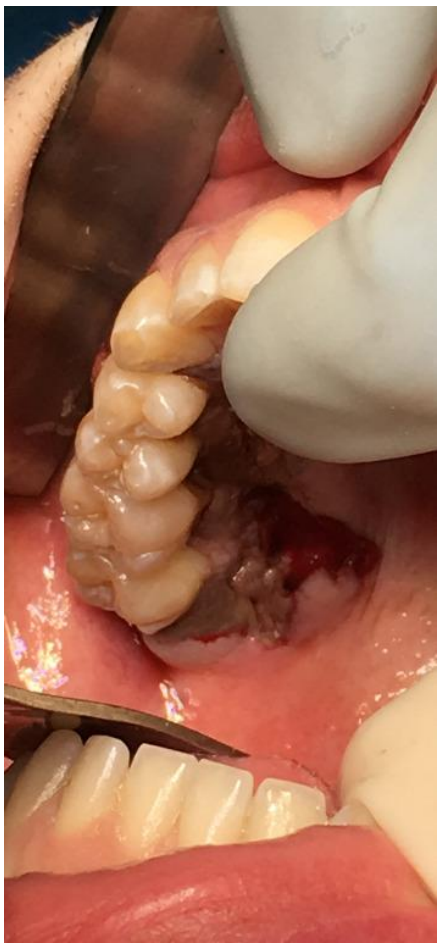

Conclusion: Our data suggest improved outcome of *Mucorales* infections by a multidisciplinary approach including: 1) Repeated (except patient #5) biopsy-controlled surgery until resection boarders are negative, 2) Systemic and in most cases combination, TDM-adjusted high dose systemic antifungal therapy, and 3) Topical therapy when possible to improve antifungal exposure in tissue not sufficiently perfused due to the angioinvasive pathology of the infection. [1]Jensen, TSR et al. *J Pediatr Hematol Oncol*. 2017;39(4):211-215.

P314

Majocchi's Granuloma by Trichophytum rubrum in a kidney transplant patient - A Case Report

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Case Report:

Introduction: *Trichophytum rubrum* is a filamentous fungus, with worldwide distribution, that usually causes superficial infections of skin and nails, namely *tinea pedis*, *tinea corporis*, *tinea cruris* and onychomycosis. Rarely, severe dermatophytosis can occur, presenting as deep dermatophytosis, Majocchi's Granuloma or extensive dermatophytosis.

Objectives and Methods: Case report of Majocchi's Granuloma in a kidney transplant patient.

Results: A case of a 55-year-old woman who underwent a kidney transplant 7 months before, under immunosuppressive therapy with tacrolimus and mycophenolate mofetil. She attended a Dermatology consultation to clarify skin lesions that appeared 6 months earlier. The skin exam revealed hard and painful plaque lesions on both legs, with an ulcer on the left leg lesion, violaceous papular lesions on the dorsum of the left foot and toes and a hard consistency nodule on the left leg. Some of the toe nails presented dystrophy or onycholysis. The patient denied any previous trauma or contact with plants or soil. Biopsies of lesions of the left leg and foot dorsum where sent for

histology and mycological culture and toe nails for mycological culture. The histological examinations showed, in the reticular dermis and reaching the hypodermis, suppurative granulomas with multinucleated giant cells and areas of necrosis. PAS (Periodic Acid-Schiff) and GMS (Grocott's Methenamine Silver) staining revealed multiple spores and septate hypha within the granulomas but not in the *stratum corneum*. No remnants of hair follicles where found. Culture of skin biopsies were positive for *Tricophytum rubrum* but nails´ culture was negative. Identification was further confirmed by sequencing of ITS region of ribosomal DNA (GenBank accession number MK967277). Oral Itraconazole 100mg bid and topic Sertoconazole where initiated. The patient was observed one month after and reported general malaise, tiredness, exertional dyspnea, whitish stools and increased abdominal volume. The physician chose to discontinue itraconazole and initiate oral terbinafine 250mg id. After two months on oral terbinafine, there was regression of the legs´ and left foot lesions with ulcer healing and disappearance of the left leg nodule. **Conclusion:** Diagnosis of deeper dermatophytosis is difficult, in part because there is no specific clinical presentation and, in many cases, it is even polymorphic. However, especially in patients with immunodeficiency, this hypothesis should be weighed. Confirmation is achieved by finding hyphae compatible with dermatophytes in the dermis and a positive culture for a dermatophyte. Treatment should include systemic antifungal agents, to which topical medication may be associated. Multiple therapeutic regimens have been proposed, but randomized trials or large case series are lacking. Antifungal therapy should be continued until the lesions are completely resolved. Surgical treatment has been reported as an option for highly localized lesions.

P315

Clinical Characteristics and Outcomes of *Lomentospora prolificans* Infections in Fungiscope™ Registry

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Objectives: *Lomentospora prolificans* are filamentous fungi commonly found in soil and polluted waters and are emerging opportunistic pathogens in immunocompromised individuals, accounting for 2.4% and 11.1% of non-*Aspergillus* invasive fungal infections (IFIs) in haematopoietic stem cell transplant (HSCT) and solid organ transplant (SOT) infections, respectively. The objective of this study was to describe clinical manifestations, treatment and outcomes of patients with *L. prolificans* infections causing IFI in cases documented in Fungiscope™ - A Global Emerging Fungal Infection Registry, created in 2003.

Methods: We performed a retrospective review of medical records of all patients with IFIs caused by *L. prolificans* in Fungiscope™ between 01/01/2008 - 12/31/2017 (10 year period). Infections were determined to be disseminated if *L. prolificans* was isolated from the blood or two non-contiguous anatomic sites. The study was approved by the UCSD Human Research Protection Program (IRB #181119).

Results: A total of 37 cases with IFIs caused by *L. prolificans*, including 7 cases from the University of California San Diego, were identified (**Table 1**). In all but one case (36/37, 97.3%), a risk factor for IFI was found, including hematologic malignancy (20/37, 54.1%), solid organ transplant (SOT) (3/37, 8.1%), ICU stay or trauma (6/37, 16.2%). The majority of infections were diagnosed based on positive