Endovascular Infusion of Amphotericin B for the Treatment of Rhino-Orbito-Cerebral Mucormycosis: A Pilot Study Assessing Technical Feasibility and Safety

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Abstract

Objectives The aim of this study was to assess the technical feasibility and safety of intra-arterial infusion of amphotericin B for the management of rhino-orbito-cerebral mucormycosis in patients unable to receive full dose and schedule of intravenous amphotericin B and/or unsuitable for surgery.

Methods Five consecutive patients underwent five sessions of intra-arterial infusion each via both external carotid arteries on alternate days. Liposomal amphotericin B (50 mg) was infused at each session. The baseline and follow-up investigations as well as local and systemic complications were charted.

Results Procedure could be completed for all participants without any local complications. One patient had transient and another had progressive deterioration in renal parameters during the follow-up period of 30 days.

Conclusions Authors conducted successfully a pilot study of multisession intra-arterial infusion of amphotericin B, with the premise that it can provide high concentration of drug at the desired site with reduced systemic complications. They recommend further larger randomized studies to evaluate its efficacy for the management of advanced rhino-oculo-cerebral mucormycosis.

Keywords ▶ mucormycosis ▶ rhino-orbito-cerebral ▶ COVID-19 ▶ amphotericin B ▶ endovascular

Introduction

Rhino-orbito-cerebral mucormycosis (ROCM), a rare but highly aggressive disease, has been increasingly reported during the novel coronavirus disease 2019 (COVID-19) pandemic from various parts of the world.¹⁻⁶ Its recommended therapy includes extensive surgery and intravenous amphotericin B (amB) injections (5–10 mg/kg/per day for ~4 weeks,


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preferably of the liposomal form), followed by a long course of oral posaconazole or isavuconazole.\textsuperscript{7–10} Medical comorbidities or poor general condition, especially in the setting of COVID-19 related lung disease, mean that patients can neither have surgery nor be given full dose of am\textsubscript{B}, the latter being a highly toxic drug.

Endovascular drug infusion has been increasingly utilized for many indications including chemotherapy and thrombolysis, with the premise of achieving a higher local concentration of the drug, while minimizing systemic side effects. Intra-arterial antibiotic infusion has also been reported in literature, including those for pyogenic and fungal liver and splenic abscesses, infected pancreatic necrosis, mandibular osteomyelitis, as well as for septic and fungal limb infections.\textsuperscript{11–18} Thus, the precedence, technical expertise, and tools are available to evaluate intra-arterial chemotherapy for ROCM.

**Objectives**

The aim of this study was to evaluate safety and technical feasibility of intra-arterial infusion of liposomal am\textsubscript{B} in ROCM patients unfit for surgery and/or full dose of intravenous am\textsubscript{B}.

**Methods and Materials**

After due approval of the Institute Ethics Committee (IEC), consecutive cases of microbiologically proven ROCM deemed unfit for surgery within 5 days of diagnosis and/or full dose of intravenous am\textsubscript{B} were included in a prospective pilot study during the period of June and July 2021. Patients with extensive and multifocal intracranial disease, pulmonary fungal disease, and those already received antifungal therapy were not included.

Digital subtraction angiography (DSA) and endovascular am\textsubscript{B} infusion technique were used in this study.

The study participants underwent a six-vessel cerebral DSA on a Philips Allura Clarity biplane DSA machine by a single operator with 14 years’ experience, to study the arterial anatomy and evaluate stenosis and occlusions, if any. Subsequently, five sessions of intra-arterial infusions of am\textsubscript{B} were performed on alternate day. Liposomal am\textsubscript{B} (50 mg) was reconstituted in 25 mL of 5% dextrose and the reconstituted drug was passed through a 5 micron filter provided with the injection vial package to obtain a clear yellowish fluid. Three different Indian brands of the drug were used, made by Cipla, Celon Labs, and Lyka laboratories, depending upon availability of the drug, as am\textsubscript{B} was in short supply and heavy demand during this period.

The reconstituted fluid was infused either in the external carotid artery (ECA) trunk via a 5 French size diagnostic catheter or in case of unstable catheter position, via a 2.7 French size microcatheter (Progreat, Terumo Corporation, Tokyo, 151-0072, Japan) placed in the internal maxillary and facial arteries. The fluid was injected at the rate of 1 mL/min, for a total injection time of 24 minutes (1 mL fluid was accounted for by wastages during syringe filling and exchanges). The total dose of 50 mg was divided equally for diffuse bilateral disease (12 mL reconstituted fluid for each side) or two-third and one-third for asymmetrical involvement (16 mL on the side with larger extent of disease and 8 mL on the side with lesser disease).

The intra-arterial infusions were given on alternate days, and investigations including blood urea, serum creatinine, serum electrolytes, and complete blood counts were checked every day till 2 weeks. The patients were kept in a dedicated mucormycosis intensive care unit or ward and monitored.

The two femoral arteries and the right radial artery were punctured on different days, so as to prevent local site complications. For femoral artery punctures, clean dressing was applied and the punctured site limb was not allowed to be flexed for 6 hours. For radial artery punctures, air-filled compression bands were used for 2 hours.

Results

The IEC had granted approval for 10 participants; however, the study was stopped after 5, as the number of new ROCM admissions reduced drastically in late July 2021. A total of 9 patients were counselled, of which 5 had provided consent. Another participant provided consent for only one session and was not included in the study. The baseline data are provided in Table 1. All patients had diabetes mellitus, uncontrolled, or newly detected during COVID-19 management and were treated with insulin. All had received steroids earlier.

The infusion could be performed in all cases for five sessions, without any direct procedure related complications. Case 3 had transient increase in serum creatinine after the third session, which resolved at 2 weeks; case 5 had progressively deteriorating renal functions. Two participants (case 4 and 5) required sedation with intravenous midazolam during the procedure.

MRI of all five cases were performed at 1 month (+ 5 days deviation), and showed extension of disease in three participants (case 1, 3, 5), with maximum changes noted in case 3.

Five out of ten eyes had complete vision loss at presentation, and none had any improvement, nor did any worsening in the other eyes; however, three patients also received intraorbital am\textsubscript{B} injections.
<table>
<thead>
<tr>
<th></th>
<th>Case 1 (►Fig. 1)</th>
<th>Case 2 (►Fig. 2)</th>
<th>Case 3 (►Fig. 3)</th>
<th>Case 4</th>
<th>Case 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, sex</strong></td>
<td>55 years, F</td>
<td>58 years, F</td>
<td>35 years, M</td>
<td>60 years, M</td>
<td>70 years, M</td>
</tr>
<tr>
<td><strong>Onset of ROCM-related symptom(s) during active COVID-19 disease</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>5 days after testing negative for COVID-19</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Gap between symptom onset and imaging</strong></td>
<td>17 days</td>
<td>25 days</td>
<td>20 days</td>
<td>14 days</td>
<td>5 days</td>
</tr>
<tr>
<td><strong>Diabetes mellitus</strong></td>
<td>&gt; 10 years</td>
<td>7 years</td>
<td>Detected during COVID-19 management; on insulin</td>
<td>Detected during COVID-19 management; on insulin</td>
<td>5 years</td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td>&gt; 10 years</td>
<td>7 years</td>
<td>No</td>
<td>No</td>
<td>Newly detected</td>
</tr>
<tr>
<td><strong>Renal profile derangement</strong></td>
<td>Yes</td>
<td>No</td>
<td>Raised blood urea</td>
<td>Yes, US showing renal parenchymal disease</td>
<td>Yes, progressively deteriorating</td>
</tr>
<tr>
<td><strong>Oxygen supplementation during hospitalization</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td>Coronary artery disease</td>
<td>Hemorrhoids</td>
<td>–</td>
<td>Past history of pulmonary tuberculosis, left orbital injury a year back with vision loss</td>
<td>On treatment with multiple antipsychotic drugs</td>
</tr>
<tr>
<td><strong>ICU care required during hospitalization</strong></td>
<td>Yes, 7 days</td>
<td>Yes, 9 days</td>
<td>Yes, 18 days</td>
<td>Yes, 35 days</td>
<td>Yes, 19 days</td>
</tr>
<tr>
<td><strong>Chief presenting complaint</strong></td>
<td>Right facial swelling and skin necrosis, nasal bleeding</td>
<td>Left eye swelling, rapidly progressing to whole face, with bilateral vision loss</td>
<td>Periorbital and facial swelling, right eye vision loss</td>
<td>Bilateral periorbital swelling, decrease vision, patient drowsy, cerebritis, brain edema</td>
<td>Visual disturbance, periorbital and facial swelling</td>
</tr>
<tr>
<td><strong>Disease symmetry</strong></td>
<td>Right &gt; left</td>
<td>Bilateral</td>
<td>Right &gt; left</td>
<td>Right &gt; left</td>
<td>Left &gt; right</td>
</tr>
<tr>
<td><strong>Clinicoradiological stage</strong></td>
<td>4c</td>
<td>4c</td>
<td>4c</td>
<td>4c</td>
<td>4c</td>
</tr>
</tbody>
</table>
| **Reason for not performing surgery** | 1. Intracranial disease with vascular involvement  
2. Coronary artery disease  
3. Deranged renal profile with hyperkalemia | 1. Bilateral central artery occlusion with complete vision loss  
2. Intracranial disease  
3. Bleeding hemorrhoids  
4. Required prone positioning and high flow oxygen for maintenance of saturation | 1. Poor pulmonary status precluding general anesthesia  
2. Refusal by patient and family  
3. Intracranial disease | 1. Renal parenchymal disease  
2. Intracranial infarcts  
3. Poor sensorium (Glasgow coma scale 8/15)  
4. Electrolyte imbalance (hyperkalemia)  
5. NSTEMI  
6. Patient on antiplatelet drugs | 1. Refusal by family  
2. Poor general health  
3. Uncontrolled electrolyte levels, progressive renal disease  
4. intracranial disease |
| **Salient DSA findings** | Right cavernous ICA stenosis, bilateral terminal internal maxillary artery occlusion | Left ophthalmic artery stenosis, right ophthalmic artery occlusion | Right ophthalmic artery occlusion | Right ophthalmic artery occlusion | Left ophthalmic artery occlusion |

Abbreviations: COVID-19, coronavirus disease 2019; CT, computed tomography; DSA, digital subtraction angiography; ICA, internal carotid artery; ICU, intensive care unit; NSTEMI, non-ST-elevation myocardial infarction; ROCM, rhino-ocular-cerebral-mucormycosis; US, ultrasound.

*Clinicoradiological staging performed as per Honavar.*

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No patient died during therapy, and none had puncture site or neurological complications.

Although the study end-point was 1 month, the participants were followed up every month, and 3 out of 5 have died by 6 months (at 1.5, 3.5, and 4.5 months approximately).

Discussion

ROCM is a very aggressive, rapidly progressing, angioinvasive disease, usually associated with uncontrolled diabetes mellitus, especially ketoacidosis, immunosuppression, malignancies, or chemotherapy\(^\text{15}\) (Fig. 1). While COVID-19 has not yet been proven to have a direct association or causality, there have been increased number of ROCM cases in patients who have active COVID-19 or more commonly who have recovered recently.\(^\text{1}\) It can be hypothesized that steroid intake in the background of uncontrolled diabetes leads to these cases\(^\text{19}\), however, these two have not been found in all such cases.

Nevertheless, the authors work in a 960-bed tertiary care institute, which was designated a dedicated COVID-19 care center and later a center of excellence for mucormycosis care by the government. Most cases reporting to the authors did have the combination of COVID-19, diabetes and steroid intake, including all the participants of this study.

Some of the patients had very extensive disease, and not suitable for surgery, which is the standard of care. Further, amB can be very toxic; thus, any mode of delivery, which can reduce its toxicity, is highly desirable. Further, it was in short supply due to the epidemic, and well as costly, and as the dose required per patient is very high,\(^\text{20}\) search for alternative modes of delivery is highly desirable.

Local drug delivery offers a possibly higher concentration of drugs, thus forming the basis of intraorbital and intrathecal antifungal injections. However, intra-arterial infusion of antibiotics, as opposed to chemotherapeutic agents, is not common. The authors could find limited literature of intraarterial amB injections, and none for ROCM.\(^\text{11–18}\)

That endovascular infusion is technically feasible is proven from our study, and in experienced hands, complications will be as for diagnostic angiograms, which is less than 0.5%. Such complications can be related to the contrast medium, amB-related toxicity, or the procedure itself, and include puncture site hematoma, thromboembolism, stroke.

Thus, this mode of therapy can be explored further in prospective randomized trials.

However, the authors also realize that multiple sessions of procedures may be required per patients, and due to scarce facility of advanced catheterization laboratories in most places, it may be difficult to accommodate larger group of patients in real life.

We had opted for repeated vascular access and infusions rather than placing an indwelling catheter for prolonged endovascular infusion for several reasons, including:

1. The catheter needed to be placed in the ECA trunk, so that the drug reaches into all its branches. However, the ECA trunk is rather a short artery and catheter would inevitably get dislodged and fall back proximally into the common carotid artery
2. As infusion had to be given on both sides, two vascular access sites would have been required, thus making the patient relatively bed-bound, keeping the legs straight and immobilized for the entire duration of the therapy.
3. Continuous heparinization would have been required to prevent thrombotic and embolic complications
4. It is practically unknown to keep intra-arterial infusion catheters in situ for 10 days.

This study has some limitations. There are frequent chances of arterial stenosis and occlusions in ROCM, as seen in our study group, and also reported in literature, which may lead to failure of drug to reach the desired site. Also, as we infused amB only in the ECA, there would be intracranial drug supply. In addition, the participants received oral posaconazole, and it is difficult to assign

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**Fig. 1** Imaging of case number 1: a 55-year-old female. (A) Clinical image at admission showing extensive necrosis of the right faciomaxillary region. (B) Coronal fat-suppressed postcontrast T1-weighted image showing extensive soft tissue swelling and enhancement in infratemporal, temporal, masticator spaces with necrotic collections (dashed white arrows) within. There is intracranial extension and abscess formation in the right temporal lobe (short thick arrow). The right cavernous sinus is involved and the right internal carotid wall appears thickened (thin solid white arrow). (C) Cerebral digital subtraction angiography image, right common carotid artery injection, lateral view, showing severe stenosis of the posterior bend of the cavernous sinus segment of the internal carotid artery (long black arrow) and filling defect suggestive of thrombus in the horizontal portion of the cavernous internal carotid artery. (D) White oval indicates diffuse blush in the faciomaxillary region in the external carotid artery territory, the internal maxillary artery is not seen, likely to be thrombosed. (E) Post-debridement clinical picture; this patient died suddenly after 6 weeks while being planned for discharge from the hospital.
the degree of disease response to amB or posaconazole. However, addition of an azole (posaconazole or isavuconazole) is highly recommended for invasive mucormycosis treatment, in addition to amB, as there is very high mortality in spite of high dosage and added surgery.\textsuperscript{21}

Another limitation of the study is that four out of five participants did not undergo salvage surgery subsequent to amB infusion, for decreasing the fungal load. Surgery is especially pertinent in the cases with radiological disease progression. Probably, after improvement in the general
physical conditions, pulmonary and renal functions, surgery could have been performed, so as to speed up the recovery process.

The authors recognize that the amB dose and schedule in the study are somewhat arbitrary; however, it is to re-emphasize that amB stays in local tissues for up to 72 hours, and novel ways of drug administration are active areas of research; for example, aerosolized amB produces high local levels of drug in lungs even after 24 hours, and persist even after 336 hours.\textsuperscript{21} Intermittent or single dosing of the drug is also being researched for both therapy and prophylaxis.\textsuperscript{21,22} The authors did not measure the serum levels of amB for the reason that local concentration of drug would be high, and the serum levels would be naturally low, considering that we infused 50 mg drug intra-arterially, instead of 5mg/kg (~350 mg for a 70 kg person) given intravenously.

That ROCM by itself is highly fatal in spite of all currently known therapeutic options, is well known, and the endovascular therapy being an unknown entity for this indication, also has potential chances for clinical failure. The reasons may be due to the highly invasive nature of the disease, but also due to failure of successful drug delivery. There has to be a consistent technique of drug delivery with constant speed and good reach of the drug to the target areas. Further, infusion of the drug intracranially does not occur, if infusion is given in the ECA territory only; thus, potentially this therapy may be applicable only to extracranial disease. Further, the iodinated contrast used for angiography can add up to the nephrotoxic effect, and the dose has to be minimized as far as possible.

**Conclusion**

Authors describe a relatively safe novel way of amB therapy in COVID-19-associated ROCM, in patients unfit for surgery at presentation and/or full dose of intravenous amB, and recommend further research to establish its efficacy.

**Conflict of Interests**

The authors declare no conflict of interest.

**Ethical Statement**

The study was conducted after approval of the Institute Ethics Committee, and has therefore been performed in accordance with the ethical standards laid down in the 1964 Helsinki Declaration and its later amendments.

**References**


