Special Grand Rounds

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History of presenting illness

Patient is a 74 year old male, known diabetic and hypertensive presented with chief complaints of –

- Toothache on right side for 20 days
- Pain and swelling over right cheek.
- Right periorbital pain and swelling.
- Drooping of right eyelid.
- Loss of vision in right eye.

1 week

History of presenting illness

Toothache on right side –

- Started 20 days back
- Acute in onset
- Dull aching ,continuous
- More in right upper jaw
- Tooth extraction was done 3 days after the onset of pain.
- Thereafter a continuous dull aching pain radiating to temporo-mandibular joint sets in with ulcers on right buccal mucosa and hard palate.

History of presenting illness

Pain and swelling over right cheek.

- Noticed ten days after tooth extraction.
- Acute onset.
- Throbbing
- Continuous.
- Swelling associated with mild redness and tenderness

History of presenting illness

Right periorbital pain and swelling.

- Developed following pain and swelling in cheek on next day.
- Acute onset periorbital and retro-orbital throbbing continuous pain.
- Swelling and mild redness of right eye, which was progressive in nature.
- Moderate protrusion of right eye.

History of presenting illness

Drooping of right eyelid and loss of vision in right eye –

- Followed periorbital pain and swelling.
- Acute onset
- Initially diplopia followed by drooping of eyelid, and blurring of vision
- In the next few hours it progressed to complete loss of vision in right eye.
- Mild redness and chemosis of right eye.

Past history

- Recovered from covid -19 two days back
- Moderate disease
- Required hospitalisation and steroids (dexamethasone for 9 days)
- No H/O oxygen support.
- H/O diabetes for 2 months on OHA's – metformin 500 mg OD.
- H/O Hypertension for 5 years on telmisartan 40 mg OD.

Past history

- History of covid vaccination – covishield 1st dose on 11th april 2021.
- No history of second dose of vaccination.

Examination

- Vitals – normal
- Examination –

  GCS- 15/15

  No meningeal signs

  Right maxillary sinus tenderness

  Ulcers on right buccal mucosa

  Necrosis of palate mucosa on right side

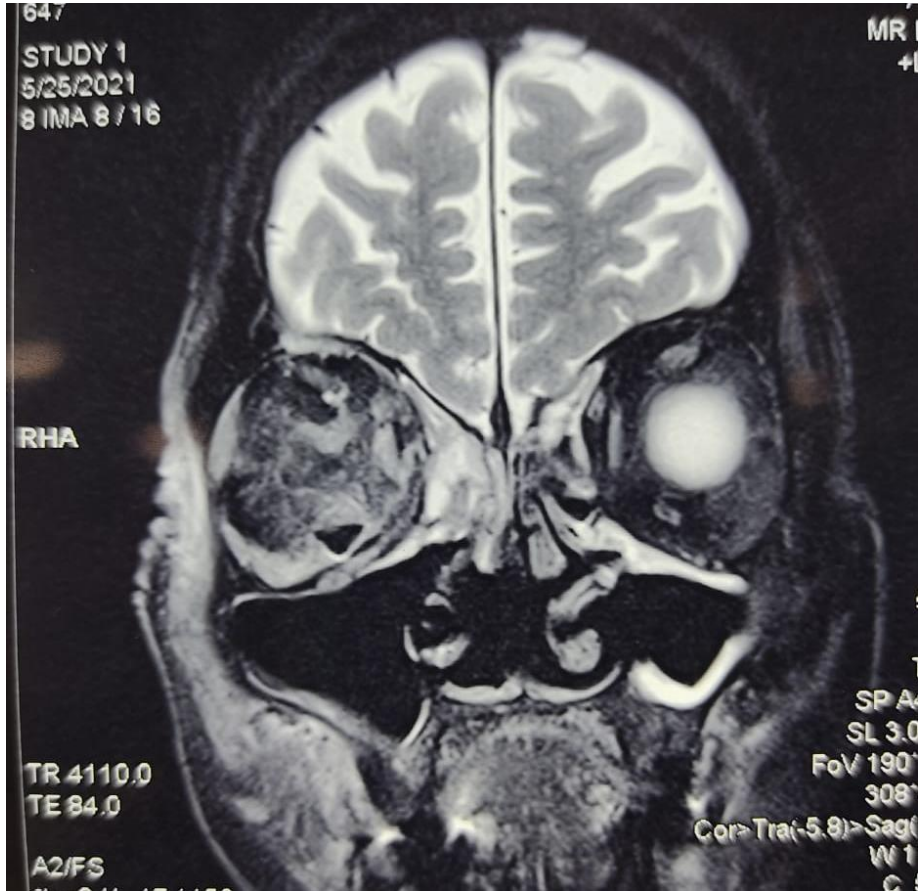
Examination

- Right eye –
  - Complete ptosis
  - proptosis
  - No PL
  - Hazy cornea
  - Pupil Normal in shape and sluggish reacting to light
  - All EOM restricted
  - Fundus – normal
- Left eye – normal
- HMF/Motor/Sensory/Cerebellar examination - normal
- DNE shows – black necrotic tisssue/ eschar – suggestive of mucormycosis

LABS -

- Routine lab investigations – normal
- RBS – 214.5mg/dl
- Hba1c – 13.2
- No ketoacidosis
- ESR – 16mm/hr
- CRP – 54.9 mg/L
- Nasal biopsy was sent for KOH examination – broad aseptate hyaline fungal hyphae branching at right angles were seen –suggestive of mucormycosis

IMAGING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5/25/2021
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RHA
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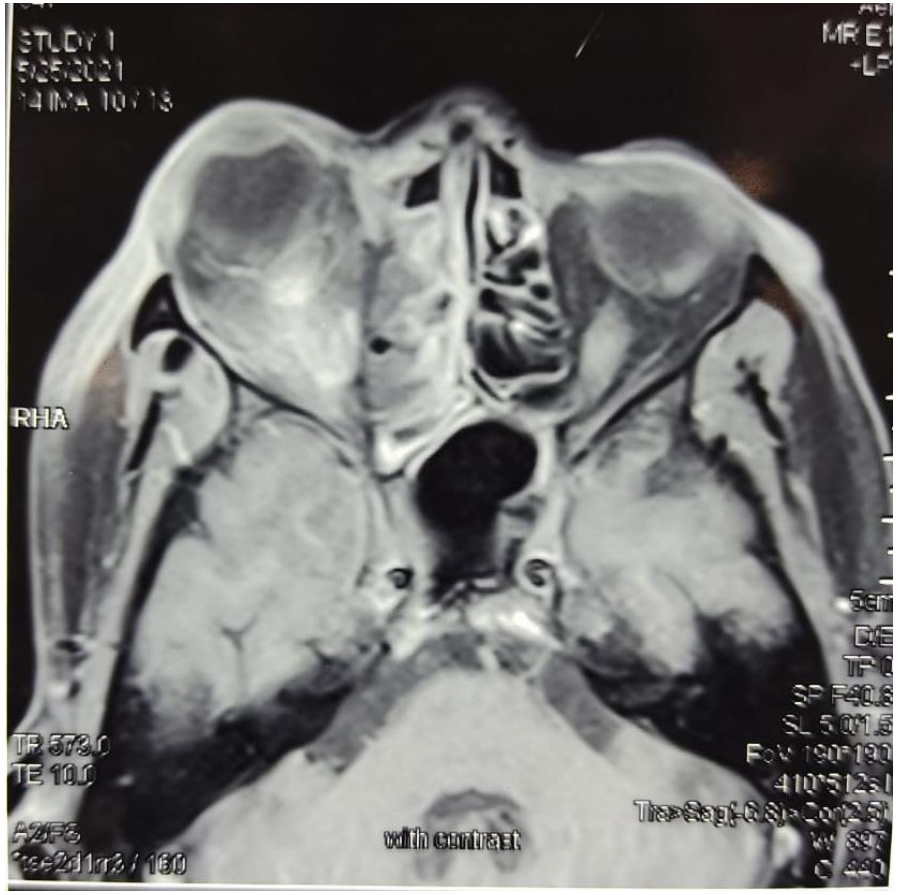
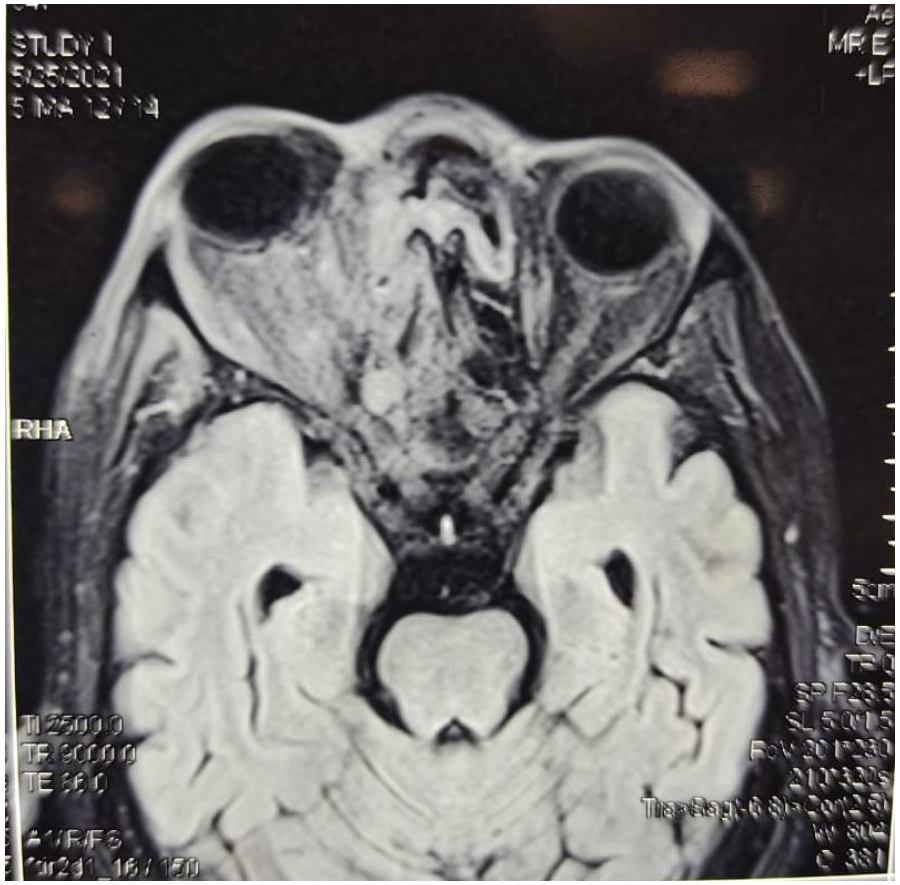
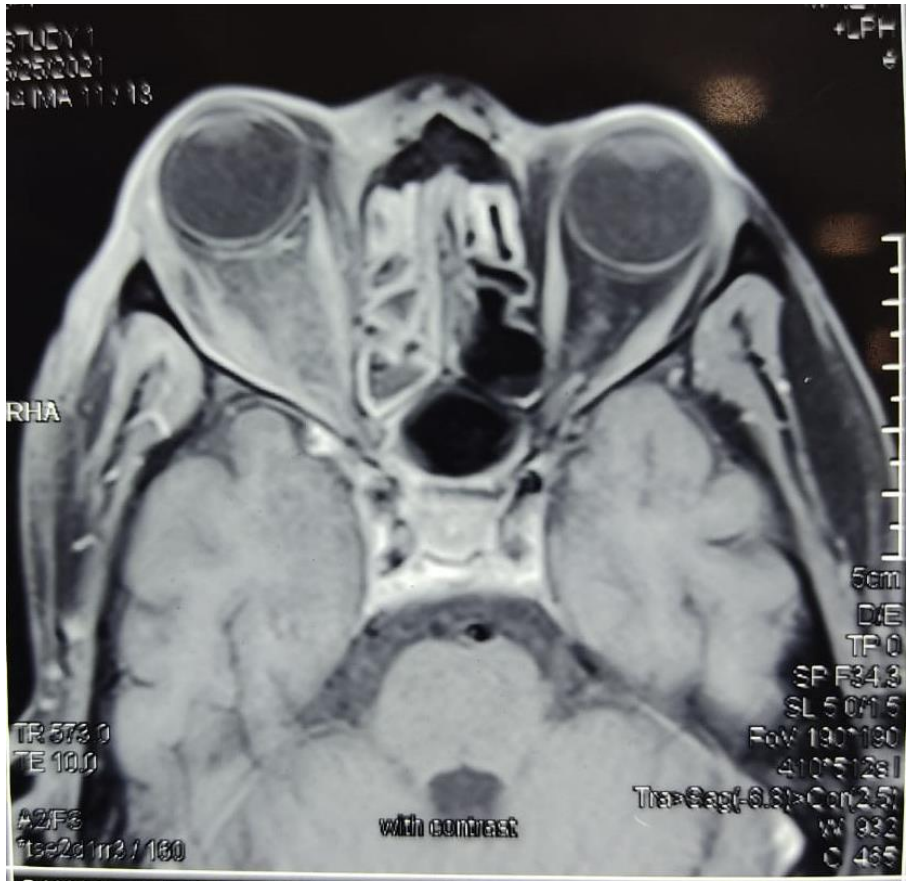
TE 84.0
A2/FS


STUDY 1
RHA
TR 572.0
TE 10.0
A2/FS
with contrast

IMAGING





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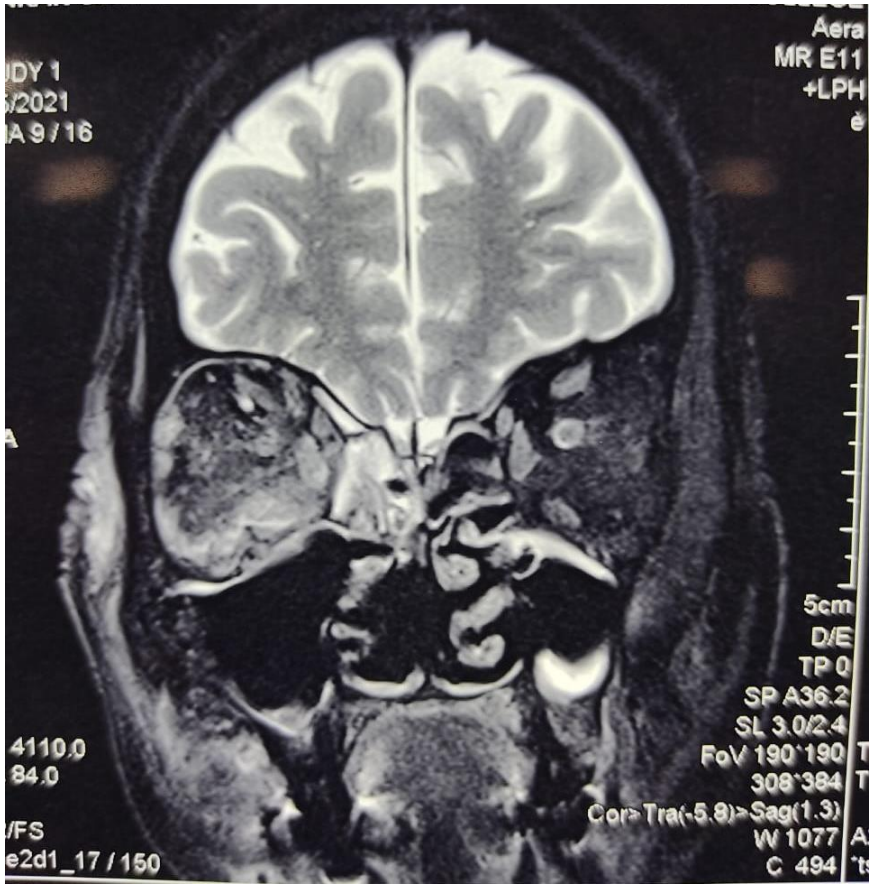
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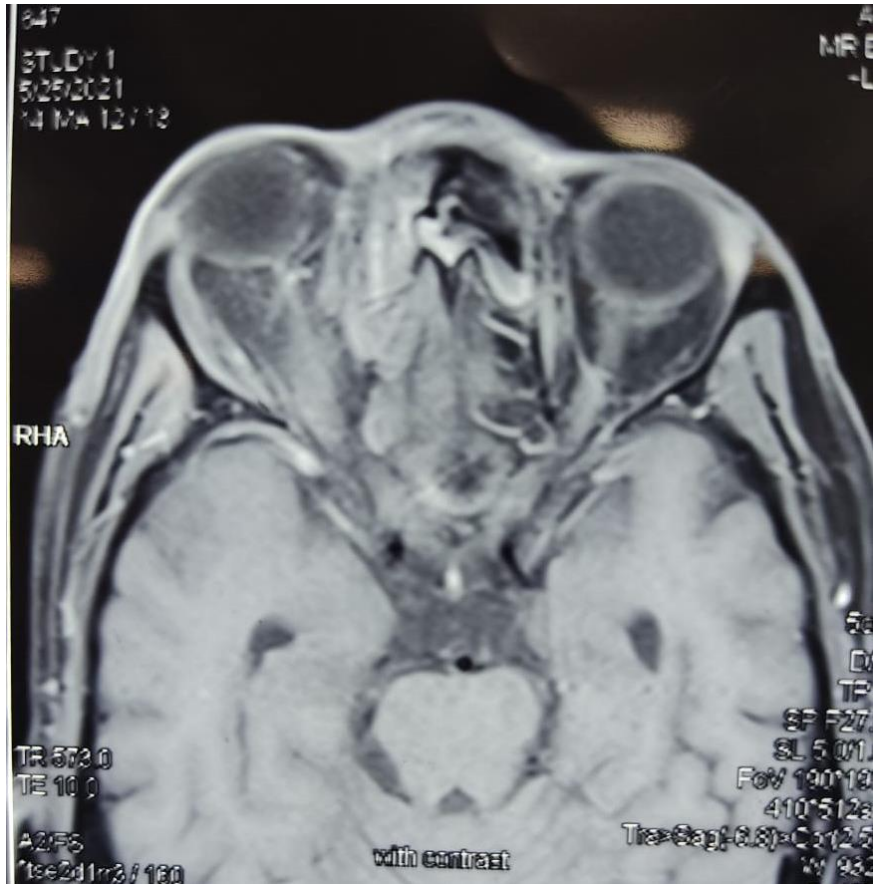
RHA
with contrast

Clinical course

- Liposomal Amphotericin B was started and continued till date (5mg/kg body weight)
- Retrobulbar liposomal Amphotericin B was given.

CLINICAL COURSE

- On fourth day of admission, patient underwent FESS – surgical debridement of frontal and maxillary sinus with antrum and medial wall of the orbital plate was done.
- 2 days after surgery, nasal pack was removed
- Inj liposomal amphotericin B was continued.
- Peribulbar swelling subsided along with the pain.
- Inj vancomycin, meropenem and metrogyl was also started with dental and ENT consultation.
- Patient is improving and has a stable clinical course
- Final diagnosis – **Rhino-orbital Mucormycosis**

THANK YOU