Case report

Cryptococcal sacroiliitis

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SUMMARY Disseminated cryptococcal disease is known to occur in patients with altered immune status. We have reported an unusual case of cryptococcal disease manifested solely by sacroiliitis, which occurred in a patient on chronic steroid therapy for autoimmune haemolytic anaemia. This case stresses the importance of considering unusual organisms as a cause of sepsis in patients with altered immune status.

Key words: infectious arthritis, mycoses, antifungal agents.

A 26-year-old woman born in Australia (of Asian descent) had been maintained on prednisolone 10 mg per day for the treatment of a severe idiopathic Coombs-positive haemolytic anaemia. Twenty months later she presented with a four-week history of severe left sacroiliac pain which was worse at night.

Examination revealed temperature 37.6°C, pulse 88/min, blood pressure 130/80 mmHg, and marked localised tenderness over the left sacroiliac joint. The ESR was 31 mm/h (Westergren), Hb 12.1 g/dl, leucocytes $8.1 \times 10^9/l$ (polymorphonuclear $6.48 \times 10^9/l$, lymphocytes $0.72 \times 10^9/l$), and platelets $133 \times 10^9/l$. X-rays revealed diffuse erosion of the lower half of the left sacroiliac joint. A 99m technetium bone scan was strongly positive in the region of the left sacroiliac joint and adjacent ilium.

Purulent fluid obtained at operation grew *Cryptococcus neoformans*. Subsequent lumbar puncture was normal; in particular cryptococcal antigen was not detected and no organisms isolated. Chest x-ray was normal. The patient was anergic to delayed hypersensitivity skin testing with multiple antigens.

A six-week course of combined intravenous amphotericin B (total dose 0.65 g) and oral 5-fluorocytosine was instituted.¹ A mild febrile reaction and nausea complicated the amphotericin treatment, and transient thrombocytopenia ($47 \times 10^9/l$) attributed to 5-fluorocytosine² occurred. At cessa-

tion of treatment a bone scan revealed significantly less isotope uptake. The patient remains well three months after cessation of therapy.

Discussion

The commonest infecting organism in septic sacroiliitis is *Staphylococcus aureus*,³ and more recently there have been increasing reports of *Pseudomonas aeruginosa* sacroiliitis associated with intravenous drug abuse.⁴

The yeast genus *Cryptococcus* has only one pathogenic species *C. neoformans*, which is widespread in nature, particularly in soil and bird droppings. It has also been identified in man, in the respiratory and gastrointestinal tracts and as a saprophyte on skin.⁵

Bone disease is an uncommon presentation of cryptococcal infection and is usually associated with evidence of disseminated infection.⁶ It is likely that the initial infection was in the metaphyseal region of the ilium with spread to the sacroiliac joint.⁷ A significant number of patients with cryptococcal infection have compromised host defence mechanisms, as is demonstrated in this case by the lymphopenia and absolute cutaneous anergy.^{2,8,9}

Corticosteroids are known to be associated with an abnormal response to cutaneous stimulation. However, it was thought that the underlying autoimmune disease in this patient was itself a significant contributory factor.

References

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