
SUCCESSFUL POSACONAZOLE TREATMENT OF CHRONIC ESOPHAGEAL CANDIDIASIS WITH ESOPHAGEAL STRICTURE DUE TO *CANDIDA GLABRATA* AND *CANDIDA ALBICANS*: A CASE REPORT

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Purpose: Patients with chronic mucocutaneous candidiasis (CMC), a primary immunodeficiency disorder, suffer from persistent and/or recurrent candidiasis of the skin, nails, and mucous membranes that can significantly impact their quality of life. Although the most common cause of these infections is *Candida albicans*, azole-resistant *C albicans* species and non-*albicans Candida* species are becoming more prevalent as causes of breakthrough infections. Consequently, new antifungal therapies with activity against resistant *Candida* species are needed. Posaconazole is a triazole antifungal with potent in vitro activity against *Candida* species, including non-*albicans Candida* species such as *C glabrata*. This case report describes the successful use of posaconazole oral suspension for the treatment of chronic esophageal candidiasis (EC) with esophageal stricture that was refractory to conventional antifungal therapy.

Clinical problem: A 40-year-old white woman with a history of CMC diagnosed at age 7 and histoplasmosis was enrolled in an open-label clinical study of posaconazole after failing sequential treatment with ketoconazole, fluconazole (up to 1200 mg per day), itraconazole, voriconazole, and amphotericin B. She also received terbinafine 250 mg for 2 months; however, this treatment also failed to resolve her EC, which was confirmed on esophagogastroduodenoscopy prior to enrollment into the posaconazole treatment program.

Clinical approach: Posaconazole oral suspension 800 mg/day was administered in divided doses (400 mg bid) as part of an open-label treatment use protocol.

Patient outcome: Baseline isolates from pharyngeal cultures were highly susceptible to posaconazole (minimum inhibitory concentration [MIC]: 1 µg/mL). After 1 month on posaconazole, the subject's esophageal symptoms completely resolved; the only residual evidence of candidiasis was cheilitis. After 60 days of treatment the patient ran out of posaconazole. Subsequently, her symptoms recurred with resumption of severe dysphagia beginning 72 hours after treatment discontinuation. At that time, a pharyngeal culture was obtained and was positive for *C albicans*, but no MIC was obtained. Upon resumption of posaconazole therapy, the EC resolved, but oral plaques and exudates persisted. Five months after posaconazole reinitiation, the plaques had completely resolved but she had persistent exudates on the tongue. Repeat pharyngeal cultures revealed *C glabrata* (posaconazole MIC: >8 mcg/mL) and *C albicans* (posaconazole MIC: 1 mcg/mL). Six months after restarting posaconazole, the patient had a few plaques on her tongue but no pharyngeal exudates and no symptoms of EC. Posaconazole therapy was continued. At seven months, the subject had no signs of thrush. She reported dysphagia from recurrent esophageal stricture, which was managed with esophageal dilation, but no abnormalities suggesting EC were reported. After 12 months of posaconazole therapy, the patient was seen at the clinic with cheilitis, mild dysphagia, and some tongue exudates. There was no evidence of EC and cultures were not repeated. These symptoms remain stable on treatment after 15 months of treatment without evidence of progression. All other symptoms have resolved. Cultures performed to evaluate these persistent findings revealed *C albicans* and *C glabrata*.

Conclusions: In this patient with CMC, posaconazole resulted in rapid and continued treatment of multidrug-resistant EC. Additionally, posaconazole was well tolerated over a relatively long-term of administration (>15 months) and provided adequate relief of symptoms despite a temporary relapse and the emergence of an organism with a higher MIC value than the baseline pathogen. The successful outcome observed in this patient who had failed all other available oral therapies provides clinical evidence for the activity of posaconazole against both *C albicans* and *C glabrata*, and suggests that the efficacy of posaconazole as first-line therapy for patients with chronic or recurrent CMC should be evaluated in a larger patient population.