LETTERS TO THE EDITOR

Candida albicans tenosynovitis of the hand

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A 72-year-old woman presented with painful swelling of the 3rd right and 1st to 4th left hand digits to the rheumatology outpatient clinic. She had been experiencing these symptoms for the last 2 months, and reported no recent fever, skin or nail lesions, increased vaginal discharge, dysuria, cough or any other mucocutaneous, genitourinary or respiratory complaints. She had a well-established diagnosis of systemic lupus erythematosus with secondary Sjögren's syndrome and antiphospholipid antibody syndrome, myasthenia gravis and autoimmune hepatitis. She was severely immunosuppressed due to long term moderate-dose glucocorticoids and immunosuppressants, including one administration of rituximab 1g IV two years earlier that resulted in toxidermia, precluding any additional rituximab courses. At the time, she was under prednisolone 15mg id and monthly IV immunoglobulin 2g/kg with adequate disease control over the previous year. On examination there was tenderness and increased circumference of the 3rd right (Figure 1) and 1st to 4th left fingers and swelling of left hand palm involving the thenar eminence and extending proximally to the wrist. Passive and active mobilization of left wrist and fingers was painful and limited, with semi-flexion con-

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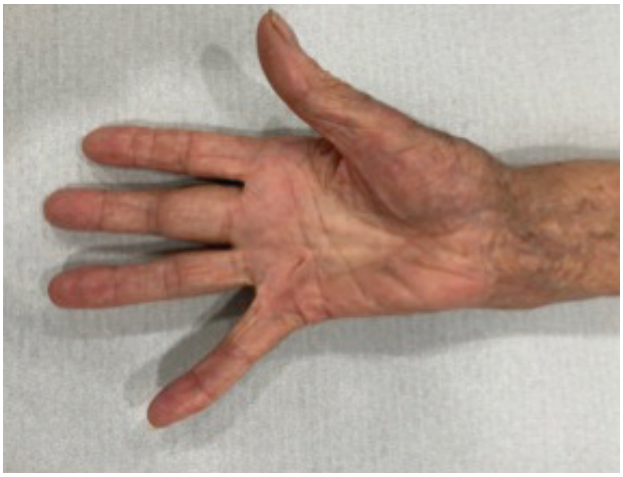

Figure 1. Right hand third digit swelling

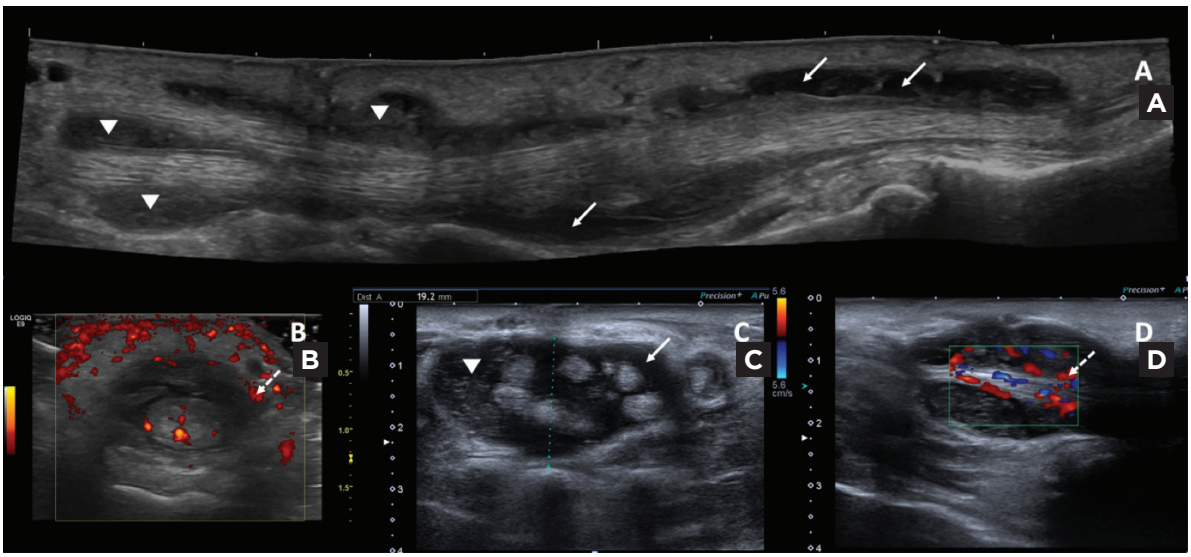

Figure 2. Right hand third digit flexor tenosynovitis with exsudative (anechoic areas) (arrows) and proliferative (hypoechoic areas) (arrowhead) components (A and B), as well as with Doppler sign (B) (dashed arrow); left hand common flexor tenosynovitis (C and D) with Doppler sign (D) (dashed arrow).

tracture. There were neither visible skin or mucosal lesions, nor nail alterations. Blood tests demonstrated mildly raised leukocyte and neutrophil counts (11,200/uL and 10,090/uL, reference 11,500 – 14,500uL and 1,900 – 7,500uL) and moderately raised C-reactive protein (5.33mg/dL, reference < 0.5mg/dL). Hand X-rays were unremarkable. On ultrasound there was exuberant flexor tenosynovitis of the 3rd right and 1st to 4th left fingers and left common flexor tendon sheet (Figure 2), About 2cc of brownish fluid were obtained by ultrasound-guided needle aspiration of the common flexor synovial sheet. Direct exam of the sample revealed many polymorphonuclear cells and cultural exam grew *Candida albicans*. Blood cultures were negative for both aerobic and anaerobic bacteria, fungi and mycobacteria. Treatment with oral fluconazole 400mg id was initiated with an 800mg loading dose, with total resolution of the complaints after 8 weeks of treatment, after which the antifungal was stopped with no recurrence of symptoms over the following 11 months.

Candida albicans is a rare cause of infectious tenosynovitis, with only 5 cases reported in the literature to date, all described in hand tendon sheets unilaterally[1-5]. Only one patient was non-immunocompromised, but had received multiple local steroid injections for median nerve entrapment previously to the disease onset[2]. This is the first case reporting bilateral tenosynovitis of the hand, highlighting the possible the role of concealed hematogenous spread of opportunistic microorganisms in atypical clinical manifestations in immunocompromised patients.

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