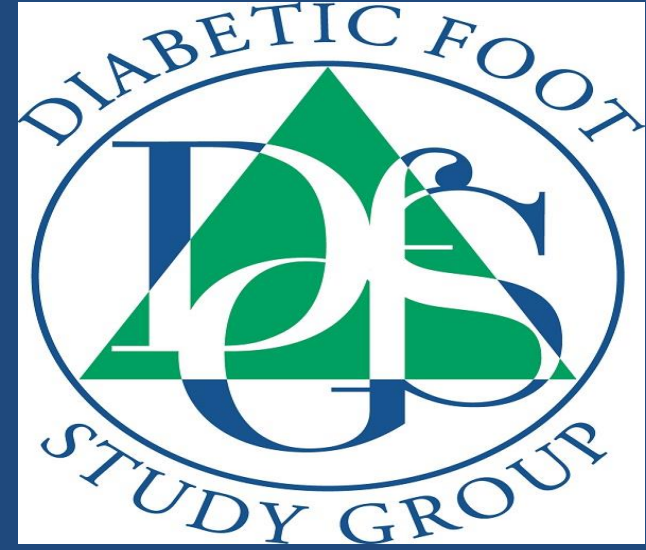




FUNGAL OSTEOMYELITIS IN DIABETIC FOOT INFECTION: A CASE REPORT

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Introduction

- Fungal osteomyelitis in a diabetic foot ulcer is relatively rare and is underrecognized and is associated with poor outcomes.
- We report the case of a 75-year-old woman with type 2 diabetes, dementia and peripheral arterial disease who developed gangrene complicated by osteomyelitis due to the fungus *Trichosporon asahii* in the distal phalanx of her left hallux.

Presentation

- She was referred to the vascular clinic with 2 weeks history of redness and swelling of the left foot with pus and skin loss from the hallux.
- She was prescribed flucloxacillin and fucibet cream in the community which had eased the redness and swelling but she developed apical gangrene of the left hallux (Fig 1).
- She was admitted to hospital and had left hallux amputation (Fig 2). An ultrasound Duplex was performed due to ongoing pain. Duplex showed left ABPI of 0.36.
- A left diagnostic angiogram was requested but abandoned as she could not tolerate the procedure.
- A decision for conservative management was made after discussion with the family with ceiling of care of antibiotics and dressings.
- She was discharged home on flucloxacillin, ciprofloxacin and metronidazole and referred to the multidisciplinary diabetic foot clinic (MTDFC).



Fig 1



Fig 2



Fig 3



Fig 4



Fig 5



Fig 6



Fig 7



Fig 8

Progress

- No deterioration of the amputation wound was noted when reviewed in the MTDFC but it was noted that the bone culture had grown *Trichosporon asahii* and she had a 6 weeks course of itraconazole.
- The wound became macerated (Fig 3) with evidence of osteomyelitis and she was prescribed triple antibiotics (doxycycline, ciprofloxacin and metronidazole) but had difficulty tolerating the doxycycline.
- The wound became sloughy (Fig 4).
- Antibiotics changed to co-amoxycylav which she tolerated.
- She developed bilateral heel ulcers.
- Further hospital admission in April 2026 with infected amputation site left hallux and dry gangrene left heel (fig 5 & 6).
- Options of left below knee amputation or conservative management discussed with family.
- Family opted for conservative management.
- Had 6 weeks of antibiotics.
- Wounds less sloughy when last reviewed in the MTDFC (Fig 7 & 8).

Conclusions

- Fungal osteomyelitis might be overlooked or diagnosed late because the clinical presentation between bacterial and fungal osteomyelitis is similar and specific laboratory testing is required.
- Early diagnosis of fungal osteomyelitis with prompt intervention could prevent amputation and decrease associated healthcare costs.
- Treating fungal osteomyelitis involves a long course of antifungal treatment, along with surgical management and intensive wound care.