

Images in Infectious Diseases

Paracoccidioidomycosis: An uncommon cause of discitis in lupus

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A 41-year-old woman with systemic lupus erythematosus (SLE) presented to the outpatient department with progressive 3-month interscapular pain that was refractory to analgesics. The patient's medications included azathioprine 50 mg, hydroxychloroquine 400 mg, and prednisone 5 mg daily. She reported a weight loss of 7 kg in the previous 2 months but denied experiencing fever or any history of trauma. She lived in a rural area and worked in the agricultural sector. Thoracic spinal radiographs obtained during the initial assessment revealed T7 vertebral collapse and diffuse nodular pulmonary opacities. The patient was hospitalized; chest computed tomography (CT) revealed the presence of diffuse micronodular disease (Figure 1) and vertebral collapse associated with signs of spondylodiscitis at T6–T7 and T7–T8, which were confirmed by magnetic resonance imaging (Figures 2 and 3). A T8 paravertebral computed tomography-guided biopsy confirmed the presence of *Paracoccidioides* spp. The patient was treated with itraconazole 100 mg daily for 3 months, resulting in the complete resolution of infection and a good outcome.

Active disease and immunosuppressive therapy are risk factors for infection in patients with SLE¹. Invasive fungal infections usually occur in immunocompromised hosts, with the most common pathogens in SLE patients being *Candida albicans*, *Cryptococcus neoformans*, and *Aspergillus* spp.^{2,3}. Osteoarticular involvement in paracoccidioidomycosis is unusual, mainly affecting the bones of the chest wall (ribs, sternum, scapula, and acromion). Discitis-osteomyelitis, particularly when caused by fungi, is a rare infection⁴. To our knowledge, only two patients with vertebral body paracoccidioidomycosis have been reported in the literature⁵.

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FIGURE 1: Chest computed tomography, with the axial pulmonary window showing multiple randomly distributed pulmonary micronodules (arrows) in both lungs.



FIGURE 2: Magnetic resonance imaging. Sagittal T2 short tau inversion recovery showing the hyperintensity of the T6–T7 intervertebral disk and the absence of the internuclear cleft. Hyperintensity of the adjacent vertebral bodies was also observed. The lesion posteriorly compressed the dural sac and the spinal cord (arrow).



FIGURE 3: Magnetic resonance imaging. Sagittal contrast-enhanced T1-weighted fat-suppressed MR weighted image of the thoracic spine showing paravertebral collections with peripheral enhancement, enhancement of the T6 and T8 vertebral bodies (arrow), a necrotic collapsed T7 vertebral body, and a posterior epidural mass with peripheral enhancement at the T4–T7 levels, suggesting epidural abscess. An anterior epidural collection at the T7 level combined with angular kyphosis resulted in spinal cord compression (arrow).

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