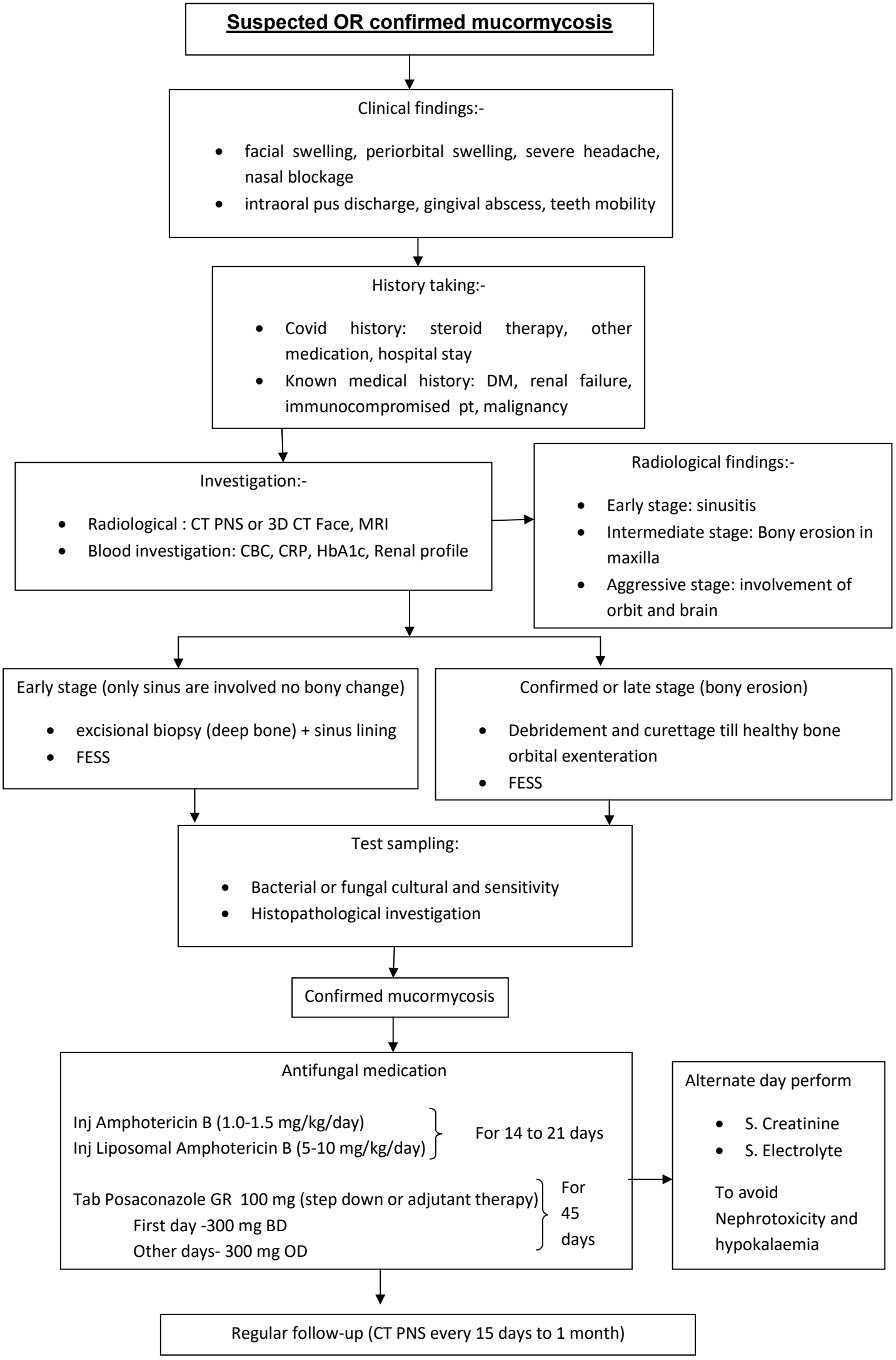
Suspected OR confirmed mucormycosis
Clinical findings:-
facial swelling, periorbital swelling, severe headache, nasal blockage
intraoral pus discharge, gingival abscess, teeth mobility
History taking:-
Covid history: steroid therapy, other medication, hospital stay
Known medical history: DM, renal failure, immunocompromised pt, malignancy
Investigation:-
Radiological : CT PNS or 3D CT Face, MRI
Blood investigation: CBC, CRP, HbA1c, Renal profile
Radiological findings:-
Early stage: sinusitis
Intermediate stage: Bony erosion in maxilla
Aggressive stage: involvement of orbit and brain
Early stage (only sinus are involved no bony change)
excisional biopsy (deep bone) + sinus lining
FESS
Confirmed or late stage (bony erosion)
Debridement and curettage till healthy bone orbital exenteration
FESS
Test sampling:
Bacterial or fungal cultural and sensitivity
Histopathological investigation
Confirmed mucormycosis
Antifungal medication
Inj Amphotericin B (1.0-1.5 mg/kg/day)
Inj Liposomal Amphotericin B (5-10 mg/kg/day)
For 14 to 21 days
Tab Posaconazole GR 100 mg (step down or adjutant therapy)
First day -300 mg BD
Other days- 300 mg OD
For 45 days
Alternate day perform
S. Creatinine
S. Electrolyte
To avoid Nephrotoxicity and hypokalaemia
Regular follow-up (CT PNS every 15 days to 1 month)

Amphotericin B administration protocol

Drugs	Recommended Dose	Duration
Amphotericin B	1.0-1.5 mg/kg/day	14 to 21 days depending on severity
Liposomal Amphotericin B	5-10 mg/kg/day	

Pre-hydration:-

- 500ml Normal saline 2 hr before infusion Amphotericin B
- To reduces the risk of renal toxicity and hypokalaemia :- 500ml Normal Saline + 1 Amp (20mmol) KCL

Hydration:-

- Dilution: 1mg in 10 ml
- Always use 5% or 10% dextrose
- Avoid Normal saline
- 500 mL NS IV given pre infusion
- If fluid overloaded, use 250 mL pre/post or skip post-hydration
- If hyperchloremic, may use normosol instead of NS
- Protect from light during administration