A patient around 70 years of age with a history of relapsed acute myeloid leukemia and previously treated pulmonary aspergillosis receiving voriconazole prophylaxis was admitted for initiation of induction therapy before proceeding.
with allogeneic stem cell transplantation. Because of drug interactions and QTc prolongation, voriconazole was transitioned to isavuconazole prophylaxis on admission. On day 13 of chemotherapy, the patient became hypotensive and febrile to 38.5°C, and acute left eye and facial pain with sinus congestion developed. Pancytopenia and profound neutropenia were present. Computed tomography scan of the sinuses revealed near-total opacification of the left maxillary sinus.

Emergent surgical débridement by an otorhinolaryngologist revealed necrotic tissue in the middle meatus extending into the middle turbinate and nasal septum (Figure 1A). Despite transient improvement postoperatively, rapidly progressive left eye ptosis, headache, and generalized malaise developed. Magnetic resonance imaging of the orbits revealed pansinus mucosal thickening with an air-fluid level in the left maxillary sinus with extra-axial thickening and intracranial and intracraniel extension (Figure 1B). Intraoperative pathologic examination demonstrated fungi with septate hyphal fragments invading the sinus tissue (magnification ×200). B, Hematoxylin and eosin stain, high power, showing many round spiculated conidia of Scopulariopsis (black arrows) and oblong conidia of Fusarium (red arrow; magnification ×400).

Scopulariopsis, and Fusarium spp due to the variety of fungal shapes visualized (Figure 2). Intraoperative fungal cultures grew Fusarium sp and Scopulariopsis sp.

The culture and histopathologic evaluation established the diagnosis of invasive rhino-orbital fusariosis involving the left maxillary sinus with associated meningitis. Scopulariopsis was determined to be nonpathogenic. The patient was treated with intravenous liposomal amphotericin B 8 mg/kg plus voriconazole as well as intranasal amphotericin B. The case highlights an increasingly noted risk of breakthrough invasive fusariosis despite antimold prophylaxis in immunocompromised hosts.1

POTENTIAL COMPETING INTERESTS
The authors report no competing interests.

ACKNOWLEDGMENTS
We extend a sincere thanks to all our fellow colleagues who participated in the care of this patient. We would like to acknowledge the pathologist involved in this case, Dr Anja Roden; the consulting infectious disease consultant on the case, Dr Enzler; and the radiologist, Dr Robert McDonald.
Correspondence: Address to Audrey N. Schuetz, MD, Laboratory Medicine and Pathology, Mayo Clinic, 200 First St SW, Rochester, MN 55905 (Schuetz.Audrey@mayo.edu).

ORCID
Nischal Ranganath: https://orcid.org/0000-0001-9538-6214; Linda X. Yin: https://orcid.org/0000-0001-8515-2051