diabetes. Early diagnosis and combined antifungal therapy with surgical debridement are essential for infection control.

Keywords: Mucormycosis, Diabetes, Spider.

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593

MUCORMYCOSIS IN THE RHINO-CEREBRAL REGION IN THE CONTEXT OF A GROWTH HORMONE–SECRETING PITUITARY MACROADENOMA: A CASE REPORT

Pâmelli Lopez Kamel *,
Luna Carolina Silva Lima,
Paula Massaroni Peçanha Pietrobom,
Gisele Cristina Gosuen,
Arnaldo Lopes Colombo

Escola Paulista de Medicina (EPM), Universidade Federal de São Paulo (UNIFESP), São Paulo, SP, Brazil

Mucormycosis (MCM) is an infection caused by fungi of the order Mucorales, characterized by angioinvasion, tissue necrosis, hematogenous dissemination, and often adverse outcomes. A 33-year-old man with diabetes presented with rhinorrhea, proptosis, periorbital edema, and reduced visual acuity in the left eye for six weeks. Computed tomography showed left-sided rhinosinusitis, a subperiosteal abscess, and facial cellulitis. Septoplasty, maxillary antrostomy, ethmoidectomy, orbital decompression, and drainage were performed, along with empiric antibiotic therapy. Despite these measures, he developed vision loss, mydriasis, and ophthalmoplegia, requiring repeat debridement, during which direct examination of the material revealed filamentous fungi with coenocytic hyphae compatible with MCM; liposomal amphotericin B (L-AmB) was started. Culture confirmed Rhizopus spp. The patient reported an initial diabetic decompensation one year earlier with irregular insulin use, and had clinical signs suggestive of acromegaly, including enlargement of extremities, sleep apnea, and progressive visual field loss. Endocrine evaluation demonstrated panhypopituitarism, elevated GH and IGF-1, and gonadotropic and thyrotropic deficiencies, confirming the diagnosis. Pituitary MRI revealed a macroadenoma with suprasellar extension ($2.4 \times 2.3 \times 3.2$ cm), which was not surgically addressed due to the active infection. After 14 days of treatment, he developed cavernous sinus thrombosis and underwent a third surgical procedure with orbital exenteration and inferior turbinectomy. Given progressive worsening despite extensive surgical clearance and L-AmB, isavuconazole was added. Despite insulin administration, glycemic control was only achieved after starting octreotide, a somatostatin analog capable of inhibiting GH and IGF-1 secretion and increasing insulin sensitivity. After eight weeks of combined antifungal therapy, with clinical and radiological improvement, he was discharged on isavuconazole, which was stopped after one month, and he remains stable under outpatient follow-up for 14 months. MCM is a medical emergency, and the association with uncontrolled acromegaly worsened prognosis. Cure depends on a multidisciplinary approach including optimized antifungal therapy, aggressive surgical management, and control of the underlying risk condition—here requiring a somatostatin analog to treat acromegaly.

Keywords: Mucormycosis, Acromegaly, Pituitary macroadenoma, Isavuconazole, Somatostatin analog.

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594

RHINO-FACIAL MUCORMYCOSIS IN A DIABETIC PATIENT: A CLINICAL-SURGICAL EMERGENCY

Nathália de Carvalho Leonardo *,
Caio de Azevedo Pessanha,
Beatriz Rastoldo Barbosa,
Natalia Graciano Assis de Oliveira Andrade,
Rodrigo Guimarães Cunha

Universidade do Estado do Rio de Janeiro (UERJ), Rio de Janeiro, RJ, Brazil

Mucormycosis is an opportunistic, aggressive, and rapidly progressive fungal infection caused by fungi of the order Mucorales, affecting predominantly immunocompromised individuals. Among the main risk factors, diabetes mellitus stands out, especially when uncontrolled, due to predisposition to fungal proliferation in environments of hyperglycemia and acidosis. The rhino-facial form, frequently associated with tissue necrosis, can invade facial structures, the orbit, and the central nervous system, and is considered a medical emergency. We report the case of a 65-year-old woman with type 2 diabetes mellitus on insulin, hypertension, and asthma, who in December 2024 developed ulceration of the hard palate with purulent discharge and loss of upper teeth. After multiple dental consultations and initially inconclusive biopsies, histopathology performed in April 2025 confirmed the presence of broad, irregular, coenocytic hyphae compatible with mucormycosis. Facial CT showed pansinusitis, bony destruction of the hard palate and sphenoid sinuses, with invasion of the pterygopalatine fossa, without intracranial involvement. She was referred to a tertiary center and started on amphotericin B deoxycholate, later switched to the liposomal formulation due to renal toxicity. During hospitalization, she developed pneumonia and cellulitis of an upper limb, both treated with broad-spectrum antibiotics. She underwent surgical debridement in two stages, with extensive resection of necrotic tissue. Direct mycological examination showed hyaline hyphae, and culture revealed a fast-growing cottony colony suggestive of Rhizopus spp. After six weeks of intravenous antifungal therapy, oral isavuconazole was started. She showed progressive clinical improvement, maintaining hemodynamic stability and renal function, and was discharged in June 2025 with outpatient follow-up in infectious diseases and endocrinology. This case reinforces