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A heart valve visit from *Sarocladium kiliense*: a case of fungal endocarditis

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Background
Blood culture-negative endocarditis remains a major clinical challenge with potentially fatal consequences, due to its intrinsic diagnostic difficulty and the inadequacy of empirical antibiotic treatment.

Case(s) description
In November 2024, a 75-year-old man underwent cardiac surgery consisting of aortic valve replacement as well as replacement of mitral valve prosthesis with new bioprosthesis due to *Staphylococcus epidermidis* endocarditis.

On May 15th, the patient was admitted to our hospital for suspected ischemic stroke. Brain CT revealed cortico-subcortical hypodensity in the left superior temporal and temporoparietal regions, consistent with acute ischemia.

During hospitalization in the Neurology ward, the patient rapidly developed fever, followed by only a slight increase in C-reactive protein(30 mg/L). Due to suspicion of endocarditis, antimicrobial therapy with ceftriaxone 2 g/day and daptomycin(10 mg/kg,850 mg/day) was initiated. Transesophageal echocardiography showed severe degeneration of the prosthetic aortic valve, with diffuse leaflet thickening and a hyperechoic nodular lesion on the right coronary cusp(Figure 1). Chest and abdominal CT scans showed bilateral renal emboli and early pleural effusion.

Repeated blood cultures tested negative. Serologic testing for *Brucella*, *Bartonella*, *Legionella*, *M.pneumoniae* and *C.burnetii* was negative, as was screening for autoimmune disease.

The patient's clinical condition progressively worsened. On May 27th, he developed acute right lower abdominal and groin pain associated with cold extremities. CT angiography revealed complete thrombotic occlusion of the right common iliac artery. Urgent iliac revascularization was performed.

Extended-incubation blood cultures(up to 162 hours), as well as culture of the thrombus, yielded *Sarocladium kiliense*(Figures 2,3). Serum β-D-glucan tested positive in two separate samples. Antifungal therapy with liposomal amphotericin B was initiated.

After multidisciplinary discussion with the cardiac surgery team, the patient was deemed not eligible for elective surgical procedure due to multiple comorbidities and poor prognosis. Antifungal therapy was discontinued and the patient was transferred to a hospice, where he died on June 24th.

Discussion
To date, this is the third case of endocarditis due to *S.kiliense* reported in literature[1,2]. When typical cause of endocarditis and differential diagnosis are excluded, fungal endocarditis should be ruled out with proper microbiological testing, even in immunocompetent patients.

Figure 1. Aortic vegetation on the right coronary cusp.

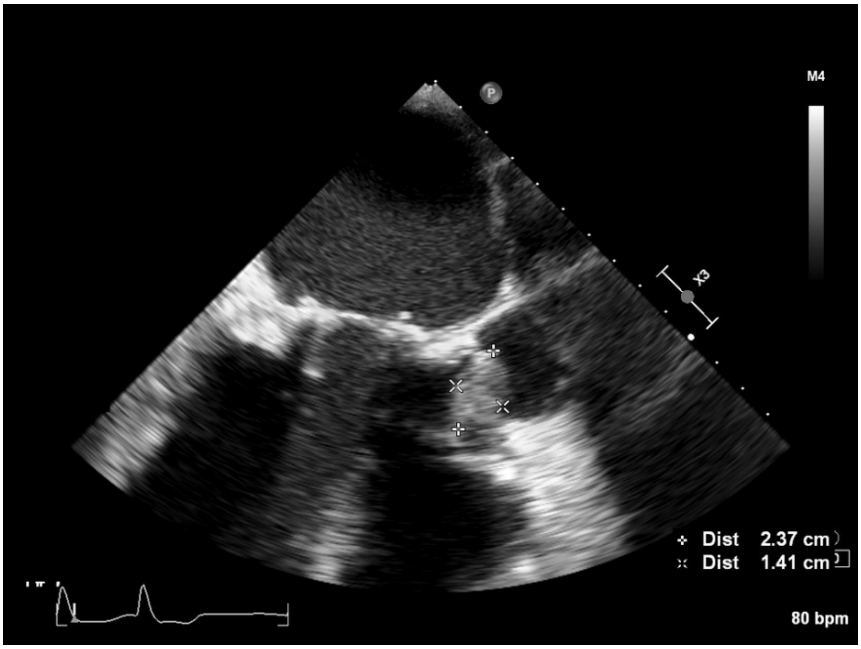

Figure 2. Sarocladium Kiliense colonies on culture medium

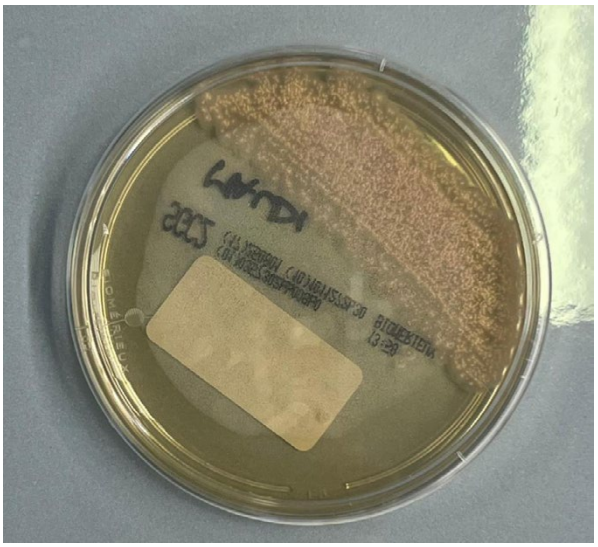

Figure 3. Antifungal susceptibility testing for S. kiliense. Legend MIC=minimum inhibitory concentration (mg/L).

	MIC
Amphotericin B	8
Voriconazole	1
Posaconazole	2
Isavuconazole	4
Itraconazole	>16

References
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Severe pulmonary and disseminated histoplasmosis in HIV-positive and HIV-negative patients in Mexico: a nine-case series from a tertiary referral centre

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Background
Histoplasmosis remains an important endemic mycosis in Mexico, affecting both immunocompromised and immunocompetent individuals. Severe pulmonary involvement is frequently under-recognised, particularly in patients without HIV infection. We describe nine confirmed cases with pulmonary and/or disseminated disease, highlighting epidemiological patterns, diagnostic performance and clinical outcomes.

Case(s) description
We conducted a descriptive case series of adult and paediatric patients diagnosed with histoplasmosis between March 2025 – November 2025 at a tertiary referral centre in Mexico. Inclusion required confirmed histoplasmosis by antigen detection, fungal culture or compatible histopathology. Demographic data, epidemiological exposures, immunological status, diagnostic methods, treatment and outcomes were obtained from medical records.

Of the nine patients included, the mean age was of 37.2 years (range 2–69); 77% were male. Patients originated from multiple endemic regions including Estado de México, Guerrero, Veracruz, Puebla and Hidalgo. Epidemiological exposure—contact with birds, caves, bats or similar environments—was documented in 77% cases. 44% of patients had HIV infection, all with advanced immunosuppression (CD4 7–194 cells/µL, all <250). Among the patients without HIV, only one had diabetes; the remaining had no identifiable immunosuppressive condition. All patients had pulmonary involvement, and 33% developed disseminated disease. Presentation was severe: 66% of patients arrived in septic shock and 44% required invasive mechanical ventilation. Coagulopathy occurred in one case. Antigen testing was positive in 77% patients, fungal cultures were positive in 77% of patients, with concordance of both methods in 55%. All patients received amphotericin B: deoxycholate in 44% and liposomal amphotericin B in 55%. Only one patient died during follow-up (11% mortality).