

Saprochaete Capitata Infection in an 80-Year Old Chronic Obstructive Pulmonary Disease (COPD) Patient: A Case Report

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Abstract

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BACKGROUND: The fungal disease caused by invasive fungus *Saprochaete capitata* is becoming an increasingly popular infection. Fungal pathogens mainly occur in patients with immunocompromised disorders such as hematologic malignancies, acute myeloid leukemia, transplant patients.

CASE REPORT: In this study, we presented a COPD patient infected with *S. capitata*. At the first check, the patient showed cough, dyspnea, chest pain on both sides. The clinical laboratory test result was characterized with high White blood cell (12.8 G/L), HIV negative. The X ray showed bronchitis and emphysema. Bronchoscopy illustrated bronchial mucositis. CT scanner demonstrated pneumonia with fuzzy nodular lesions and thick interstitial organization in both lungs. The patient was treated with ciprofloxacin 800 mg/day; cefuroxime 2250 mmg/day. However, the fever appeared 2 weeks thereafter. The *S. capitata* was discovered in the bronchial fluid. The patient was then treated with fluconazole 400 mg/day for 14 days. At the end of treatment, all signs and symptoms of *S. capitata* infection disappeared and the patient recovered.

CONCLUSION: This case study showed that *S. capitata* infection can occur in the COPD patients and fluconazole is a pertinent drug for treatment of the infection.

Introduction

Candida and *Aspergillus* spp. are mainly the causes of invasive fungal infections in hospitals. However, infection with rare fungal pathogens has become more popular in recent years. Infections caused by *Saprochaete capitata* are one of the emerging diseases. *S. capitata*, previously known as *Geotrichum capitatum*, *Trichosporon capitatum*, *Blastoschizomyces capitatus*, *Dipodascus capitatus*, is a non-fermentative, urease-negative ascomycetous yeast classified in Saccharomycetaceae family [1], [2], [3], [4], [5], [6], [7]. *S. capitata* fungus grows well in the Saboraud agar, their colonies are similar to yeast, but their morphology characterizes with long and short segments with different sizes. This fungus is mainly found in natural environments such as soil, sand and wood pulp [8]. In addition, it has also been found in poultry feces, gastrointestinal tract, respiratory tract,

and is a part of the normal microflora of human skin [9]. They are known as the fungi that live in the respiratory tract and digestive tracts of humans, they are invasive pathogens like other yeast species [10].

S. capitata infection is mainly seen in patients with neutrophil leukemia (87%), more rarely in patients with other non-hematological diseases such as diabetes, neuralgia, organ transplantation and inflammations [11] (Table 1). In this report, we described a case of fungal infection caused by *S. capitata* in COPD patients.

Table 1: Some report cases cause by *Saprochaete capitata*

No.	Case	Age	Symptoms/ problems	Treatment	References
1	Acute myeloid leukemia	41	Erythema, high fever	caspofungin and liposomal amphotericin B	[12]
2	Kidney transplant	82	hypertensive nephrosclerosis	liposomal amphotericin B	[13]
3	Burkitt lymphoma	74	fever and central nervous system	fluconazole and caspofungin	[12]
4	Acute myeloid leukemia	57	Fever, diarrhoea and skin rash	levofloxacin and fluconazole	[14]
5	Pneumonia, asthma	86	shortness of breath, productive cough and fatigue	itraconazole	[15]

Clinical Case

An 80-year-old man was diagnosed with COPD and Gout 10 years ago. The patient came to the hospital with productive cough, dyspnea, chest pain on both sides a week before. Examination revealed symptoms including vesicular breathing, coarse crackle and wheeze in both lungs, no hypertension, non-diabetic, no fever. The laboratory blood test results were: Red blood cell 4.36 T/L, hematocrit 138 g/l, White blood cell 12.8 G/L (Lymphocyte 17.4% and Granulocyte 74.1%), HIV negative, Genxpert DPG (-), AFB (-). The X-ray showed bronchitis and emphysema. Bronchoscopy illustrated bronchial mucositis (Figure 1).



Figure 1: X – ray of patient before treatment

CT scanner demonstrated the pneumonia with fuzzy nodular lesions and thick interstitial organization in both lungs (Figure 2). The patient was treated with ciprofloxacin 800mg/day; cefuroxime 2250 mg/day; ventolin 40mg/ day; pulmicort 500mg; salbutamol 16mg/ day.

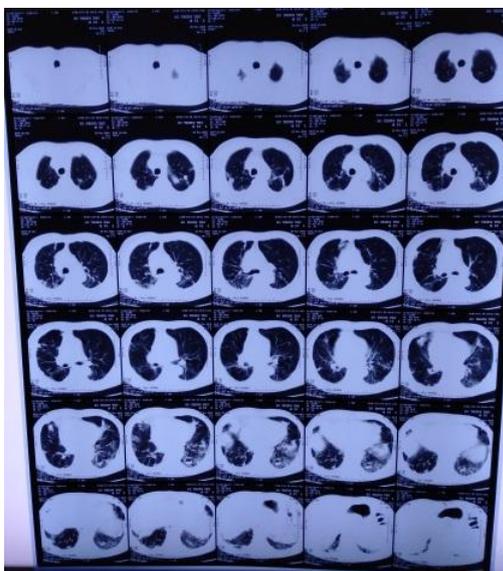


Figure 2: CT scan of the patient before treatment

After 2 weeks, cough and shortness of breath decreased, fever, however, developed. The patient was then treated with methylprednisolon 40 mg per day for 7 days. After the cease of drug, fever again developed. Therefore, the patient was treated with raxadin 2000 mmg + moxifloxacin 400 mmg + doxycyclin 1000 mmg per day for another 7 days. The patient was still feverish, tired, screeching and snoring was in both sides of the lung. The phlegm of patient was sampled and cultured to find fungi. *S. capitata* was detected by semi-automatic Vitek system (Figure 3 and 4), the blood cultured showed negative.

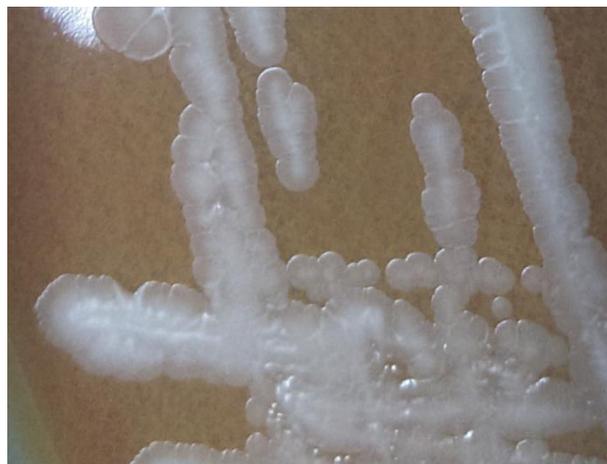


Figure 3: *Saprochaete capitata* on SAB media at 72 hour at 37°C

After 14 days of treatment with fluconazol 400 mg per day, the patient recovered and all the symptoms disappeared. The phlegm cultured showed negative.



Figure 4: *Saprochaete capitata* staining with lactophenol cotton blue under microscope (X 400)

Discussion

Saprochaete capitata has determined considerable taxonomic evaluation [16]. Evaluation of this fungus under microscopy showed the septal pores and cell wall structure with lots of arthroconidia and few blastoconidia [1]. In our case, *S. capitata* grow well on the Saboraud agar at 37°C, the colonies are similar to those of yeast. However, it is, with different dimensions of segments under microscope (Figure 4), similar to the filamentous fungi. Conventionally, detection of these fungi in the culture medium basing on their morphology is an important diagnosis. Using automatic or semi-automatic system may be a great choice. The Vitek 2 system version 07.01 was used to confirm *S. capitata*. This system has been shown to possess an accuracy rate of 98%. Besides, D 32C (bioMérieux), and RapID Yeast Plus (Innovative Diagnostic Systems) systems also were applied to diagnosis of this fungus [17], [18]. Unfortunately, their morphology is very similar to that of *S. clavata* [17].

S. capitata infection is becoming an emerging disease, particularly in immunocompromised such as haematological malignancies, associated cancer and onychomycosis [19]. Factors such as extended neutropenia, active chemotherapy, broad-spectrum antibiotics use and reduced local defense system by breaking down the skin and mucosa were mainly beneficial factors for this infection [20]. The haematological malignancy including acute leukemia is the disease in the most popular patients and estimated incidence is around 0.5% [1], [21]. Extremely, all of breaking through infections with acute leukemia developed in patients who were in intensive chemotherapy [1]. Moreover, broad spectrum antibiotic was used for treatment of all patients who developed neutropenic fever. The 30-day mortality is 30 days it related with invasive disease ranges from 60 – 80% [1]. In this case, the patient was treated with two antibiotics for 14 days. The symptoms decrease at the end of antibiotic treatment. However, the patient appeared fever in the afternoon. This case indicates the antibiotics ciprofloxacin and cefuroxime are not really effective with *S. capitata*. Positive blood culture was found in almost of case infection with 77.3%. While our case showed negative in blood culture. The pneumonia in *S. capitata* usually associated in haematological malignancies or multiple diseases. It could make the infection becomes more severe [15].

The in vitro study of susceptibility *S. capitata* is quite weak. Published literature showed that *S. capitata* is susceptible to flucytosine (MIC values 0.25-0.5 mg/mL), itraconazole (MIC values 0.12-0.50 mg/mL), voriconazole (MIC values 0.25-0.5 mg/mL) and posaconazole (MIC values 0.03-0.25 mg/mL). However, these organisms are less susceptible to fluconazole with a MIC between 16 and 32 mg/mL in most studies [3], [22], [23]. Amphotericin B was

effective in inhibition of these fungus only with high concentration (MIC values 0.5-2.0 mg/mL) [24]. *S. capitata* was demonstrated to intrinsically resist to echinocandins [25]. Girmenia et al. reported that amphotericin B, flucytosine, fluconazole, itraconazole, and voriconazole had high efficacy against *S. capitata* isolates. Other authors indicated that amphotericin B and voriconazole were more potent than other drugs in inhibition of *S. capitata* [23]. In these cases, demonstrated *S. capitata* reduce susceptible to anidulafungin at 8 mg/mL MIC value as expected. Fluconazole is less effective than itraconazole, voriconazole and azoles against *S. capitata*. The data of optimal treatment to *S. capitata* infection is not enough. In this infection indicated use of amphotericin B alone or in combination with flucytosine is a quality treatment. *S. capitata* infection treat with fluconazole and echinocandins were also quite good choice. Breakthrough infections of *S. capitata* reported in neutropenic patients collected echinocandins [7], [26], [27]. In our case, *S. capitata* was effectively treated with fluconazole 400 mg/day per 14 days, but it is need more evidence of MIC value. This case also demonstrates that antibiotic treatment of this infection only reduces some symptoms, but it is unable to thoroughly treat the infection. Identification of fungi is the most important for diagnosis and treatment.

In conclusion, *S. capitata* infected mostly to haematological malignancies patients, also with immunosuppressive and immunocompetent patients. In this case, the COPD patient was infected with *S. capitata*, treated with fluconazole 400 mg/day. The signs and symptoms disappeared after 2 weeks. The MIC of *S. capitata* should be do in the further study.

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