Colonic mucormycosis

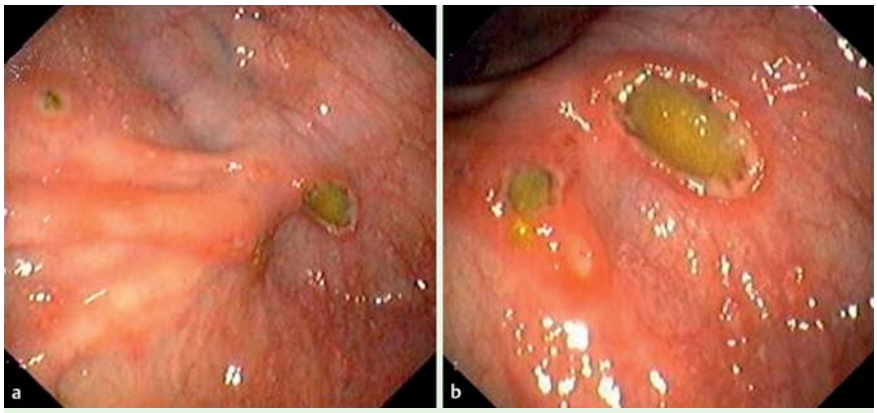

Fig. 1 Endoscopic views in a 48-year-old man recently treated with steroids who was later found to have myelodysplasia showing: **a** ulcers with exudate in the cecum; **b** ulcers with exudate in the ascending colon.

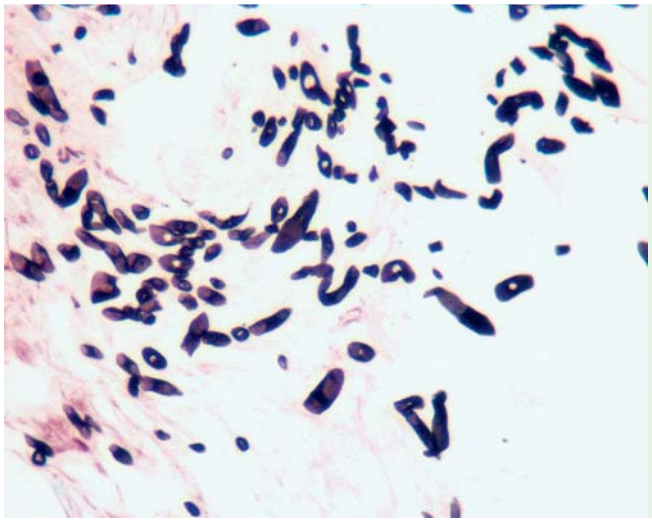

Fig. 2 Histological appearance of the biopsy specimen showing numerous hyphae of *Mucor* species (Grocott's silver stain; magnification × 400).

A 48-year-old man with Reiter's disease who had recently been treated with prednisolone (40 mg orally) and sulfasalazine (500 mg three times per day orally) was admitted to our hospital with abdominal pain, vomiting, and persistent fever. Empirical antibiotics were started but he developed septic shock soon after admission and was transferred to the infectious diseases intensive care unit. A computed tomography (CT) scan of his abdomen and pelvis showed thickening of the wall of the descending and transverse colon.

A colonoscopy was performed and large oval-shaped ulcers with exudates and erythematous borders were identified and biopsied in the cecum (**Fig. 1a**) and ascending colon (**Fig. 1b**); in the transverse and descending colon and in the sigmoid colon, small ulcers and erosions were seen; the mucosa was normal in the terminal ileum and rectum. Histological examination of the biopsies revealed an intense mononuclear infiltrate and the presence of numerous hyphae suggestive of *Mucor* species and less frequent hyphae suggestive of *Candida* species (**Fig. 2**). Intravenous amphotericin B was therefore started. Blood cultures were negative and culture of the biopsy material was not performed.

Endoscopic improvement was documented with a further colonoscopy 2 days later. As he remained persistently pancytopenic, a bone marrow biopsy was performed and he was was diagnosed as having myelodysplasia. He completed 3 weeks of treatment with amphotericin B and was discharged with clinical and laboratory evidence of recovery on oral posoconazole, which was to be continued for 2 months.

The underlying hematological disorder and the immunosuppressive course of steroids were considered risk factors for the mucormycosis. Although there was no culture performed on the biopsy material, the potential for invasive disease in this particular clinical context led us to commence appropriate antifungal therapy because invasive gastrointestinal mucormycosis has a mortality rate of over 90% [1]. Clinical infections in humans are extremely rare and typically occur in those with immune-compromised states such as hematological malignancies, diabetes mellitus, severe malnutrition, or following transplantation [1,2]. In this case, endoscopic evaluation was crucial in the clinical decisions made in the management of this patient.

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Competing interests: None

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Bibliography

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