MOLD CELLULITIS

Mold Exposure + Dermatitis + Cutaneous & Soft Tissue Infection

IN ER

History: Pulling up old flooring? Steroids given?

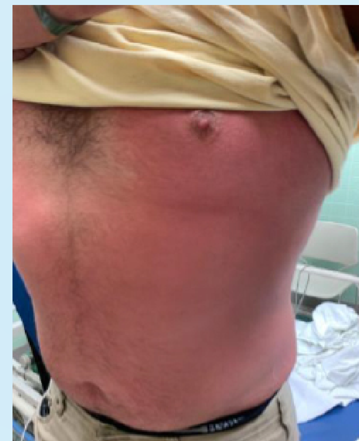
Exam: Erythema, skin induration, weeping pustules, do a fluoresceine

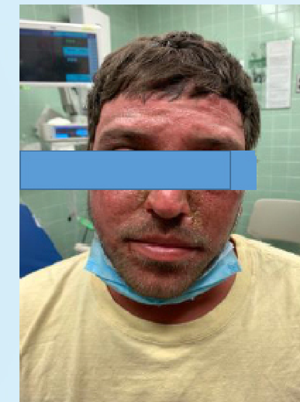
Labs: Galactomannon, beta d-glucan Swab all areas

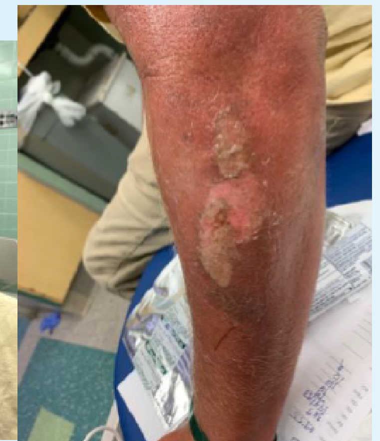
Bedside: Irrigate, clean, baci and non-stick dressings Consider shower table

Surgery: Consider OR with skin subs especially if areas extensive

Background: Mold exposures occur commonly along the Gulf Coast among those pulling up old flooring. Some patients get progressive dermatitis with itching and "burning" pain. Any contaminated body surface can be affected, such as face, eyes, neck, upper trunk, extremities, and genitalia. Symptoms worsen over 3-5 days, during which time skin breakdown, cellulitis, and severe eye symptoms emerge. Corneal ulcers are common on fluoresceine test and ophthalmology exam. ER bounce-backs are common. Disease progression to deep soft tissues occur severe cases, necessitating inpatient care and systemic treatments to stop progression. In our practice, Micafungin resistance has been demonstrated (treatment failures). Penicillium, Cladosporium, aspergillus fumigatus, candida albicans, and nonsporulating molds are commonly cultured.







Admission?

Advanced / Inpatient

- ➔ sick appearance, evidence of bacterial infection or cellulitis, soft tissue swelling, corneal or periorbital edema
- ➔ involves face or genitalia
- ➔ Larger areas e.g. 5% TBSA, making self care untenable

SYSTEMICS

- Voriconazole (6mg/Kg x2 doses, then 4mg/Kg q12)
- Isovuconazole considered for severe cases (ID consult)
- **Vanc & Cefepime** if cellulitic

TOPICAL

- ketoconazole ointment (low cost, and available)
- Aquaphor to closed areas

Outpatient?

Less severe / Discharging

- ➔ able to perform self care, symptoms under control

TOPICAL

- ketoconazole ointment (low cost, and available)
- Aquaphor to closed areas

SYSTEMIC

- ketoconazole 200mg qd x7d total (lower cost, available)
- Bactrim DS x 7 days total (MRSA)