CLINICAL PRACTICE

Clinical Images

Palatal Mucormycosis

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A 75-year-old man with refractory acute lymphoblastic leukemia was hospitalized for dyspnea, hypotension, and neutropenia ($<0.10 \times 10^9/L$). Four weeks earlier, he initiated treatment with inotuzumab ozogamicin (an anti-CD22 antibody-drug conjugate). Home medications included prophylactic voriconazole, acyclovir, and trimethoprim-sulfamethoxazole. Computed tomography of the chest showed scattered pulmonary masses up to 3 cm in diameter. Bacterial and fungal cultures from blood and bronchoalveolar lavage were sterile. His condition improved with vanco-

mycin, cefepime, and isavuconazole. On hospital day 16, he reported mouth pain. Examination revealed bilateral maxillary sinus tenderness and an ulcerative hard palate lesion with necrosis (Fig. 1 panel a). Absolute neutrophil count was $0.02 \times 10^9/L$. Magnetic resonance imaging showed diffuse paranasal sinus mucosal thickening (Fig. 1 panel b). Palatal biopsy and culture confirmed angioinvasive mucormycosis. Rhino-orbital-cerebral mucormycosis develops following the inhalation of fungal spores by an immunocompromised host. Palatal mucormycosis reflects tissue invasion from paranasal sinus infection and is a sign of aggressive disease portending a poor prognosis.^{1,2} Palatal ulceration, necrosis, and perforation can result.² Treatment for rhino-orbital-cerebral mucormycosis (with or without palatal invasion) is intravenous antifungal therapy and surgical debridement.³ Resection was too morbid given the poor prognosis of his refractory leukemia. Amphotericin B and caspofungin were administered without improvement. The patient died 1 week later.

Fig. 1 a Photograph of the patient's hard palate showing an ulcerative lesion with necrotic eschar (white arrows) and sloughing necrotic mucosa (black arrows). b Magnetic resonance imaging showing diffuse paranasal sinus mucosal thickening, most prominent on the right (arrowhead).

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Compliance with Ethical Standards:

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