erythema of the right lower limb. He reported a lateral malleolar ulcer on the right foot for two months, without prior treatment. Laboratory tests showed leukocytosis and a marked increase in C-reactive protein. He was initially treated with ceftriaxone and clindamycin for 14 days, with partial improvement of the skin findings but worsening of the ulcer. MRI revealed signs of malleolar osteomyelitis. Surgical debridement was performed and deep tissue was collected for culture. Identification by MALDI-TOF and sequencing of the ITS region confirmed *T. asahii*, and direct examination demonstrated septate hyphae and blastoconidia. Intravenous voriconazole was started, followed by transition to oral therapy, maintained for six months. Treatment was combined with negative pressure wound therapy, dermal matrix implantation, and surgical grafting, leading to hospital discharge after nine weeks. The patient has had no clinical recurrence to date.

Comments: This case expands the clinical spectrum of *T. asahii*, demonstrating its ability to cause invasive osteoarticular infection even in the absence of immunosuppression. Intrinsic resistance to amphotericin B, fluconazole, and echinocandins highlights voriconazole as the antifungal of choice. The combination of accurate microbiological diagnosis, prolonged antifungal therapy, and extensive surgical management was decisive for therapeutic success. In the context of increasing invasive mycoses, updated clinical-laboratory protocols are needed to support early recognition and appropriate management of emerging fungal infections.

Keywords: *Trichosporon asahii*, Osteomyelitis, Skin And Soft Tissue Infection, Invasive Fungal Infection.

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CENTRAL NERVOUS SYSTEM FUNGAL INFECTION DUE TO MUCORMYCOSIS: CASE REPORT

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Introduction: Mucormycosis is an invasive disease caused by filamentous fungi belonging to the order Mucorales. It affects the central nervous system by direct extension from infected paranasal sinuses or by hematogenous dissemination, typically originating in the lungs.

Case report: A 51-year-old female with poorly controlled type 2 diabetes mellitus denied smoking, alcohol use, or allergies. In August 2024, she developed frontal and paranasal sinus headache with nasal discharge and fever. Oral antibiotics were initially prescribed; however, she progressed with clinical worsening, periorbital edema, subpalpebral hematoma, mental status changes, and progressive visual loss, and was transferred to the ICU. She developed hypertension, tachycardia, and oxygen saturation of 94% on room air. During the investigation, she underwent endoscopic nasal debridement, which confirmed rhino-cerebral mucormycosis, with fungal hyphae and tissue necrosis. Laboratory tests showed leukocytosis, elevated C-reactive protein, and severe hyperglycemia. MRI demonstrated signs of a large acute bilateral frontal hemorrhagic lesion. Treatment was initiated with liposomal amphotericin B (total dose 16,800 mg) plus isavuconazole, as well as ceftriaxone, vancomycin, and metronidazole for secondary bacterial skin infection, correction of hydroelectrolytic disturbances, and glycemic control. With further clinical worsening, blood culture grew *Klebsiella pneumoniae*; catheter-associated bloodstream infection was treated with Torgena for 10 days. After treatment, the patient improved clinically with neurological stability. In January, she was re-evaluated due to headache episodes and nasal discharge; pansinusectomy was noted with no further complications, and long-term follow-up was planned with isavuconazole 200 mg/day and prolonged monitoring.

Comments: The patient's clinical history, imaging and laboratory findings, and hospital course clearly demonstrate the complexity and aggressiveness of this opportunistic infection. Mucormycosis shows tropism for blood vessels, which may explain local necrosis and the potential for cavernous sinus thrombosis and intracranial hemorrhage, as observed in this case.

Keywords: Fungal, Mucormycosis, Central Nervous System, Amphotericin, Isavuconazole.

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SEVERE INVASIVE FUNGAL INFECTION CAUSED BY *SCEDOSPORIUM APIOSPERMUM* IN A DIABETIC PATIENT: CASE REPORT

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Scedosporium apiospermum is an opportunistic fungus that, although rare, has emerged as an etiological agent of severe infections, often with difficult diagnosis and treatment. One clinical manifestation of invasive fungal infection caused by *S. apiospermum* is central nervous system involvement, especially in immunocompromised patients such as those with diabetes mellitus. The neurotropism of this fungus is significant and is associated with contiguous spread and hematogenous dissemination. The reported case is a 70-year-old male, a bricklayer, hypertensive, diabetic with a history of recurrent sinusitis, who developed severe frontal headache and retro-ocular pain in the left eye for 2 months; antibiotic therapy had been taken irregularly. After 15 days, despite

treatment, he progressed to ptosis and amaurosis of the left eye, unintentional weight loss, lower limb paresis, and decreased level of consciousness. He was referred to a tertiary hospital after another visit to an urgent care unit and underwent brain MRI, which showed partial opacification of the sphenoid sinuses with surrounding bony sclerosis consistent with chronic sinusitis, associated with multifocal bony erosions, small organized extra-axial frontobasal bilateral fluid collections in the anterior interhemispheric fissure and suprasellar cisterns, with involvement of the left optic nerve (orbital apex syndrome). Surgery was performed with biopsy and specimen collection, and nasal secretion culture grew *S. apiospermum*. Given invasive meningoencephalitis, combined antibiotic therapy plus voriconazole was initiated. Despite treatment, the patient developed infectious complications associated with mechanical ventilation and bloodstream infection, and died 60 days after hospital admission. Patients with diabetes mellitus have an increased risk of fungal infections due to metabolic and immunological changes associated with the disease, as chronic hyperglycemia may reduce T-cell response, neutrophil function, and humoral immunity. This report highlights the importance of this etiological agent to support clinical reasoning regarding differential diagnoses.

Keywords: Voriconazole, *Scedosporium*, Sinusitis.

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NASAL INFECTION CAUSED BY *CLADOSPORIUM* SPP. MIMICKING MUCOSAL LEISHMANIASIS: A CASE REPORT

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Infections caused by *Cladosporium* spp. are rare in humans and are generally associated with opportunistic processes in immunocompromised individuals or prolonged environmental exposure, particularly in tropical regions. These are dematiaceous, filamentous, pigmented fungi widely distributed in the environment, which rarely cause invasive infections and are more often implicated in allergic or cutaneous conditions. Mucosal involvement is considered atypical and is poorly documented in the literature, making diagnosis and clinical management difficult. We report the case of a 64-year-old female, previously healthy, with a history of rural work, referred to our service with a diagnostic hypothesis of mucosal leishmaniasis. For approximately one year she had progressive left-sided nasal obstruction, associated with oropharyngeal secretion, dry cough, dysphonia, and dyspnea on minimal exertion, without fever, weight loss, or other systemic symptoms. Otorhinolaryngological evaluation showed an ulcerated lesion in the adenoid region and crusting on the left nasal septum. She also brought an external serologic test with reactive IgM for leishmaniasis. Biopsy of the lesions was performed; histopathology showed a chronic ulcerated inflammatory process. Mycological culture grew *Cladosporium* spp., while a molecular test performed on the collected material was negative for *Leishmania* spp. Bacterial and mycobacterial cultures were also negative. CT of the paranasal sinuses showed nonspecific inflammatory changes, without evidence of fungal invasion. Based on the mycological finding and exclusion of other etiologies, itraconazole 400 mg/day was started, with outpatient day-hospital follow-up and periodic otorhinolaryngology reassessments. This case highlights the relevance of including uncommon fungal infections in the differential diagnosis of atypical chronic nasosinusal conditions, especially in patients with significant environmental exposure. Given the scarcity of reports of mucosal infection by *Cladosporium* spp., clinical follow-up may contribute to better understanding of disease evolution and the effects of systemic antifungal therapy.

Keywords: *Cladosporium* spp., Nasal Fungal Infection, Mucosal Leishmaniasis.

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OSTEOARTICULAR INFECTION CAUSED BY *HISTOPLASMA CAPSULATUM*

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Osteoarticular fungal infections are chronic, debilitating, and challenging diseases with considerable morbidity. Tenosynovitis caused by *Histoplasma capsulatum* is very uncommon: only seven confirmed reports exist in the literature. We report the case of a 53-year-old woman with hypertension and a history of chronic synovitis of the right knee for more than 18 months, during which she received two corticosteroid injections. She sought care in November 2022 with erythema of the right lower limb associated with ipsilateral knee pain. She had mild leukocytosis with neutrophilia and normal inflammatory markers. Knee MRI showed patellar chondropathy with bone marrow edema in the medial femoral condyle; periarticular marrow signal changes with an edema pattern at the margins of the medial and lateral tibial condyles; moderate joint effusion; and synovial lining thickening and heterogeneous signal, suggesting synovitis. Arthrocentesis with biopsy was performed and empirical ampicillin-sulbactam was given for 7 days; she was discharged for outpatient follow-up. Biopsy showed chronic granulomatous synovitis with multinucleated giant cells, areas of necrosis, and a large number of yeasts suggestive of *H. capsulatum*. She was admitted in