



Monaldi Archives for Chest Disease

eISSN 2532-5264

<https://www.monaldi-archives.org/>

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Monaldi Arch Chest Dis 2023 [Online ahead of print]

To cite this Article:

Joseph R, Venkatnarayan K, Nanaiah A, Ramachandran P. **A case of hoarseness of voice following COVID-19 infection.** *Monaldi Arch Chest Dis* doi: 10.4081/monaldi.2023.2472

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A case of hoarseness of voice following COVID-19 infection

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Author Contributions All the authors have contributed towards patient diagnosis and management and manuscript preparation and revision.

Statement of Ethics A written consent has been obtained from the patient for publishing the case.

Disclosure Statement The authors have no conflicts of interest to disclose.

Funding Sources No funding obtained in relation to the above manuscript.

Acknowledgement None

Abstract

Mucormycosis is a fatal angio-invasive fungal infection associated with a high mortality. Apart from the traditional risk factors, COVID-19 infection and steroid therapy for the same have been recently identified to predispose to this life-threatening infection. Usual presentations of mucormycosis include rhino-orbito-cerebral, pulmonary, gastrointestinal, renal and cutaneous involvement. We report an unusual case of mediastinal involvement by mucormycosis in a patient recovering from moderate COVID-19 pneumonia. Early diagnosis, prompt initiation of antifungal therapy accompanied by timely surgical debridement were pivotal in averting morbidity and mortality in this patient.

Key words: hoarseness, mediastinal mucormycosis, COVID associated mucormycosis

Introduction

The recent COVID-19 pandemic triggered a rise in the cases of mucormycosis worldwide, especially in India. [1] This surge was attributed to various causes, hyperglycemia and inadvertent use of corticosteroids being the most important. COVID-19 infection shares a bidirectional relationship with diabetes mellitus. Corticosteroids used in the treatment of moderate to severe COVID-19 related hypoxemic respiratory failure further worsen the hyperglycemia and immune dysregulation associated with the infection. [2] The predominant site of involvement reported with COVID-19-associated mucormycosis is rhino-orbito-cerebral, followed by pulmonary, disseminated and gastrointestinal. Prompt initiation of antifungal therapy, surgical debridement of necrotic tissue and control of the underlying risk factor are the three pillars to managing this disease which otherwise carries a high mortality. [1,3]

Case Report

A 47-yr-old gentleman, a reformed smoker with diabetes mellitus and hypertension, developed fever and myalgia for 3 days and was diagnosed with COVID-19 infection. He was initially advised home isolation and monitoring in view of mild symptoms. Over the next 3-4 days, he developed breathlessness and was hospitalized for acute hypoxemic respiratory failure in another centre. He was treated with supplemental oxygen, intravenous Remdesivir, intravenous Ceftriaxone and steroids (Dexamethasone 8mg twice a day) for 7 days. Eventually he improved and was discharged after 10 days of hospitalization.

A week later, he started having dry cough and hoarseness of voice for which he was referred to our center for further evaluation. There was no history of fever, hemoptysis, dysphagia or stridor. On examination, he was hemodynamically stable, maintaining a saturation of 96% on room air with an unremarkable systemic examination.

Laboratory investigations were within normal limits except for leucocytosis of 14,350 cells/mm³. Blood sugars were poorly controlled with a HbA1c of 9.8%. A computed tomography (CT) scan of the thorax was performed which showed multiple necrotic mediastinal lymph nodes with circumferential thickening and partial luminal obliteration of the left main bronchus. A few peripheral based ground glass opacities were noted in the lung parenchyma which were consistent with COVID-19 infection [Figure 1]. Flexible bronchoscopy showed left vocal cord palsy and a bulge at the carina extending into the left main bronchus with partial luminal obliteration. On further negotiation into the left main bronchus an ulcerative lesion was seen with purulent secretions at the origin of the left main

bronchus. Endobronchial biopsies were obtained from the margins of this lesion and bronchial washings were taken [Figure 2]. Bronchial washings were negative for bacterial cultures, acid fast bacilli and cartridge based nucleic acid amplification was negative for *Mycobacterium tuberculosis*. However, it showed aseptate fungal hyphae on potassium hydroxide Calcofluor stain. Fibrinopurulent exudates with few entangled broad aseptate fungal hyphae, morphologically resembling *Mucor* were seen on histopathological examination of the endobronchial biopsies. PAS (Periodic Acid-Schiff) and GMS (Grocott's Methenamine Silver) stains ratified the above findings [Figure 3]. CT scan of the paranasal sinuses showed no features suggestive of fungal sinusitis or orbital involvement.

A diagnosis of mediastinal mucormycosis with endobronchial involvement was made and liposomal amphotericin B (5mg/kg/d) was initiated along with glycemic control measures. In view of airway luminal compromise and the potential for involvement of other mediastinal structures, a surgical debridement was planned. The case was discussed with the thoracic surgeons and since the patient was otherwise stable and operable, a mini thoracotomy with drainage of pus and subcarinal lymph node excision was performed. Lymph node aspirate was negative for acid fast bacilli and bacterial cultures but fungal stains revealed aseptate fungal hyphae. Histopathological examination of the excised subcarinal lymph node showed fibro-collagenous tissue with necrosis, dense inflammation, occasional multinucleated giant cell and histiocytic response with broad aseptate fungal hyphal colonies suggestive of *Mucor*. Intravenous liposomal Amphotericin B was continued post-operatively till a cumulative dose of 4 grams. Patient was then switched to oral Posaconazole 300mg/d and discharged. Posaconazole was continued for 3 months and then stopped. A repeat CT thorax done after therapy, showed significant resolution of the mediastinal nodes and restoration of left main bronchus luminal patency [Figure 1D-F]. Repeat bronchoscopy showed complete resolution of endobronchial ulcers and carinal bulge. A small pit was seen at the origin of left main bronchus which was likely post-operative [Figure 2C, D]. On the last follow up after 1 year of therapy, the patient remains asymptomatic with significant improvement in hoarseness of voice as well.

Discussion

Mucormycosis is a fatal angio-invasive opportunistic infection caused by ubiquitous fungus of the order Mucorales. Traditionally identified risk factors for mucormycosis include diabetes mellitus, hematological malignancies, neutropenia, renal failure, use of

immunosuppressants and solid organ transplants. In contrast to the western countries where hematological malignancies are the major risk factors, mucormycosis in India is predominantly seen in patients with diabetes mellitus [1].

The emergence of the corona virus disease 2019 (COVID-19) pandemic compounded the situation by bringing together two major predisposing factors namely diabetes and corticosteroid use. COVID-19 shares a bidirectional relationship with diabetes. Diabetics are predisposed to increased risk of and progression to severe infection. On the other hand, the pro-inflammatory state associated with COVID-19, has direct and indirect effects on pancreatic β cells and insulin target organs leading to hyperglycemia [2]. Corticosteroids were the only drugs to show promise in the initial stages of the pandemic. However, inadvertent use of steroids combined with underlying diabetes mellitus and hyperglycemia, heightened the predisposition to develop secondary infections including fungal infections in these patients. Apart from COVID-19-associated aspergillosis, several cases of mucormycosis were reported following COVID-19 infection especially from the Indian subcontinent [3].

Although the definite pathophysiology underlying COVID-19-associated mucormycosis (CAM) remains unknown several theories have been put forth. The inflammatory state induced by hyperglycemia is augmented by antiviral immune response and the resultant pro-inflammatory milieu enhances the expression of fungal virulence factors permissive for the development of CAM. Additionally, nasal epithelial receptors promoting fungal invasion are upregulated by COVID-19 infection, presence of diabetic ketoacidosis and higher iron concentrations. This susceptibility is further increased by the accompanying lymphopenia, impaired neutrophil function secondary to the use of corticosteroids and inadvertent use of antibiotics in these patients. Animal studies have shown male predisposition to mucormycosis in the presence of diabetic ketoacidosis which was also observed in clinical practice [4,5]. Worldwide, uncontrolled diabetes and corticosteroid use were the most common predisposing conditions identified for CAM. Rhino-orbito-cerebral mucormycosis was the most common manifestation in India with pulmonary involvement seen mainly in the intensive care setting. A high mortality rate was reported in these patients with significant morbidity in the form of vision loss amongst survivors [4]. Presence of pulmonary or disseminated mucormycosis and admission to intensive care unit were independent predictors of mortality among these patients. Combination antifungal therapy (amphotericin followed by azoles) was associated with improved survival [3].

Mediastinal involvement by mucormycosis is an unusual presentation. It is hypothesized that inhaled fungal spores reach the mediastinal lymph nodes through alveolar macrophages. Owing to the propensity for angioinvasion and tissue necrosis, the resultant mediastinal inflammation can involve the bronchi and other vital structures [6]. The earliest case was reported by Connor et al in a patient with leukemia with invasion of the myocardium, coronary and spinal arteries by mucormycosis on post mortem examination [7]. A systematic review of 12 cases of mediastinal mucormycosis, reported a high mortality of 89%. Most common presenting symptoms were secondary to compression on the mediastinal structures including dyspnea, hoarseness and superior vena caval obstruction. Bronchial perforations were noted in two cases [6,8].

The importance of a multi-disciplinary team including the clinician, radiologist, thoracic surgeons, microbiologist and pathologist in diagnosing and managing these patients cannot be over-emphasized. Early diagnosis, prompt initiation of antifungals and surgical debridement along with management of the underlying predisposing conditions are vital components of an optimal management strategy. The duration of antifungal therapy needs to be individualised based on the response to therapy which in turn depends on the underlying predisposing conditions, structures involved and extent of surgical debridement feasible in the given patient. The right time for surgery as well needs to be decided on a case-to-case basis, depending upon the patient's condition and the feasibility of debridement of the involved structures. A diligent pre-operative evaluation and discussion with the thoracic surgeons especially in patients with involvement of mediastinal structures is extremely crucial [9]. Apart from antifungals and surgical debridement, supportive therapy in the form of optimizing glycaemic control and reversal of the underlying immunosuppression as feasible are of paramount importance. Mediastinal irrigation with antifungals may have an additional benefit of local source control [10].

Our patient presented with exclusive mediastinal symptoms and was referred to our centre with a suspicion of malignancy. Radiologically, mucormycosis presenting with isolated mediastinal lymphadenopathy is extremely rare. Hence, radiologically a possibility of fungal infection was not considered. In a recent consensus statement on COVID-19 associated pulmonary mucormycosis, 89% of the guideline group thought mediastinal adenopathy was 'not suggestive' of mucormycosis [9]. However, an early suspicion following the bronchoscopy, proper sample processing for a possible infective etiology and a prompt diagnosis helped in optimal management. The importance of a multidisciplinary team

involving the microbiologist, pathologist, pulmonologist and the thoracic surgeons in diagnosis and management is evident from this case. We believe that timely surgical debridement was pivotal in averting mortality in our patient by preventing further spread to vital mediastinal structures.

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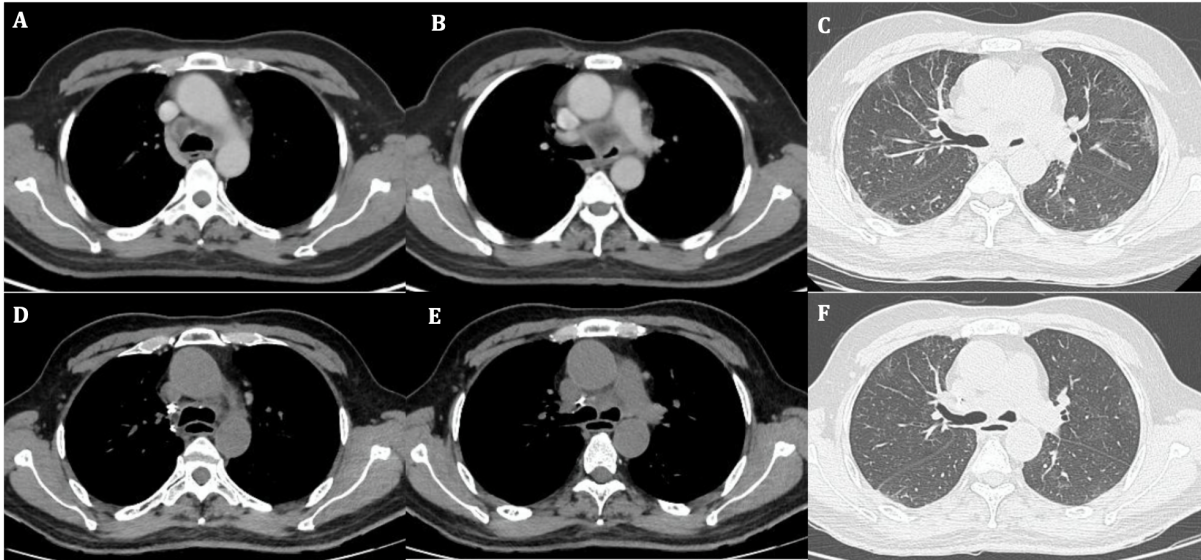


Figure 1: CT thorax done at the time of diagnosis: A, B – Necrotic mediastinal lymph node enlargement in the paratracheal and pre-carinal region with compression of the left main bronchus; C – ground glass opacities in the peripheral subpleural location; CT thorax done after 6 weeks of therapy: D, E, F – near complete resolution of the lymph node enlargement and the ground glass opacities

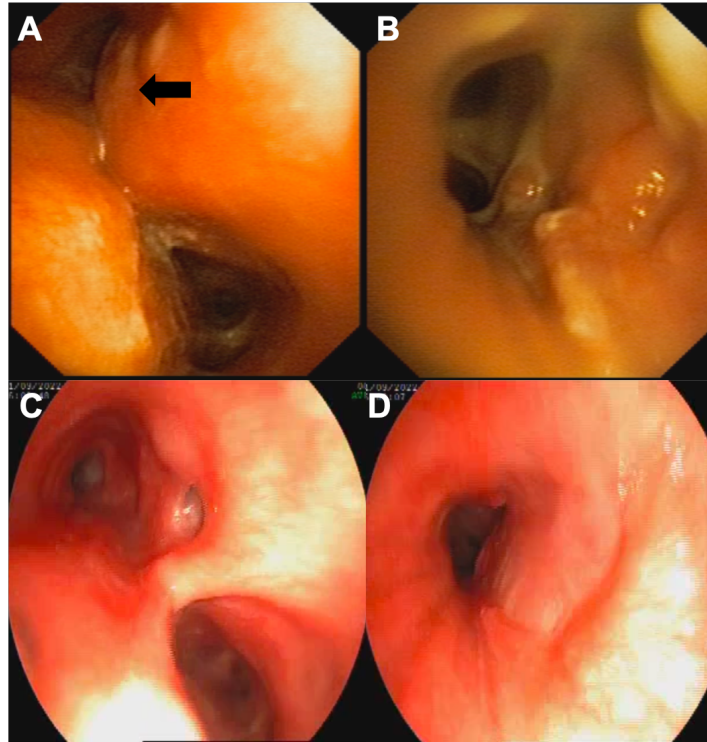


Figure 2: Bronchoscopic images showing A – Bulge seen at the level of carina at the origin of left main bronchus (black arrow); B – Distal end of left main bronchus showing ulcerative lesions with purulent secretions; Follow up bronchoscopy images showing C – resolution of carinal bulge with a bronchial pit; D – complete resolution of left main bronchus ulcerative lesions

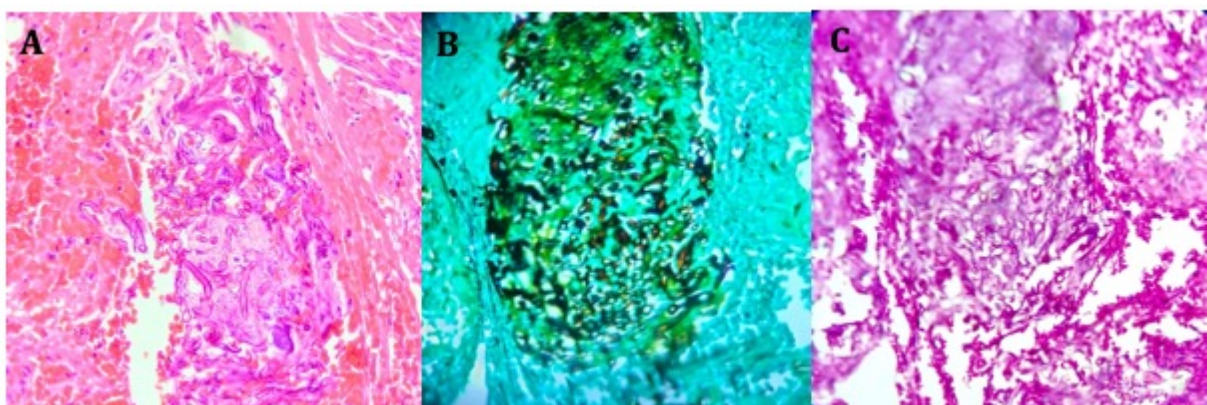


Figure 3: Endobronchial tissue biopsy A - Hematoxylin and Eosin stain (40X) shows broad aseptate fungal hyphae morphologically resembling mucor; B - GMS (Grocott's Methenamine silver) stain (40X) highlights the fungal organisms; C - PAS (Periodic acid-Schiff) stain (40X) highlights the fungal organisms