infections post liver transplant in the indian scenario and this data can be used to plan appropriate preventive strategies

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A case of liver transplant in leptospirosis induced acute on chronic liver failure

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**Background:** Solid organ transplants are increasing in India. Guidelines on liver transplant postoperative infections are limited. We report a child with leptospirosis who underwent a liver transplant.

**Methods & Materials:** We review a case of a 12 year old male with Wilsons disease who presented with febrile illness and acute on chronic liver failure who was admitted at a tertiary care center and subsequently underwent a liver transplant.

**Results:** A 12 year old boy with Wilsons disease presented with a febrile illness and acute on chronic liver disease. He was evaluated for the cause of acute on chronic liver failure and found to have leptospirosis based on identifying spirochetes in the blood and urine. He was treated initially with cefaperazone-sulbactam and subsequently with doxycycline. His pretransplant period was complicated by Acinetobacter pneumonia and bacteremia. After optimizing the clinical condition he underwent a living donor liver transplant. He improved post-transplant for 2 weeks. Subsequently he developed multiple skin necrotic areas which was concerning for septic emboli. He had unexplained leukocytosis. Computerized tomography revealed cavitary lesions in the left upper lobe and right lower lobe, consolidation of left lower lobe, kidney infarction and mucosal thickening of the maxillary and sphenoid sinus. Due to the high risk of biopsy, bronchoscopy was done and bronchoalveolar fluid (BAL) was analyzed. Fungal stain of the BAL was positive and culture was suggestive of Mucor in both the left upper and lower lobes. He was started on Amphotericin B deoxycholate. Subsequently he developed seizures and had features of brain death, presumed due to spread of the mucormycosis.

**Conclusion:** There is no report of liver transplant post leptospirosis. This child underwent a liver transplant following leptospirosis in the background of Wilsons disease. He survived for a few weeks post-transplant but unfortunately died due to mucormycosis, a disease more common in a country like India. Here we were able to diagnose the mucormycosis ante-mortem with BAL and did not require tissue. Strong clinical suspicion, better diagnostics and early initiation of therapy is warranted. Unfortunately due to extensive fungal disease, we could not salvage him.

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An unusual presentation of invasive aspergillosis - Diagnostic and management dilemmas

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**Background:** Invasive Aspergillosis is a fungal infection occurring with increased incidence in patients who are receiving chemotherapy, immunosuppressive therapy or long term corticosteroid therapy. Among these, it more commonly afflicts patients with pre-existing respiratory compromise such as COPD or bronchial asthma. Typically it presents with fever, cough, dyspnoea, pleuritic chest pain and occasionally with haemoptysis.

**Methods & Materials:** Case Report:

A 60 year old male patient presented to the emergency department with complaints of an intermittent, high grade fever for the
past two days. A physical examination revealed only the presence of mild hepatomegaly. As part of a routine work up for pyrexia of unknown origin (PUO), a chest x-ray performed revealed multiple bilateral nodular lesions. A subsequent contrast enhanced CT scan of the chest showed bilateral heterogeneously enhancing mass lesions, with features suggestive of a neoplastic aetiology.

The patient rapidly deteriorated, developing neurological symptoms. (GCS: 3). Brain imaging studies reiterated the high probability of metastatic lesions. However, in view of the patient’s symptomatology and his immunocompromised state, fungal assays were sent and serology revealed a positive Aspergillus antigen.

Results: We report an unusual presentation of Invasive Aspergillosis in a patient with well controlled Aplastic Anaemia. The initial diagnosis misleadingly pointed towards neoplastic lesions in the lung with metastasis to the brain.

IMAGE 1: Periodic acid Schiff (PAS) stain showing the hyphae of the fungal species (H&E; 400x)

IMAGE 2: Contrast enhanced CT shows multiple lung nodules. CT guided biopsy was suggestive of aspergilloma

IMAGE 3: Contrast enhanced CT brain shows multiple non-enhancing hypodense lesions in bilateral cerebral hemispheres

Conclusion: This case exemplifies that a high index of clinical suspicion and an increased awareness of the possibility of invasive aspergillosis is paramount in improving patient outcomes. It also serves to show the difficulties faced with the parallel use of different treatment regimens and how unconventional treatment protocols may sometimes prove effective.

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Rare case of amphotericin-B resistant cryptococcocal meningitis in HIV non reactive patient

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Background: Cryptococcal meningitis is caused by cryptococcal neoformans and cryptococcal gatti. The incidence of cryptococcus meningitis has risen dramatically in past two decades especially in Eastern Africa and South-East asia due to HIV epidemic and increasing use of immunosuppressive drugs. Infection usually acquired through inhalational route causing primary pulmonary cryptococcosis with dissemination to extra pulmonary sites in immunocompromised. Commonly presents with fever, headache, altered sensorium and neck stiffness. Very few cases of cryptococcal meningitis in Non-HIV patients that too with amphotericin resistence has been reported.

Methods & Materials: We are reporting one such case who presented with fever, headache, vomiting for three weeks without any history of exposure to bird excreta. Neck rigidity was absent. Fundus examination was normal, routine test was normal USG/ CXR (PA vie) with normal NCCT head.

Results: CSF routine microscopy showed 102mg/dl proteins and 74mg/dl sugar and CSF culture showed budding yeast cells with india ink preparation positive for cryptococcus. Cryptococcal antigen was positive in CSF but negative in serum. HIV (1&2)