

## ■ S-501 ■

Successful Treatment of *Trichosporon asahii* Fungemia with Fluconazole in a Non-neutropenic Patient with Lung Cancer

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Invasive trichosporonosis is rare, but frequently fatal. *Trichosporon asahii* fungemia usually occurs in neutropenic hematologic malignant patients, patients with HIV infection, organ transplant recipients, and recipients of prosthetic heart valves. In this report we describe a 69-year-old man case of *Trichosporon asahii* fungemia in a non-neutropenic patient with lung cancer. He was diagnosed as nonsmall cell lung cancer on March 2010. He received concurrent chemoradiation therapy until May 2010 and consolidation chemotherapy on June 2010. One week after the last chemotherapy, he was admitted to intensive care unit with acute respiratory failure. A chest CT revealed diffuse ground glass opacities and consolidation in mainly right lung. Bronchoalveolar lavage was not performed because of neutropenic fever and hypoxemia. After a week of neutropenic state, WBC count was recovered. Since admission, he was treated with intravenous piperacillin-tazobactam for about three weeks. He was also treated with bactrim for suspected *Pneumocystis jirovecii* for two weeks, even though the organism was not proved microbiologically. Seven days after stopping piperacillin-tazobactam, he developed fever without change of chest image. Because of pyuria on urinalysis, he was retreated with intravenous piperacillin-tazobactam for urinary tract infection. Three days later, two blood cultures yielded *Trichosporon asahii*, and urine culture yielded *Candida albicans*. Therefore, fluconazole was added empirically and maintained for three weeks. He responded to the fluconazole and has been stable since then. Our case in this report was non-neutropenic patient with lung cancer, and had not central venous catheter. However, he received broad-spectrum antibiotics. In one report, most invasive trichosporosis was associated with prior antibiotic therapy, use of a central catheter, malignancy, and ICU admission. In some reports, Azoles had good in vitro activity, whereas amphotericin B and echinocandins were not active against *Trichosporon* isolates. Although an optimal therapy for trichosporonosis has yet to be identified, our observations in this case provide the usefulness of fluconazole in a non-neutropenic patients with solid tumor.

## ■ S-502 ■

Psoas abscess caused by *Staphylococcus lugdunensis* : first case report in Korea

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*Staphylococcus lugdunensis* is a member of coagulase-negative staphylococci (CoNS) which is uncommon microbial culture isolate with virulent potency. Despite CoNS are usual skin commensals and often regarded as contaminant or colonizer when isolated from cultures of clinical specimens, clinical course and microbiological characteristics of *Staphylococcus lugdunensis* may resemble those of *Staphylococcus aureus* rather than other CoNS. Invasive infectious diseases such as infective endocarditis, peritonitis, skin and soft tissue infection, vascular prosthetic infection, septicemia, osteomyelitis have been described to be associated with *Staphylococcus lugdunensis*. We report the first case of psoas abscess caused by *Staphylococcus lugdunensis* in Korea. A 45-year old woman presented to a community hospital with fever and right flank pain. On admission date, her body temperature was 37.8°C, laboratory test revealed white blood cell count of 18950 cells/μl (90.7% neutrophils), ESR of 77 mm/hr, CRP of 22.86 mg/dl. Abdomen-pelvic CT scan was obtained, which illuminated 12x5cm sized right-sided psoas abscess. Percutaneous abscess drainage was performed and culture from the drained fluid isolated oxacillin-sensitive *Staphylococcus lugdunensis*. Initial antimicrobial therapy, intravenous ceftriaxone plus metronidazole, was maintained for 15 days. Defervescence and normalization of leukocytosis and CRP level was achieved, and the patient was placed on oral ciprofloxacin. After 9 days of administration of oral ciprofloxacin, patient was transferred to a tertiary teaching hospital due to prolonged treatment and for further management. Cefazolin was administered intravenously. On 26th day of total antibiotics therapy, interval reduction of size of abscess was noted on CT. The patient was discharged for outpatient follow-up with oral ciprofloxacin and rifampicin in consideration of antibiotic sensitivity and tissue penetration. To our best knowledge, this is the very first case report of *Staphylococcus lugdunensis* psoas abscess in Korea.