

[PICTURES IN CLINICAL MEDICINE]

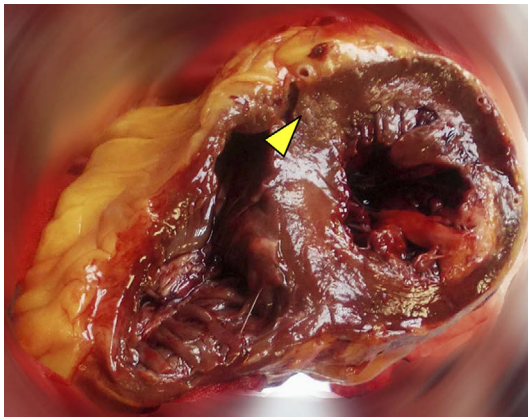
Candida albicans Myocarditis and Renal Abscess

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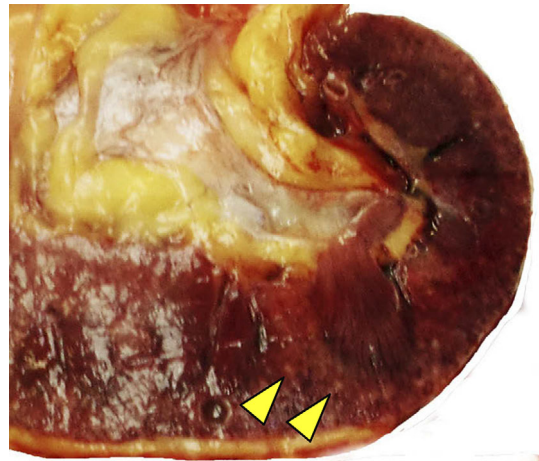
Key words: invasive candidiasis, diabetes mellitus, myocarditis, renal abscess

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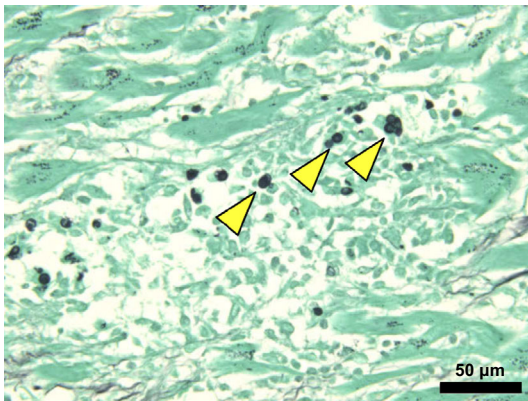
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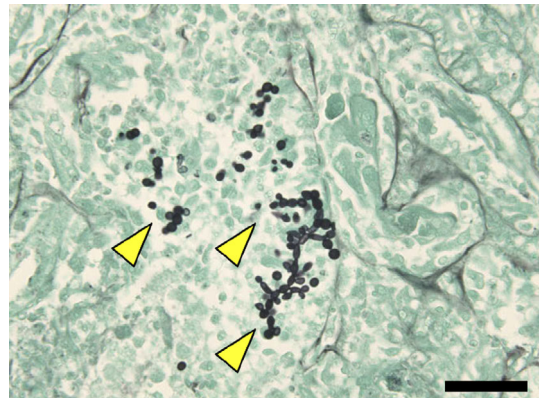
Picture 1.



Picture 2.



Picture 3.



Picture 4.

A 79-year-old man with emphysema, dementia and diabetes mellitus presented with a fever. Under a diagnosis of pneumonia, he underwent antibiotic therapy, which was initially effective. On hospital day 21, he again presented with a high fever. A cardiac examination revealed sinus tachycardia but no heart murmur. *Candida albicans* was cultured from his blood, urine, and peripheral venous catheter.

Transthoracic echocardiography revealed no abnormal findings. His blood level of beta-D-glucan exceeded 300 pg/mL. Despite undergoing antifungal therapy, he died six days later.

A postmortem autopsy showed small white nodules (ar-

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row) in his cardiac muscle (Picture 1) and renal cortex (Picture 2). A pathological analysis by Gomori-Grocott methenamine silver nitrate staining revealed fungi (arrow) in these nodules both in his heart (Picture 3) and kidney (Picture 4). There were no sources of candida infection in his oral cavity, lung, gastrointestinal tract, or skin.

Although tachycardia, heart murmur and congestive heart failure are common features of candida myocarditis, none of those are specific for it (1). Furthermore, since the sensitivity of a blood culture in invasive candidiasis patients is less than 50% (2), there are presumably more patients with this illness than have been reported.

The authors state that they have no Conflict of Interest (COI).

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References

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2. Clancy CJ, Nguyen MH. Finding the “missing 50%” of invasive candidiasis: how nonculture diagnostics will improve understanding of disease spectrum and transform patient care. *Clin Infect Dis* **56**: 1284-1292, 2013.

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