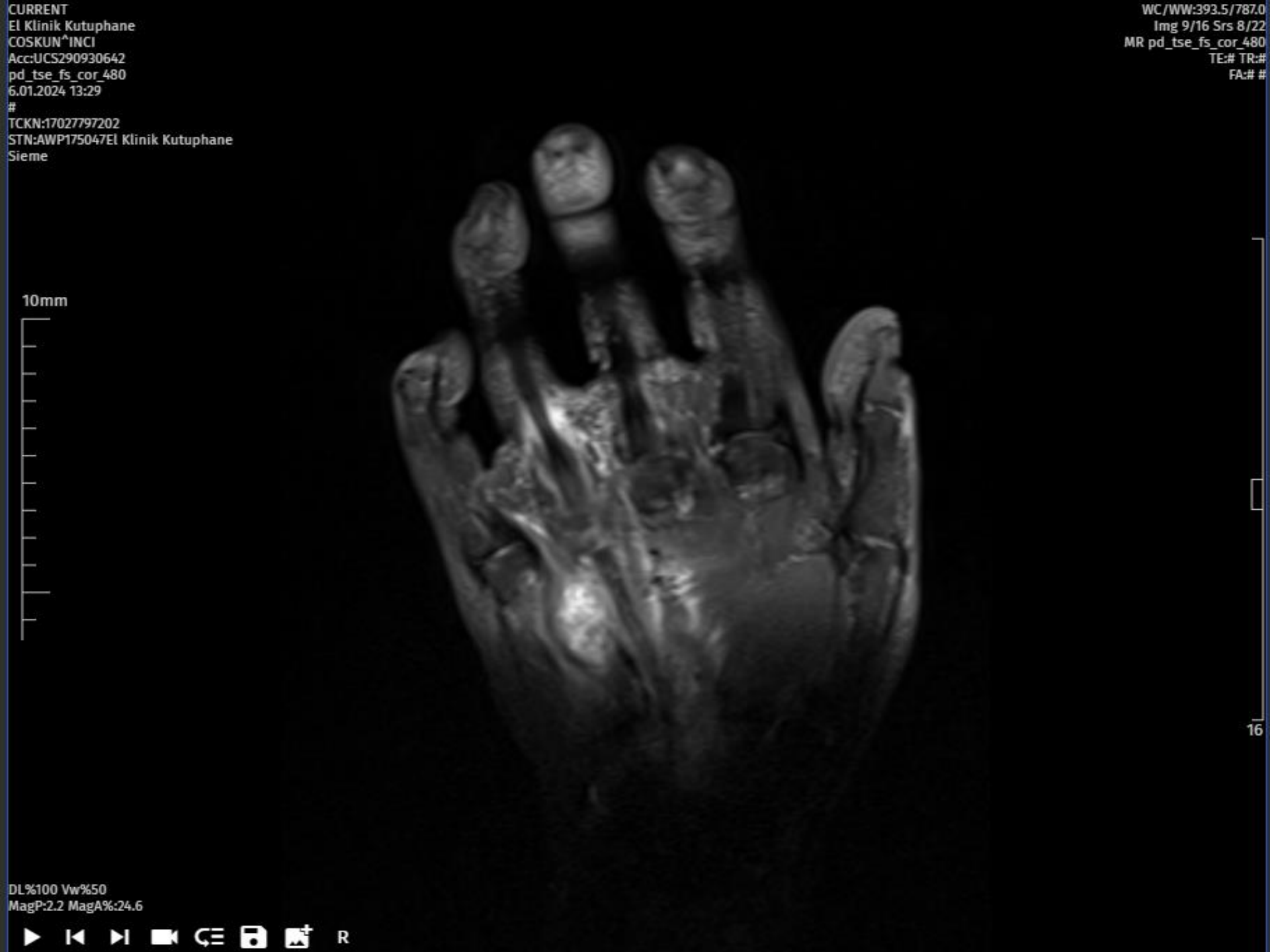
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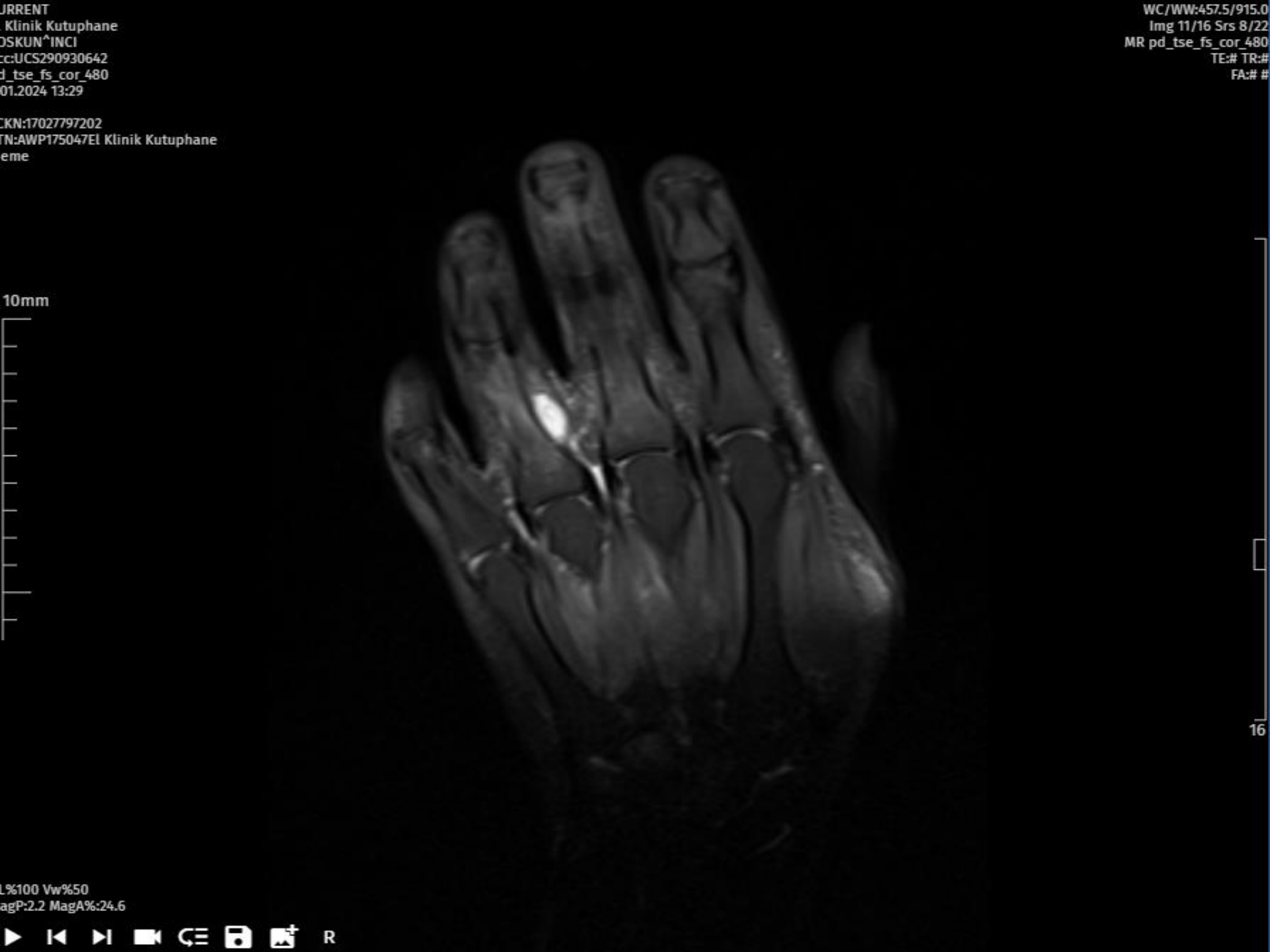
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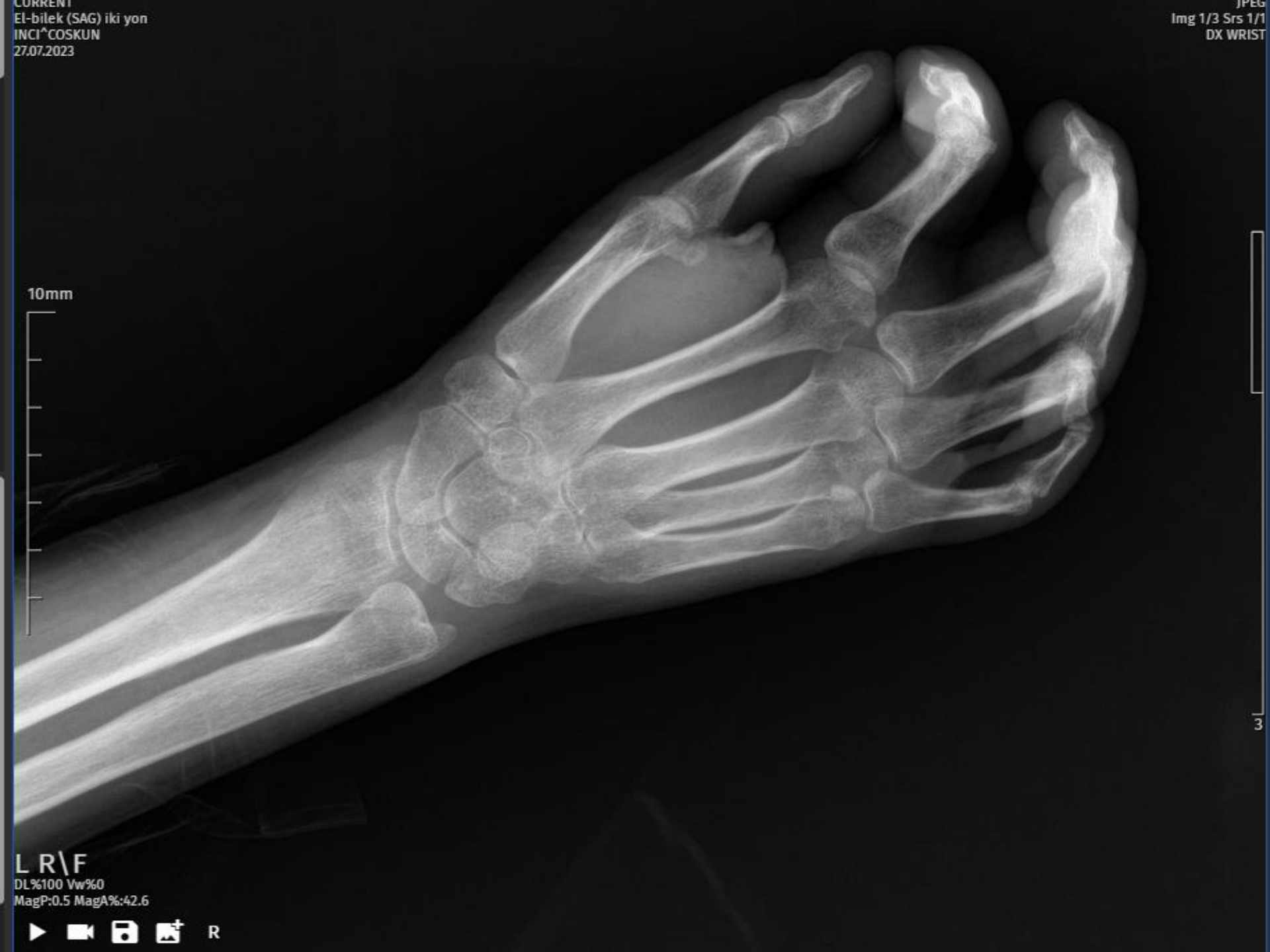
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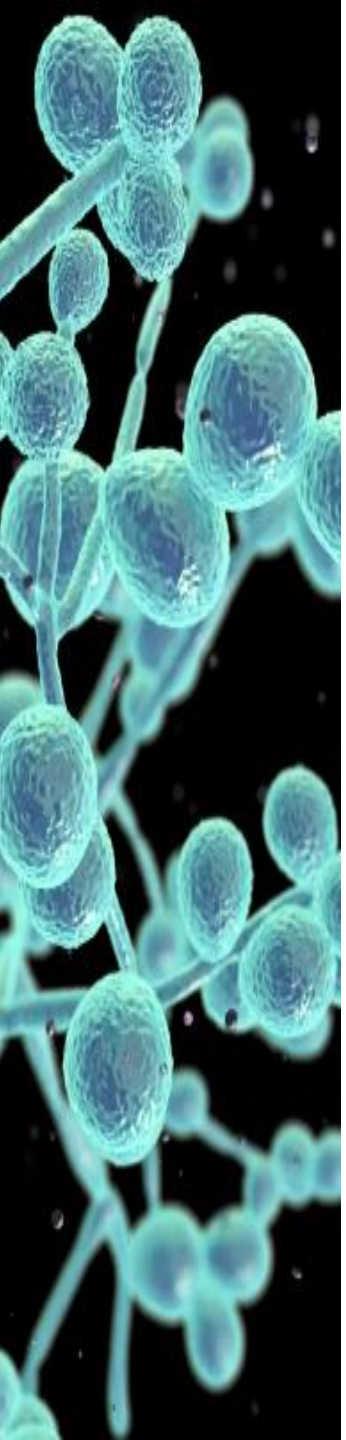
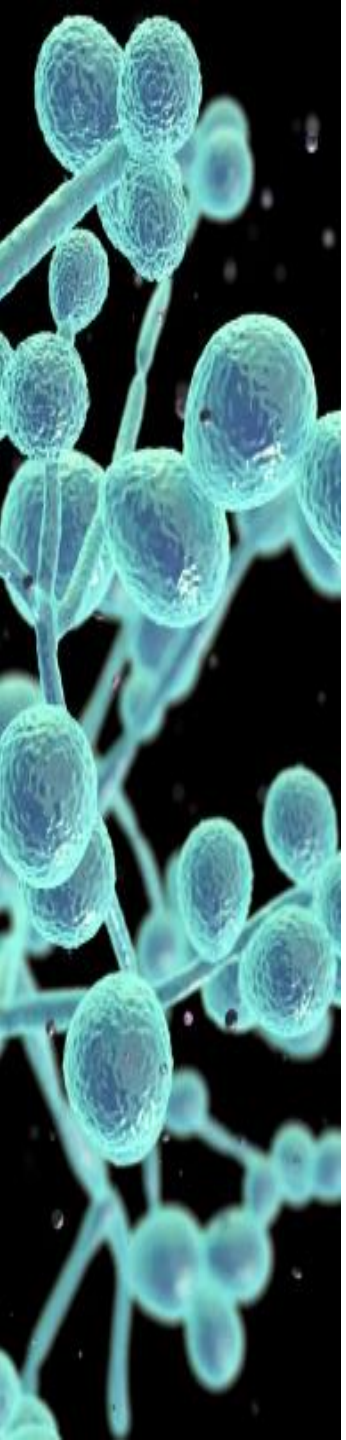


- ***Candida albicans*** grew in the wound culture, and it was sensitive to fluconazole. The patient preferred treatment at an external center for further follow-up and was withdrawn from our follow-up.



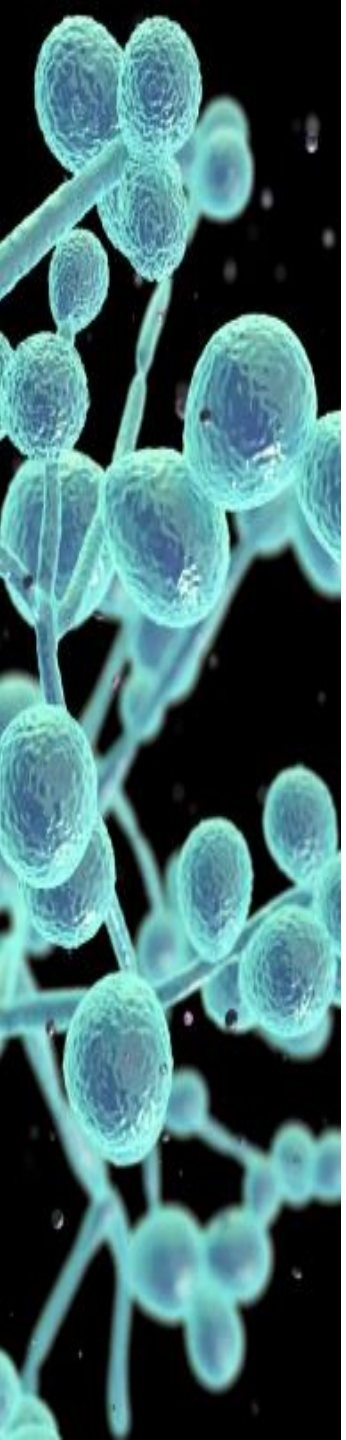
Conclusion:

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.



References:

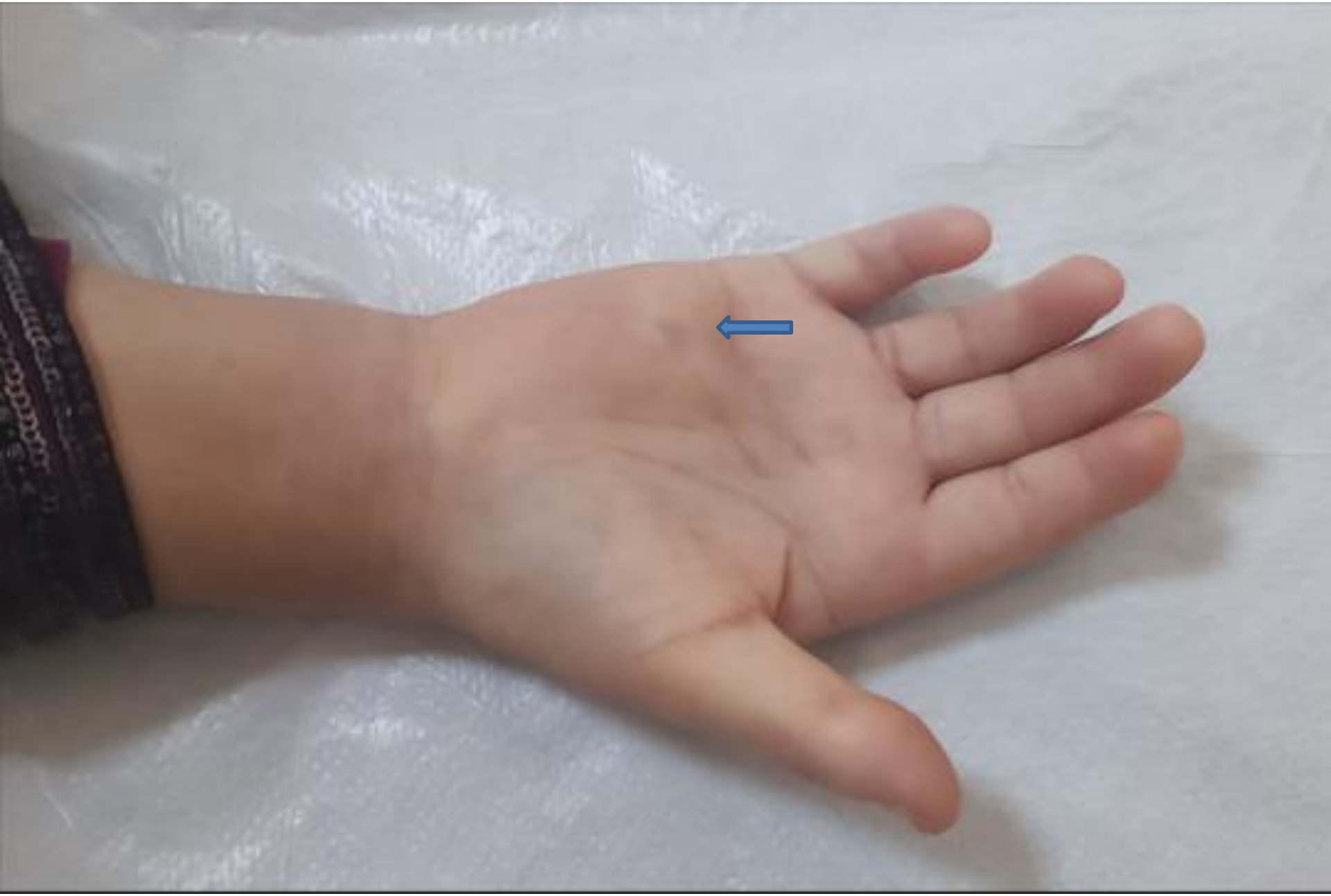
- 1-Gamaletsou MN, Kontoyiannis DP, Sipsas NV, Moriyama B, Alexander E, Roilides E, Brause B, Walsh TJ . **Candida osteomyelitis: analysis of 207 pediatric and adult cases (1970-2011).** Clin Infect Dis. 2012;55(10):1338. Epub 2012 Aug 21.

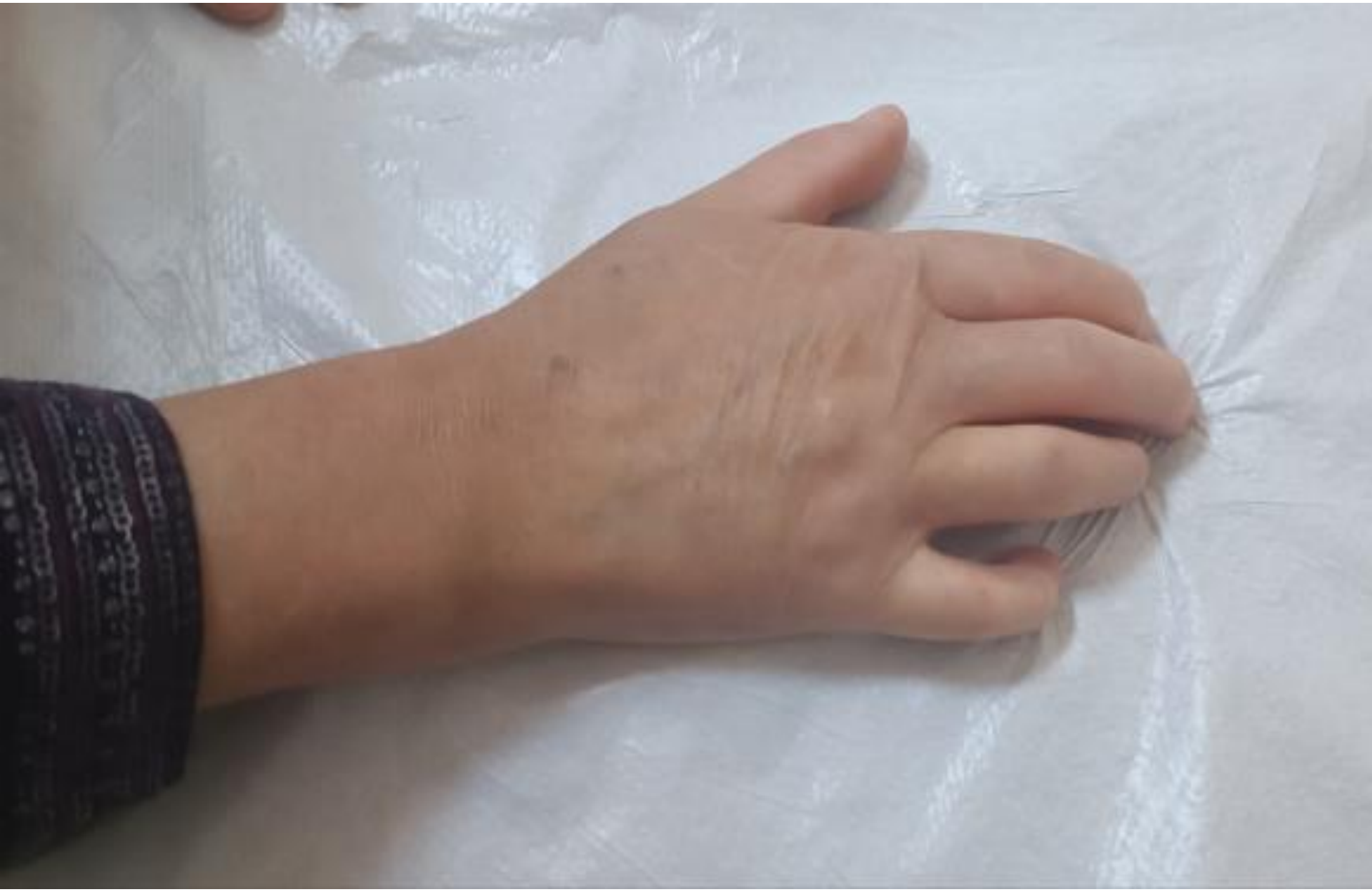
- 2-Tenazinha C[1], Barros R[1], Romão V.C[1] **Candida albicans tenosynovitis of the hand** ARP Rheumatol. 2022 Apr-Jun;1(2):183-184.

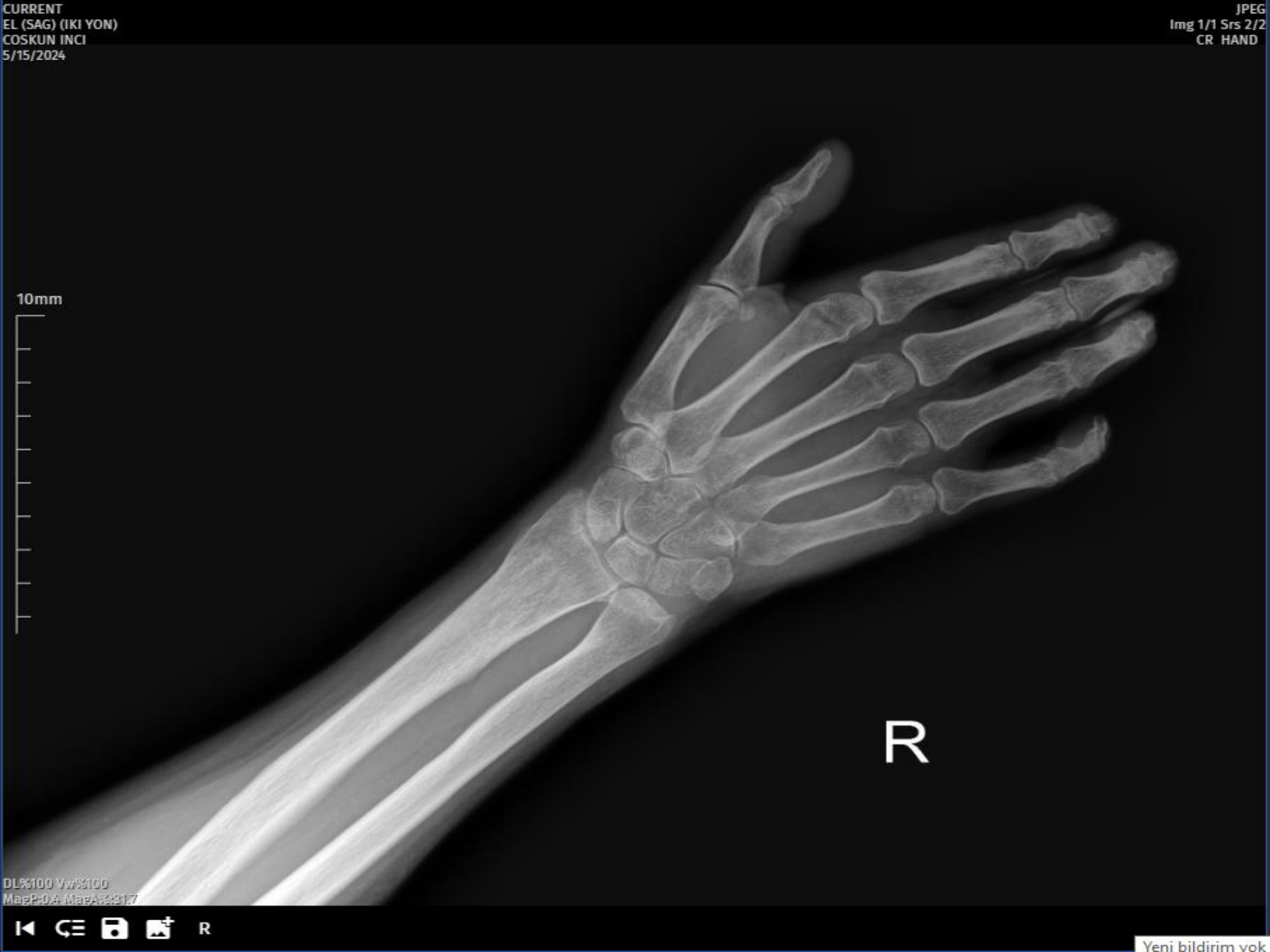
- 3-Yuan R T, Cohen M J. **Candida albicans tenosynovitis of the hand.** J Hand Surg Am 1985 Sep;10(5):719-22.
  doi: 10.1016/s0363-5023(85)80217-3.

- 4-Nakamura H, Makiguchi T, Tsunoda A, Shirabe K, Yokoo S. **Candida Costochondritis Induced by Traumatic Small Bowel Perforation: A Case Report**.
  Cureus. 2023 Aug 22;15(8):e43923.
  doi: 10.7759/cureus.43923. eCollection 2023 Aug.

- 5-Soriano A, Honore PM, Puerta-Alcalde P, Garcia-Vidal C, Pagotto A, Gonçalves-Bradley DC, Verweij PE. **Invasive candidiasis: current clinical challenges and unmet needs in adult populations.** J Antimicrob Chemother. 2023 Jul 5;78(7):1569-1585. doi: 10.1093/jac/dkad139.



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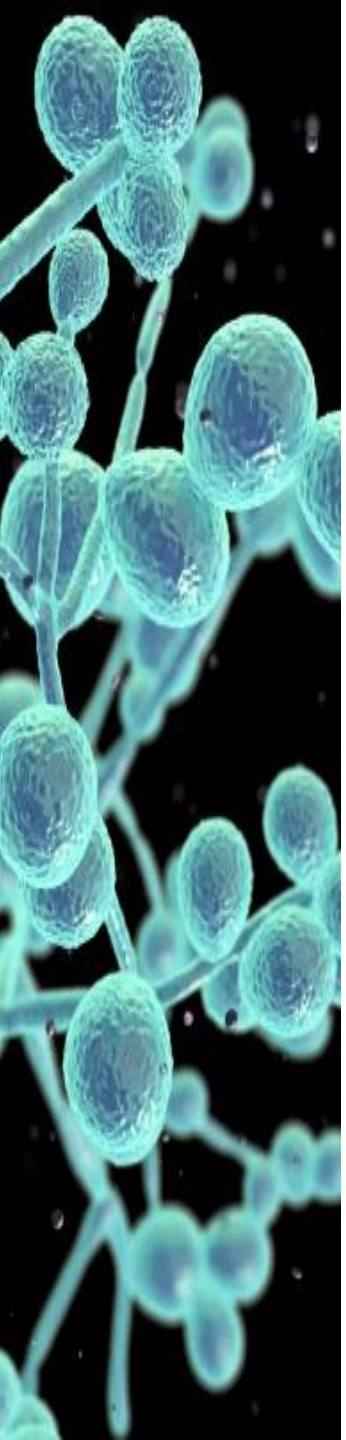


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Danke
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