PO-16

Bilateral endogenous endophthalmitis as the first presentation of fungal sepsis

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A 64-year-old patient was hospitalized at the Department of Gastroenterology of University Medical Centre Maribor due to complications of alcoholic liver cirrhosis and unexplained fever. Despite the initiated antibiotic therapy, inflammatory parameters were increasing. During bedside rounds, the patient told the attending physician that his vision was getting worse, which led to an urgent ophthalmological examination. Signs of bilateral endophthalmitis were present with hypopyon, whitish sub- and intraretinal lesions with infiltration of whitish material into the vitreous space, and intraretinal hemorrhages. Visual acuity was counting fingers bilaterally. We performed bilateral emergency vitrectomy, samples of undiluted and diluted vitreous were taken, vancomycin, ceftazidime, and amphotericin B were administered intravitreally. After 4 days, due to the appearance of deterioration of endophthalmitis, we administered voriconazole intravitreally bilaterally.

Candida albicans grew from vitreous samples and blood cultures, and beta D glucan was also positive. Fluconazole was administered intravenously, also anidulafungin due to suspected fungal endocarditis. The inflammation in the eyes subsided, and visual acuity improved. Four weeks after vitrectomy, signs of worsening endophthalmitis with the growth of fungal foci were again present, so we administered voriconazole intravitreally again in both eyes, and again three days later. At the check-up four months after the vitreoretinal procedure, the visual acuity was 1.0 bilaterally without correction, there were still yellow-whitish inflammatory lesions near the arcades and in the macula, which had almost completely atrophied, and systemic fluconazole was discontinued.

Obojestranski endogeni endoftalmitis kot prva prezentacija glivične sepse

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64-letni bolnik je bil hospitaliziran na GE UKC Maribor zaradi zapletov alkoholne ciroze jeter in nepojasnjene vročine. Kljub uvedeni antibiotični terapiji so bili vnetni parametri v porastu. Med vizito je pacient povedal lečeči zdravnici, da slabše vidi, na kar je bil opravljen urgentni oftalmološki pregled. Obojestransko so bili prisotni znaki endoftalmitisa s hipopionom, belkastimi sub in intraretinalnimi lezijami s pronicanjem belkastega materiala v steklovinski prostor ter intraretinalne krvavitve. Vidna ostrina je bila obojestransko gibi prstov pred očmi. Lečečemu internistu smo podali sum na endogeni endoftalmitis, najverjetneje glivični. Opravili smo obojestransko urgentno vitrektomijo, odvzeli vzorce nerazredčene in razredčene steklovine, intravitrealno aplicirali vankomicin, ceftazidim in amfotericin B. Čez 4 dni smo zaradi izgleda ponovnega poslabšanja obojestransko aplicirali vorikonazol intravitrealno.

Iz vzorcev steklovine in hemokultur je porasla Candida albicans, tudi beta D glukan je bil pozitiven. Intravensko so uvedli flukonazol, nato zaradi suma na glivični endokarditis še anidulafungin. Vnetje na očeh se je umirjalo, vidna ostrina izboljševala. Četrti teden po vitrektomiji so bili ponovno prisotni znaki poslašanja endoftalmitisa z rastjo glivičnih žarišč, zato smo ponovno aplicirali vorikonazol intravitrealno v obe očesi, in čez tri dni še enkrat. Na kontroli štiri mesece po vitreoretinalnem posegu je vidna ostrina obojestransko 1,0 brez korekcije, ob arkadah in v makulah so še rumeno-belkaste vnetne lezije, ki že skoraj povsem atrofirajo, sistemski flukonazol ukinemo.

Pri polimorbidnem bolniku z nepojasnjenim porastom vnetnih parametrov s klinično sliko obojestranskega endoftalmitisa lečečemu internistu podamo sum na glivično sepso, ki je bila nato tudi mikrobiološko potrjena. Origo sepse je ostal nepojasnjen, zdravljenje je bilo uspešno.