further worsening of the skin condition, he was again treated with adrenaline and injectable antihistamine, without improvement, and later developed eye swelling with purulent discharge. He was hospitalized 4 days earlier and treated with hydroxyzine, oxacillin, and antihistamines. On exam, he had hyperemic, scaly lesions with crusts extending over cervical, facial, retroauricular, and thoracic regions. Laboratory tests showed lymphopenia (1,699/mm^3), left shift (segmented neutrophils 7,286/mm^3), hyponatremia (132 mEq/L), elevated AST (58 U/L) and normal CRP (0.5 mg/dL). The diagnostic hypothesis was SSSS. This case illustrates a typical SSSS presentation in an infant, with rapid progression and lack of response to antihistamines, and absence of mucosal involvement. Laboratory findings of lymphopenia, hyponatremia, and elevated AST support an infectious process. Oxacillin use was appropriate. Ocular discharge suggests secondary infection, warranting continuous monitoring. This case reinforces the importance of SSSS as a differential diagnosis in children with acute, rapidly progressive dermatosis.

Keywords: Staphylococcal infection, Skin infections, Childhood dermatoses.

https://doi.org/10.1016/j.bjid.2026.105084

459

NEPHROTIC SYNDROME SECONDARY TO TUBERCULOSIS – A DIAGNOSTIC CHALLENGE

Anna Eugênia Villela Martins Naves [a,*],
Natália Sousa Costa [a],
Moara Alves Santa Bárbara Borges [b],
Adriana Oliveira Guilarde [b],
Vanessa Lara Guimarães [b]

[a] *Hospital Estadual de Doenças Tropicais (HDT), Goiâna, GO, Brazil*
[b] *Hospital das Clínicas da Universidade Federal de Goiás (UFG), Goiânia, GO, Brazil*

Tuberculosis (TB) is a preventable and curable infectious disease caused by Mycobacterium tuberculosis. More than 10 million people continue to develop TB every year, a number that has been rising since 2021. Although TB mainly affects the lungs, extrapulmonary forms occur in 10–20% of cases. Genitourinary TB is the second most common site, present in 2–20% of those with pulmonary TB and in 30–40% of extrapulmonary TB. Pyuria, proteinuria, and renal dysfunction may be early manifestations of granulomatous renal disease. Isolated hematuria is also a possible presentation of renal TB. A 51-year-old male experiencing homelessness, alcohol user, smoker, and illicit drug user, was referred to a tertiary hospital due to generalized edema for two weeks, associated with marked penile and scrotal edema, oliguria with reddish urine, dyspnea, and dry cough. Initial workup for edematous syndrome showed urinary sediment with proteinuria and hematuria. A 24-hour urine collection confirmed nephrotic-range proteinuria (24g/24h). Due to respiratory complaints, chest CT was performed and revealed centrilobular micronodular opacities, sometimes with a tree-in-bud pattern. Sputum smear microscopy was negative, and rapid molecular test for TB (TRM-TB) in sputum showed only trace detection, insufficient for a diagnosis of pulmonary TB in an immunocompetent patient. Further investigation included 5 urine samples for TRM-TB and culture. The first two were negative; the third sample showed trace detection, confirming extrapulmonary TB with renal involvement. Standard therapy with rifampicin, isoniazid, pyrazinamide, and ethambutol was initiated. Due to severe behavior, disorganized speech, and agitation, lumbar puncture was performed to rule out TB of the central nervous system, with normal CSF and negative TRM-TB. Kidney biopsy showed crescentic glomerulonephritis with C3 deposition, without tubulointerstitial involvement. The patient improved regarding edema and renal function after RIPE regimen and was later transferred to a psychiatric unit to continue treatment. Renal TB requires high clinical suspicion, and diagnosis usually requires at least 3–6 urine samples for TRM-TB and culture.

Keywords: Nephrotic syndrome, Tuberculosis, Diagnosis.

https://doi.org/10.1016/j.bjid.2026.105085

460

CHRONIC SINUSITIS AS A TRIGGER FOR BELL'S PALSY: CASE REPORT

Thais Borges Magnus [a,*],
Yasmin Lambert Mildner [b],
Eduarda Maria Baldi [b], Sofia Melke Gonçalves [c],
Manuela Borges Carlos [d]

[a] *Centro de Demandas de Três Cachoeiras, Três Cachoeiras, RS, Brazil*
[b] *Universidade de Santa Cruz do Sul (UNISC), Santa Cruz do Sul, RS, Brazil*
[c] *Universidade Luterana do Brasil (ULBRA), Canoas, RS, Brazil*
[d] *Universidade do Sul de Santa Catarina (UniSul), Tubarão, SC, Brazil*

Introduction: Bell's palsy is the most common peripheral facial paralysis, characterized by sudden, unilateral facial muscle weakness of unknown etiology. Although more than 50% of peripheral facial paralysis cases are idiopathic, infectious, traumatic, neoplastic, congenital, and iatrogenic causes are also recognized. The primary pathophysiology involves inflammation and compression of the facial nerve, frequently associated with herpes simplex virus type 1. While idiopathic in nature, upper respiratory tract infections, including chronic sinusitis, have been implicated as potential triggers.

Objective: To report a pediatric case of Bell's palsy potentially related to chronic sinusitis.

Case report: J.L.F.M., a 6-year-old boy, initially presented with frontal headache and, 24 hours later, developed left hemifacial paralysis. He had no systemic symptoms. Neurological examination was normal except for facial expression asymmetry. Laboratory tests were negative for acute infection