Varón, 61 años, **+5 meses tras trasplante bipulmonar**,

-I**nmunosupresión (cuádruple terapia) + hipo-gammaglobulinemia (CMV: R+D+)**,

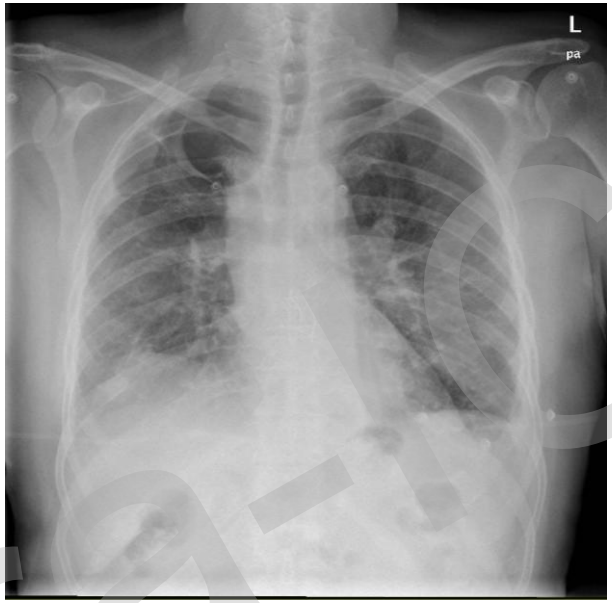
-Peritrasplante:

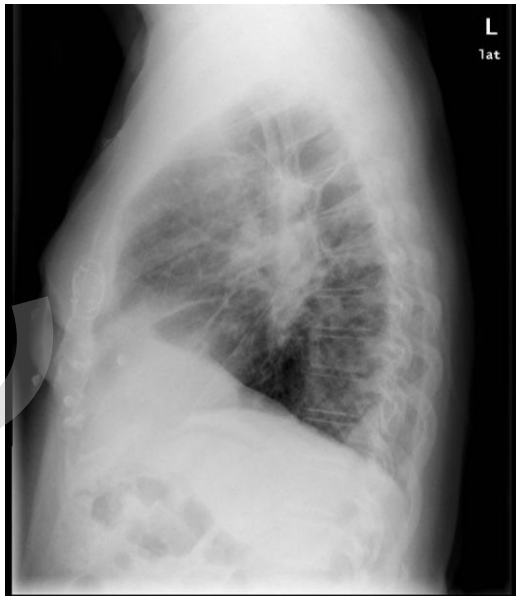
- donante con MRSA
- *K. pneumoniae* oxa-48 (BAS mes +1)

- Virus parainfluenza (nasofaringe: mes +5)

Mes +5: F**iebre**, **reactantes elevados**, **neumonía basal derecha** y **dolor muy intenso en región gemelar tras traumatismo**,

Mes +5



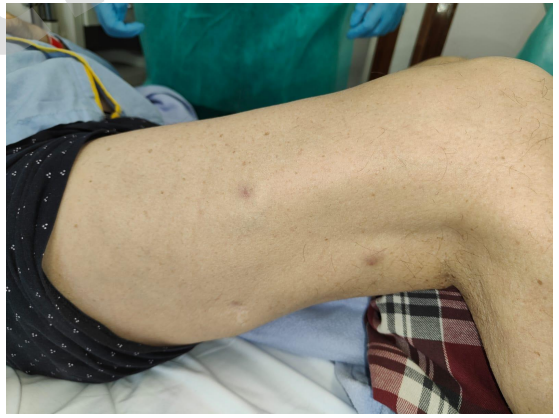


-F**iebre**, **reactantes elevados**, NF parainfluenza

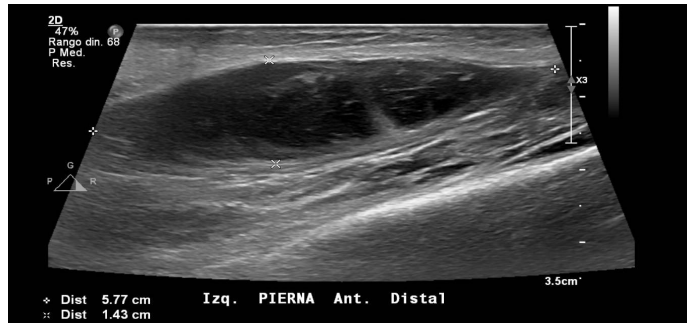
-**Neumonía basal derecha**
- **consolidante,**

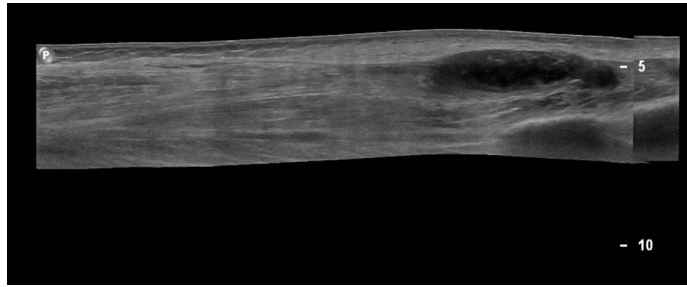
-D**olor muy intenso en región gemelar tras**
-**traumatismo**
- facitis/celulitis miositis

Colección heterogénea intramuscular, probable hematoma por lesión miofascial/miotendinosa, con cambios inflamatorios que en el contexto sugieren sobreinfección y asociando **fascitis/celulitis**. Focos hipoecoicos intramusculares a distancia , posibles focos de **piomiositis a distancia** (diseminación hematógena)



A los pocos días: nódulos subcutáneos, duros y muy dolorosos.





Aspecto	Piomiositis	Fascitis Necrotizante	Gangrena
Definición	Infección bacteriana primaria del músculo esquelético	Infección rápidamente progresiva de fascia y tejido subcutáneo	Muerte tisular por infección o isquemia
Velocidad de progresión	Subaguda (días-semanas)	Muy rápida (horas-días)	Variable; puede ser rápida en forma húmeda/gaseosa
Dolor	Localizado, moderado-intenso	Dolor desproporcionado al examen físico	Dolor variable; puede disminuir si hay necrosis avanzada
Signos cutáneos	Edema leve, piel poco afectada inicialmente	Eritema, ampollas, necrosis cutánea, crepitación	Tejido negro/violáceo, mal olor en gangrena húmeda
Agentes frecuentes	Staphylococcus aureus (incl. MRSA)	Polimicrobiana o Streptococcus pyogenes	Polimicrobiana, Clostridium (gaseosa)
Hemocultivos	Frecuentemente negativos	Frecuentemente positivos en casos graves	Variables según etiología
Imagen (RM/TC)	Abscesos intramusculares	Engrosamiento fascial, gas en tejidos	Gas y necrosis tisular extensa
Tratamiento	Antibióticos + drenaje si absceso	Cirugía urgente + antibióticos IV amplio espectro	Desbridamiento/amputación + antibióticos
Pronóstico en inmunodeprimidos	Mayor riesgo de bacteriemia y multifocalidad	Alta mortalidad, progresión más rápida	Mayor riesgo de sepsis y extensión
Pronóstico en no	Generalmente bueno con	Grave pero mejor si	Depende de rapidez de

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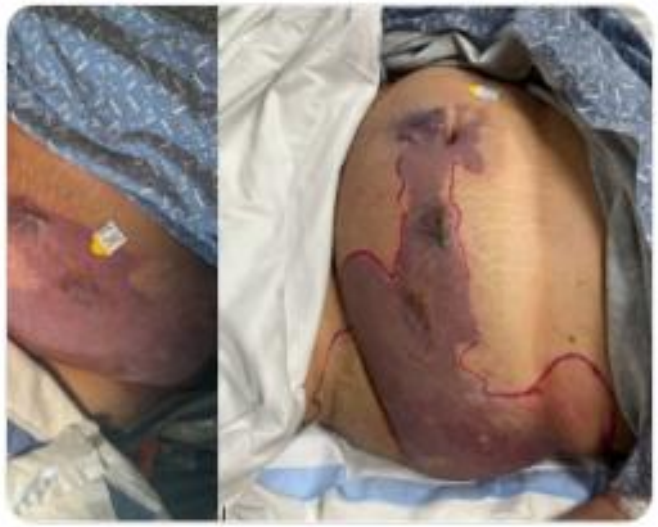
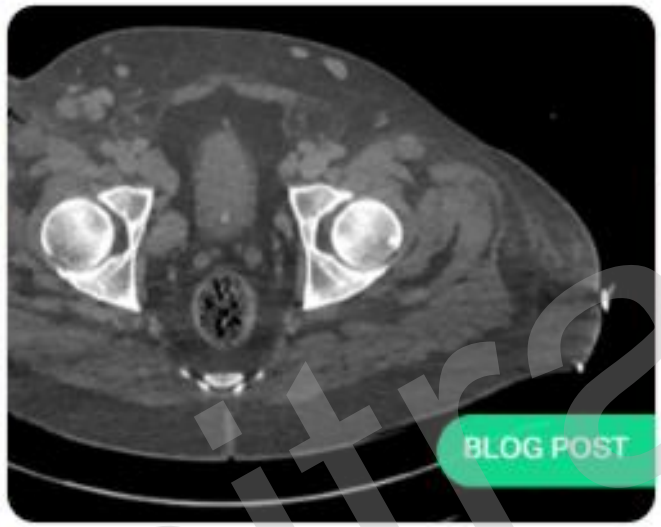
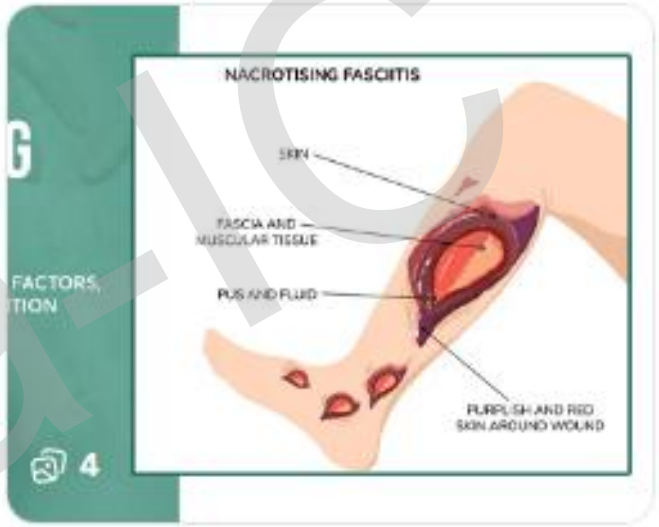
Pronóstico en no	Generalmente bueno con	Grave pero mejor si	Depende de rapidez de

FASCITIS NECROTIZANTE

🔬 Tipo I – Polimicrobiana (la más frecuente)







Características:

- Infección **mixta** (aerobios + anaerobios).
- Representa 70–80% de los casos.
- Más común en pacientes con:
- Diabetes
- Inmunosupresión
- Enfermedad vascular periférica
- Postquirúrgicos

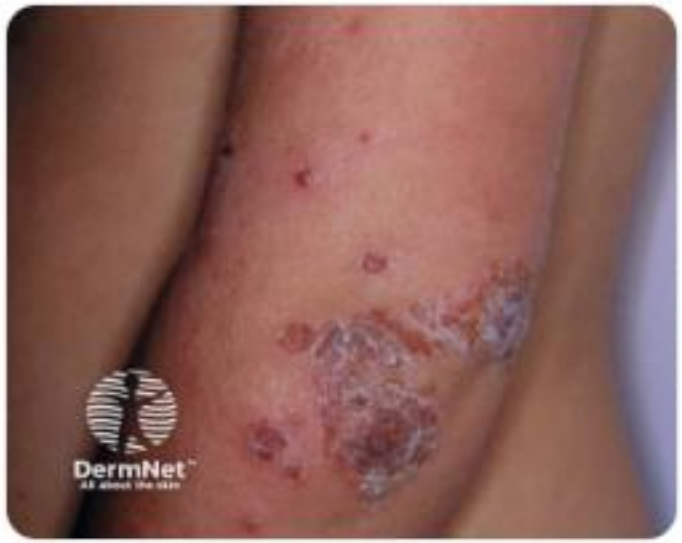
Microorganismos frecuentes:

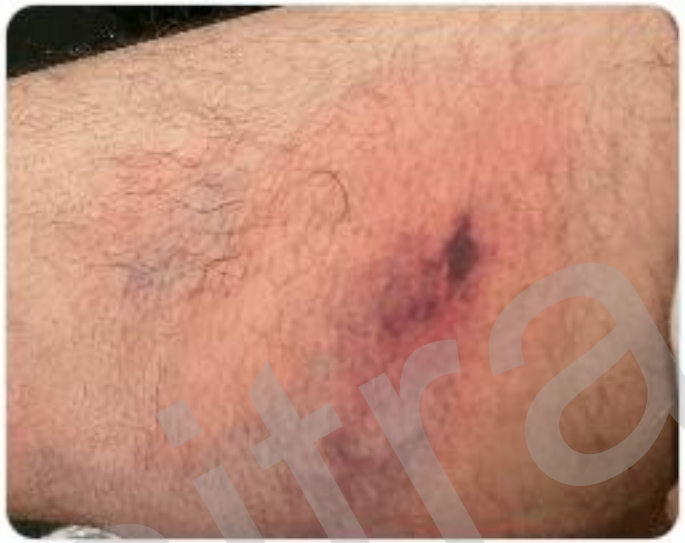
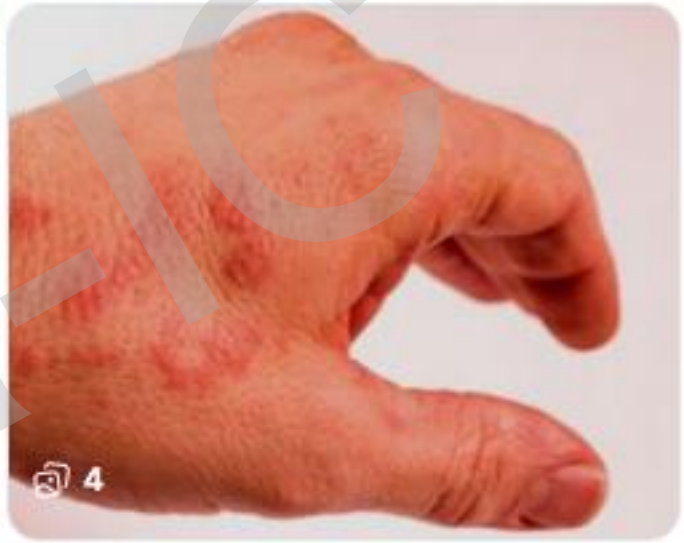
- *Streptococcus* spp.
- *Staphylococcus aureus*
- Enterobacterias (*E. coli*, *Klebsiella*)
- Anaerobios (*Bacteroides*, *Clostridium*)

Localización frecuente: Periné (Gangrena de Fournier), abdomen, extremidades.

FASCITIS NECROTIZANTE

Tipo II – Monomicrobiana (Estreptocócica)



Características:

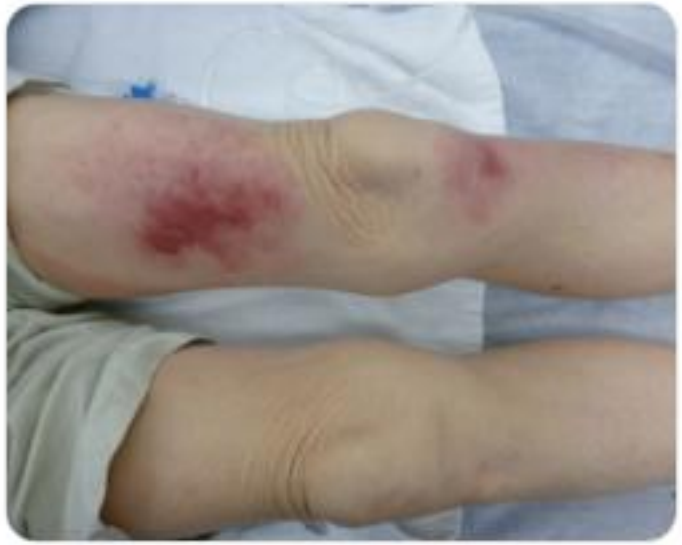
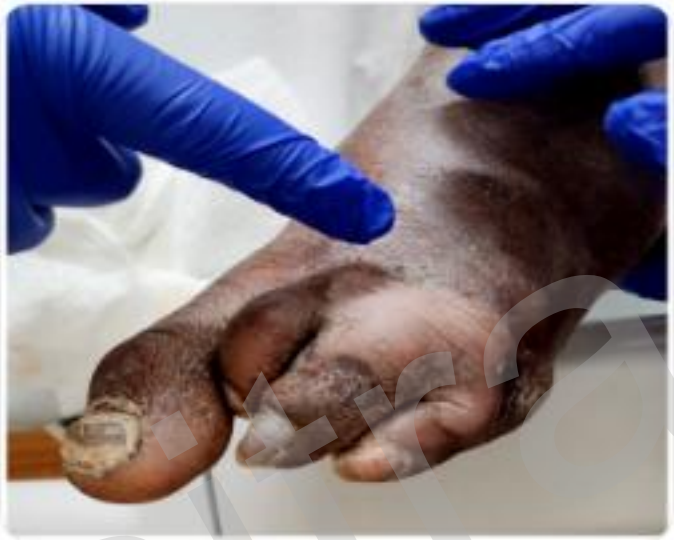
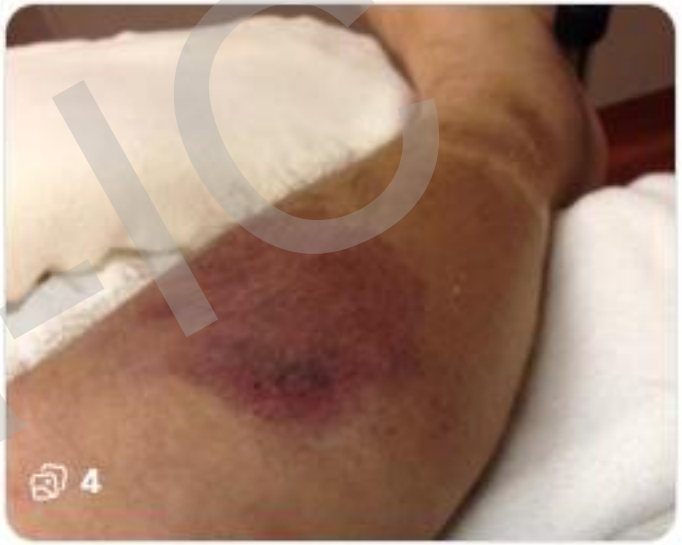
- Causada principalmente por **Streptococcus pyogenes** (estreptococo β-hemolítico del grupo A).
- Puede asociarse a **streptococcal toxic shock syndrome**.
- Puede afectar pacientes previamente sanos.
- Evolución muy rápida.

A veces asociado con:

- *Staphylococcus aureus* (incluyendo MRSA).

FASCITIS NECROTIZANTE

Tipo III – Monomicrobiana por Gram negativos o Clostridial

Causas principales:

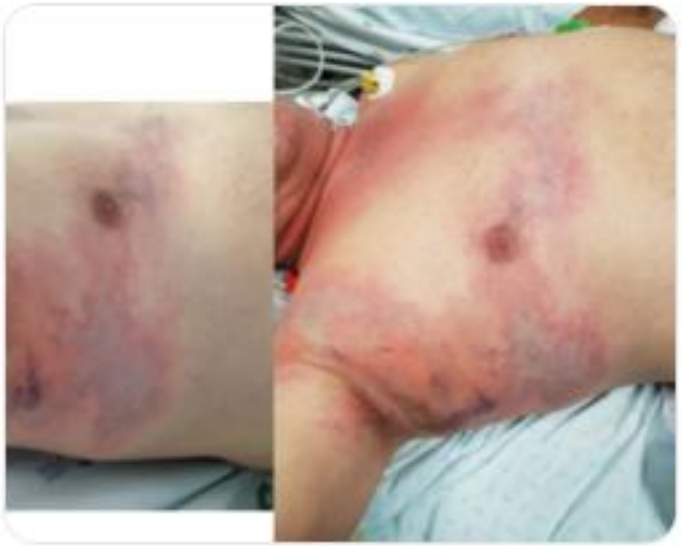
- **Vibrio vulnificus** (exposición a agua salada o mariscos crudos).
- **Clostridium perfringens** (mionecrosis/gangrena gaseosa).

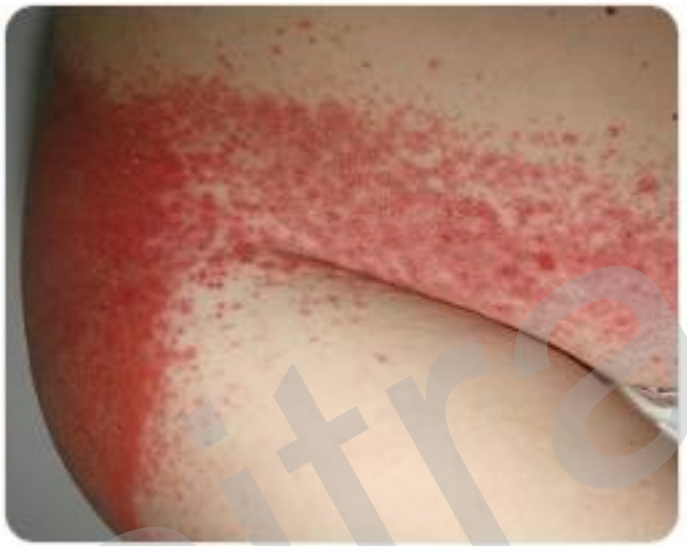
Características:

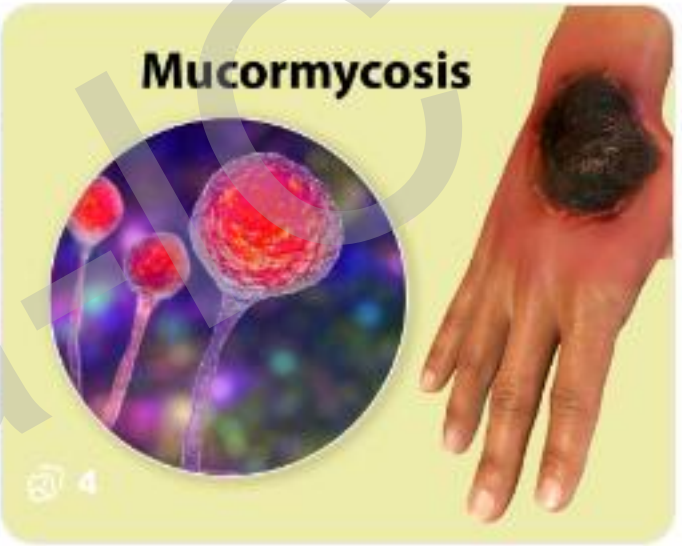
- Progresión extremadamente rápida.
- Ampollas hemorrágicas.
- Alta mortalidad.

FASCITIS NECROTIZANTE

Tipo IV – Fúngica







Agentes causales:

Candida spp.

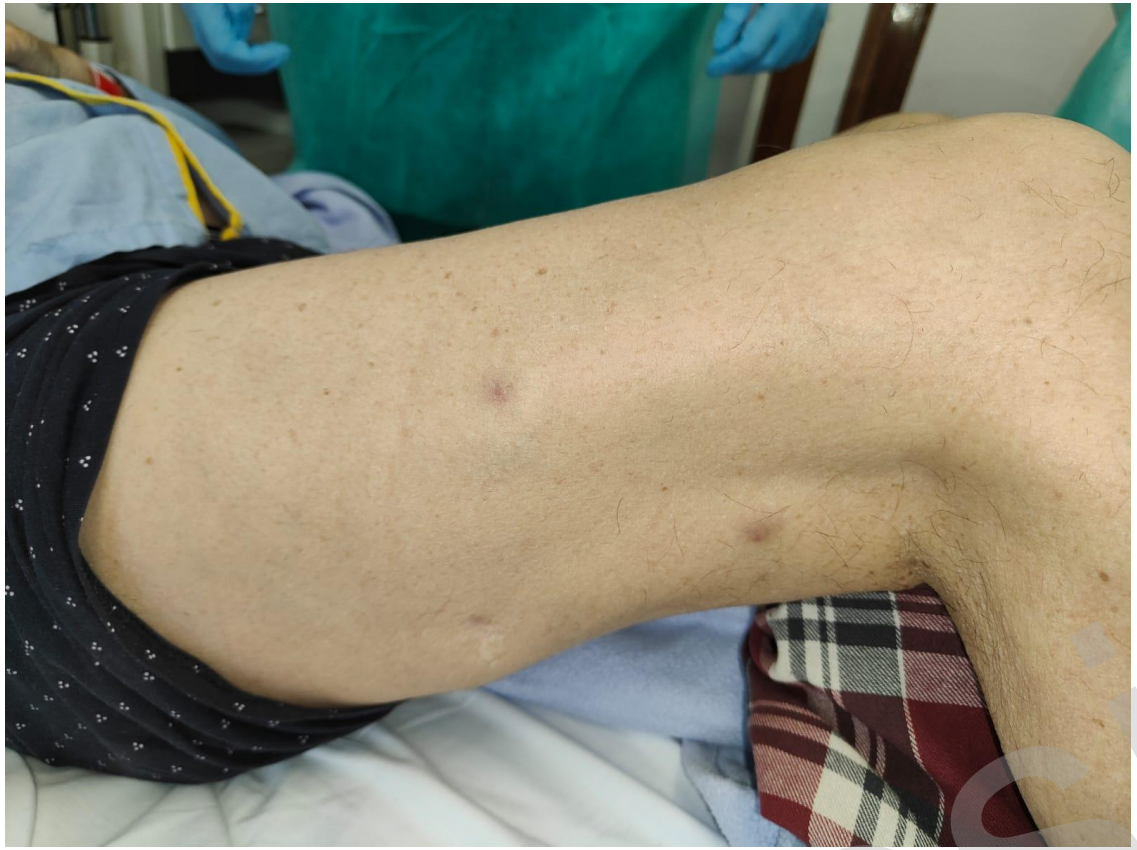
Hongos filamentosos como *Mucor* (mucormicosis cutánea).

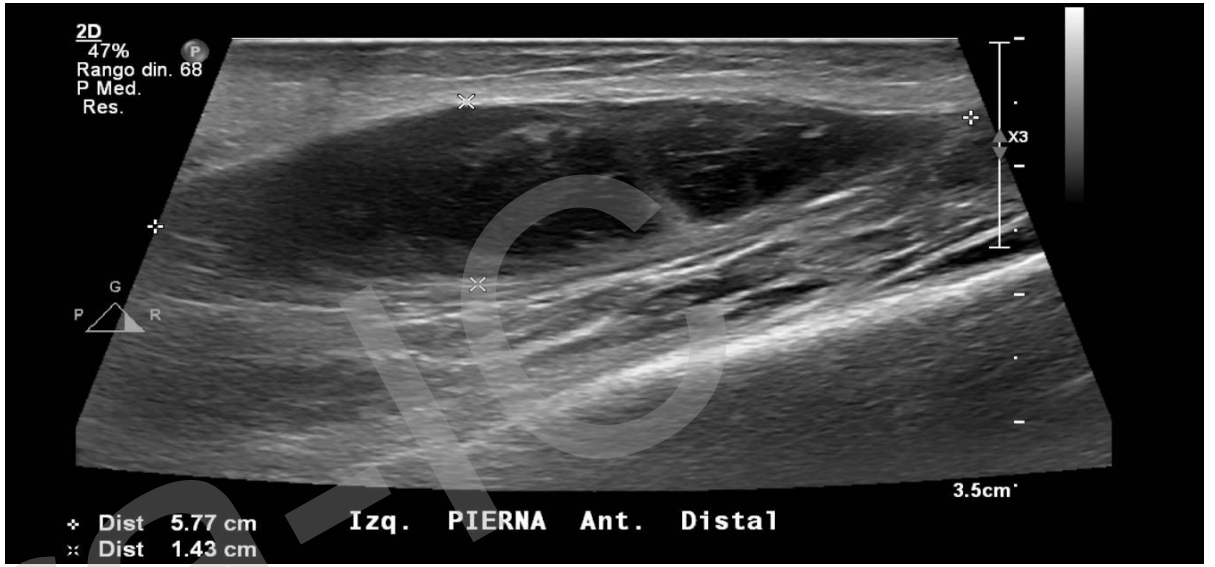
Características:

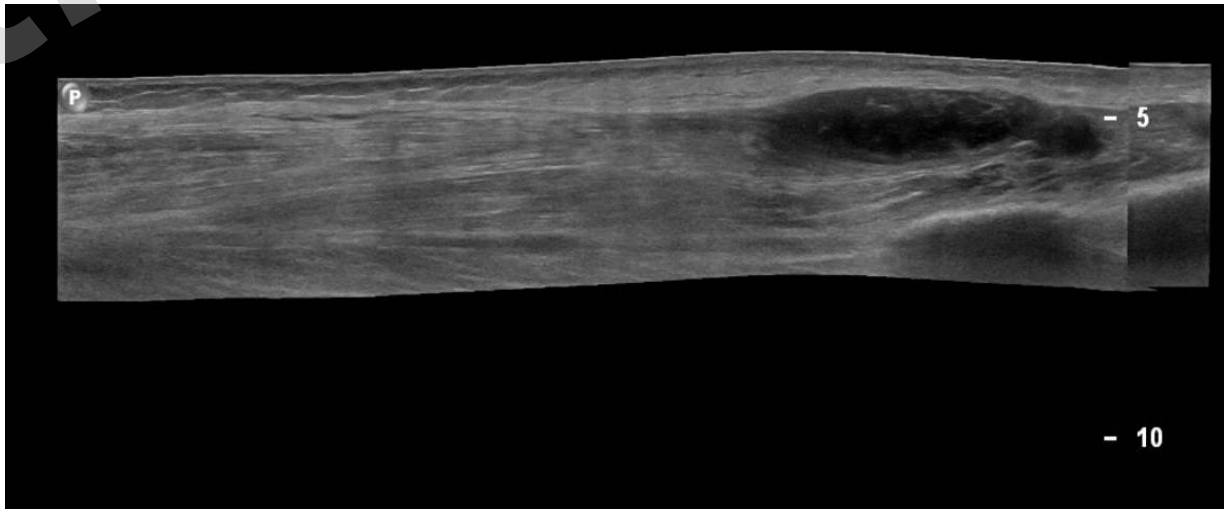
Poco frecuente.

Pacientes inmunocomprometidos.

Trauma severo o quemaduras.







Colección heterogénea intramuscular, probable hematoma por lesión miofascial/miotendinosa, con cambios inflamatorios que en el contexto sugieren sobreinfección y asociando **fascitis/celulitis**. Focos hipoecoicos intramusculares a distancia , posibles focos de **piomiositis a distancia** (diseminación hematógena)

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Bacterial, Fungal, Parasitic, and Viral Myositis

Nancy F. Crum-Cianflone*

Infectious Diseases Division, Naval Medical Center, San Diego, California, and Infectious Disease Clinical Research Program, Uniformed Services University of the Health Sciences, Bethesda, Maryland

TABLE 2. Infectious causes of myositis

Organism group	Organism(s)[c]
Gram-positive bacteria	*Staphylococcus aureus*[*]
	Group A *Streptococcus*[**]
	Streptococcus (groups A, B, C, and G, *S. pneumoniae*, *S. anginosus*)[***]
Gram-negative bacteria	*Aeromonas hydrophila*[***]
	Burkholderia mallei, *B. pseudomallei*[***]
	Citrobacter freundii[**]
	Enterobacter spp.[**]
	Escherichia coli[**]
	Haemophilus influenzae[***]
	Klebsiella oxytoca, *K. pneumoniae*[***]
	Morganella morganni[**]
	Neisseria gonorrhoeae[***]
	Pasteurella spp.[**]
	Proteus spp.[**]
	Pseudomonas spp.[**]
	Salmonella spp.[**]
	Serratia marcescens[***]
	Vibrio vulnificus[***]
	Yersinia enterocolitica[***]
Anaerobic bacteria	*Bacteroides* spp.[**]
	Clostridium spp.[**]
	Fusobacterium necrophorum and *F. nucleatum*[***]
	Streptococcus spp. (anaerobic, e.g., *Peptostreptococcus*)[**]
	Veillonella spp.
Mycobacterium spp.	*Mycobacterium avium* complex[***]
	Mycobacterium bovis[***]
	Mycobacterium haemophilum[***]
	Mycobacterium leprae[**]
	Mycobacterium tuberculosis[***]
Atypical bacteria	*Actinomyces* spp.[**]
	Bacillus spp.[**]
	Bartonella spp.[***]
	Borrelia burdorferi[***]
	Brucella spp.[**]
	Coxiella burnetii[***]
	Francisella tularensis[***]
	Legionella pneumophila[***]
	Leptospira spp.[***]
	Mycoplasma pneumoniae[**]
	Nocardia spp.[***]
	Rickettsia rickettsii and *R. conorii*[***]
	Treponema pallidum[***]
Fungi	*Aspergillus* spp.[***]
	Blastomyces dermatitidis[***]
	Candida spp.[*]
	Coccidioides spp.[***]
	Cryptococcus neoformans[***]
	Fusarium spp.[***]
	Histoplasma capsulatum[***]
	Pneumocystis jiroveci[***]
Parasites	*Entamoeba histolytica*[***]
	Echinococcus spp.[***]
	Microspordia spp. (*Brachiola*, *Trachipleistophora*, *Pleistophora*)[***]
	Onchocerca volvulus[***]
	Plasmodium spp.[**]
	Sarcocystis spp.[**]
	Schistosoma spp.[***]
	Spirometra mansonoides[***]
	Taenia solium[**]
	Toxocara canis[***]
	Toxoplasma gondii[***]
	Trichinella spp.[*]
	Trypanosoma cruzi[***]
Viruses	Adenovirus[***]
	Cytomegalovirus[***]
	Dengue virus[***]
	Enteroviruses (coxsackie B virus and ECHO virus)[**]
	Epstein-Barr virus[***]
	Hepatitis B and C viruses[***]
	Herpes simplex virus 2[***]
	HIV[**]
	HTLV-1[**]
	Influenza A and B viruses[*]
	Mumps virus[***]
	Parainfluenza virus[***]
	Parvovirus B19[***]
	Varicella-zoster virus[***]
	West Nile virus[***]

Crum-Cianflone NF et al. Clin Microbiol Rev 2008;21(3):473

TABLE 1. Causes of noninfectious myositis or myopathic symptoms

Myopathy-related disease or manifestation
Idiopathic inflammatory myopathies
Polymyolitis
Dermatomyositis
Inclusion body myositis
Myositis associated with collagen vascular diseases
Polyarteritis nodosum
Wegener's granulomatosis
Systemic lupus erythematosus
Rheumatoid arthritis
Scleroderma
Sjogren's syndrome
Leukocytoclastic vasculitis
Hypersensitivity vasculitis
Polymyalgia rheumatica
Mixed connective tissue disease
Adult Still's disease
Myositis associated with malignancies
Other forms of myopathies
Inflammatory myopathies
Myositis associated with eosinophilia
Myositis ossificans
Giant cell myositis
Myopathies due to drugs and toxins
Diseases causing myopathic signs and symptoms
Metabolic myopathies
Inborn errors of metabolism
Disorders in glycogen metabolism
Lipid storage disorders
Mitochondrial myopathies
Endocrine disorders
Hypo- and hyperthyroidism
Acromegaly
Addison's disease
Cushing syndrome
Hyperaldosteronism
Hyperparathyroidism
Electrolyte abnormality
Nutritional deficiency
Neuropathic disorders
Muscular dystrophies
Others, including diseases of the neuromuscular junction
Medication-related adverse events
Other causes
Sarcoidosis
Amyloidosis
Behcet's disease
Atherosclerotic emboli

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Tropical pyomyositis

Common Microorganisms, Host factors, and Geographic Distribution.

S. No	Microbiology	Host factors	Geographical distribution
1.	Staphylococcus aureus	Most common cause in immunocompetent host	90% of cases in tropical countries 75% of cases in temperate countries
2.	Group A streptococcus	More common in children and young adults	25% of pyomyositis in pediatrics age group
3.	Gram negative bacilli *Escherichia coli* , *Klebsiella* spp, *Pseudomonas* spp and anaerobes	Immunocompromised hosts	Not limited to any specific geographic region
4.	Tuberculosis	Immunocompromised hosts, particularly those with advanced HIV infection or receiving steroids, anti-TNF-alpha inhibitors, or Janus kinase (JAK) inhibitors."	In Tb endemic countries
5.	Fungal (Candida, Aspergillus spp, Mucorales)	Immunocompromised hosts especially in neutropenic hosts and poorly controlled diabetes	Not limited to any specific geographic region
6.	Histoplasmosis	Immunocompromised hosts, particularly those with advanced HIV infection or receiving steroids, anti-TNF-alpha inhibitors, or Janus kinase (JAK) inhibitors."	Nitrogen-rich soil, typically found along riverbanks
7.	Dematiaceous fungi	Immunocompromised hosts, especially renal transplant recipients	Not limited to any specific geographic region
8.	Nocardia	Immunocompromised hosts especially in poorly controlled diabetes and patients on steroids	Not limited to any specific geographic region

Kumar P, et al. Best Practice & Research Clinical Reumatol 2025;29(2):102041

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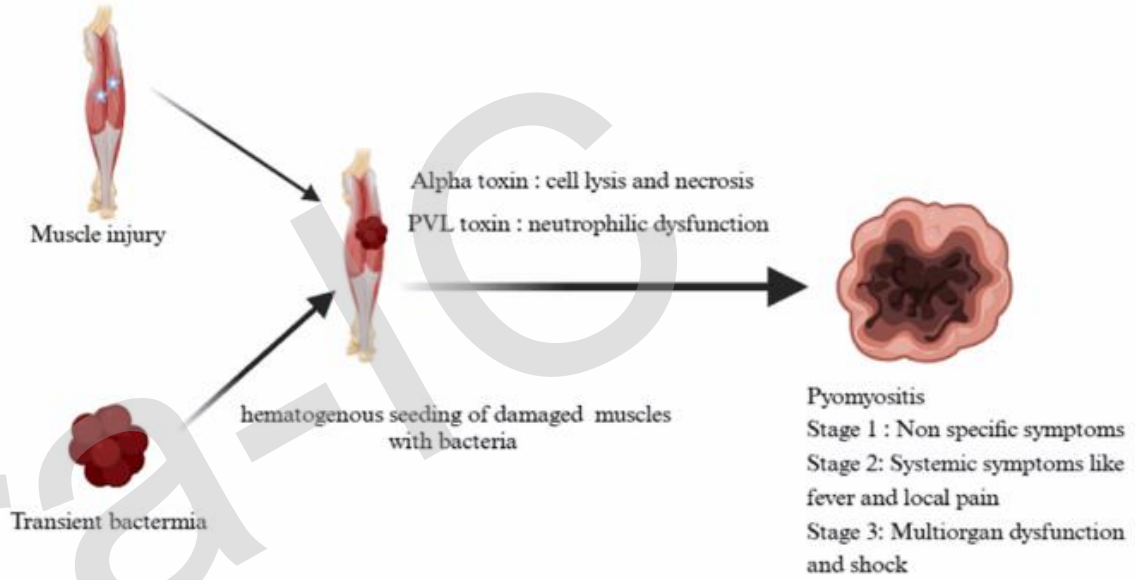

FIG. 1

Pathogenesis and clinical stages of pyomyositis.

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Nocardia Infection in Solid Organ Transplant Recipients: A Multicenter European Case-control Study

Coussement J CID 2016;63(3):338

Estudio caso-control: 117 casos vs 234 controles
36 centros europeos
- Pulmón 101 (86%)
  - -Nódulos: 68 (75%) cavitados: 32 (22%)
  - -Consolid: 37 (40%)
  - -Intersticial 11 (12%)
- Piel/PB 37 (32%)
- Diseminada 50 (43%)
- Prof TMP/SMZ: no prevención

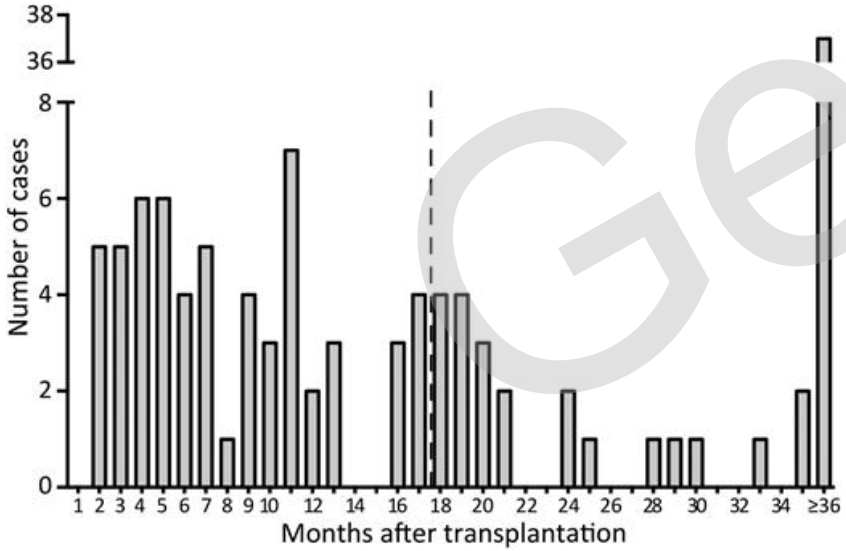


Figure 1. Distribution of the time (in months) between solid organ transplant and the occurrence of

Especies

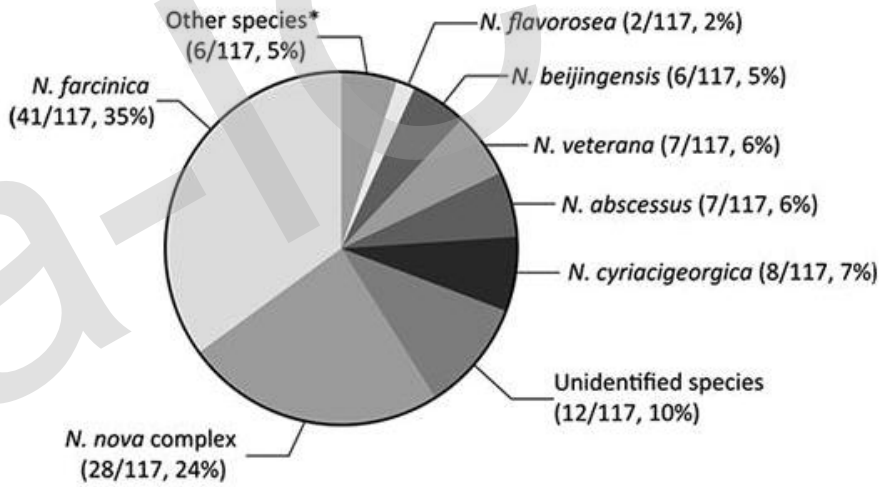


Figure 2. Distribution of the various *Nocardia* species identified using molecular biology in the 117

Factores riesgo. An multivariante

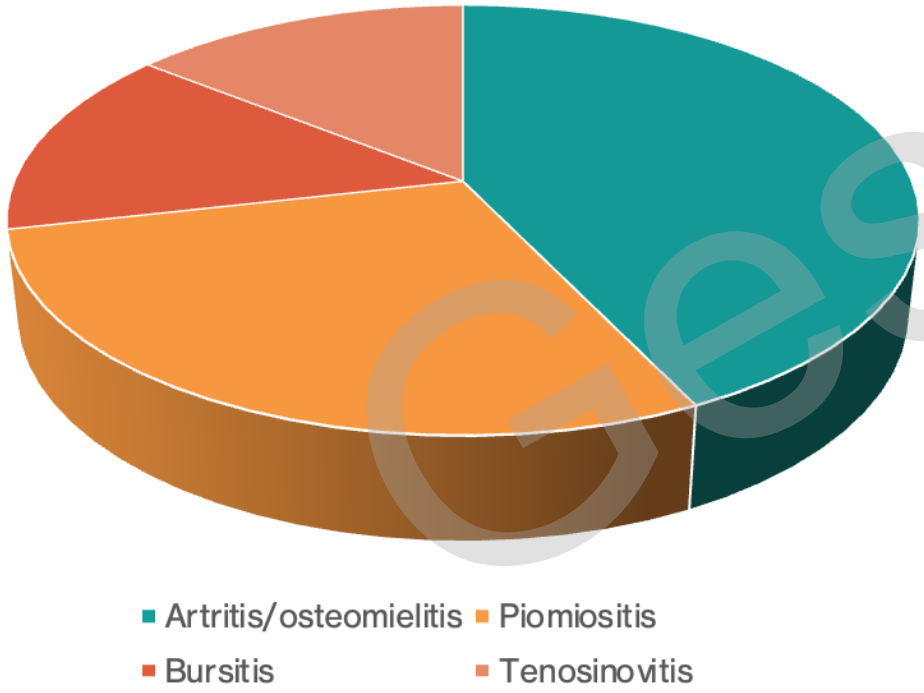
Characteristic	OR (95% CI)	*P* Value
High calcineurin inhibitor level in the month before nocardiosis	6.11 (2.58–14.51)	<.001
Use of tacrolimus at diagnosis	2.65 (1.17–6.00)	.015
Corticosteroid dose at diagnosis (per mg [a])	1.12 (1.03–1.22)	.002
Age at diagnosis (per year)	1.04 (1.02–1.07)	<.001
Length of first ICU stay after transplant (per day)	1.04 (1.00–1.09)	.049

Musculoskeletal infections associated with *Nocardia* species: a case series

Mayo Clinic (3 centros)

9 casos

7 (78%) varones, edad (med): 57



3 formas diseminadas: las 3 en Tx renales

Duración tratamiento:

- 21 días: tenosinovitis
- 467 días: osteomielitis

Khodaadi RB et al. J Bone Joint Infect 2024;9:207

Tropical pyomyositis

Common Microorganisms, Host factors, and Geographic Distribution.

S. No	Microbiology	Host factors	Geographical distribution
1.	Staphylococcus aureus	Most common cause in immunocompetent host	90% of cases in tropical countries 75% of cases in temperate countries
2.	Group A streptococcus	More common in children and young adults	25% of pyomyositis in pediatrics age group
3.	Gram negative bacilli *Escherichia coli* , *Klebsiella* spp, *Pseudomonas* spp and anaerobes	Immunocompromised hosts	Not limited to any specific geographic region
4.	Tuberculosis	Immunocompromised hosts, particularly those with advanced HIV infection or receiving steroids, anti-TNF-alpha inhibitors, or Janus kinase (JAK) inhibitors."	In Tb endemic countries
5.	Fungal (Candida, Aspergillus spp, Mucorales)	Immunocompromised hosts especially in neutropenic hosts and poorly controlled diabetes	Not limited to any specific geographic region
6.	Histoplasmosis	Immunocompromised hosts, particularly those with advanced HIV infection or receiving steroids, anti-TNF-alpha inhibitors, or Janus kinase (JAK) inhibitors."	Nitrogen-rich soil, typically found along riverbanks
7.	Dematiaceous fungi	Immunocompromised hosts, especially renal transplant recipients	Not limited to any specific geographic region
8.	Nocardia	Immunocompromised hosts especially in poorly controlled diabetes and patients on steroids	Not limited to any specific geographic region

Kumar P, et al. Best Practice & Research Clinical Reumatol 2025;29(2):102041

Indian Journal of Medical Microbiology
Volume 54, March–April 2025, 100791

Case Report

A rare encounter: Tuberculous pyomyositis in an immunosuppressed post-transplant patient

Sai Kavya Sree [a] ✉, Stephen Raj [a] ✉, Mani Bhushan Kumar [a] ✉, Rakesh Yadav [a] ✉, Sunil Kumar Dhatwalia [a] ✉, Vanji Nathan Subramani [b] ✉, Mahesh Prakash [c] ✉, Sunil Sethi [a] ✉

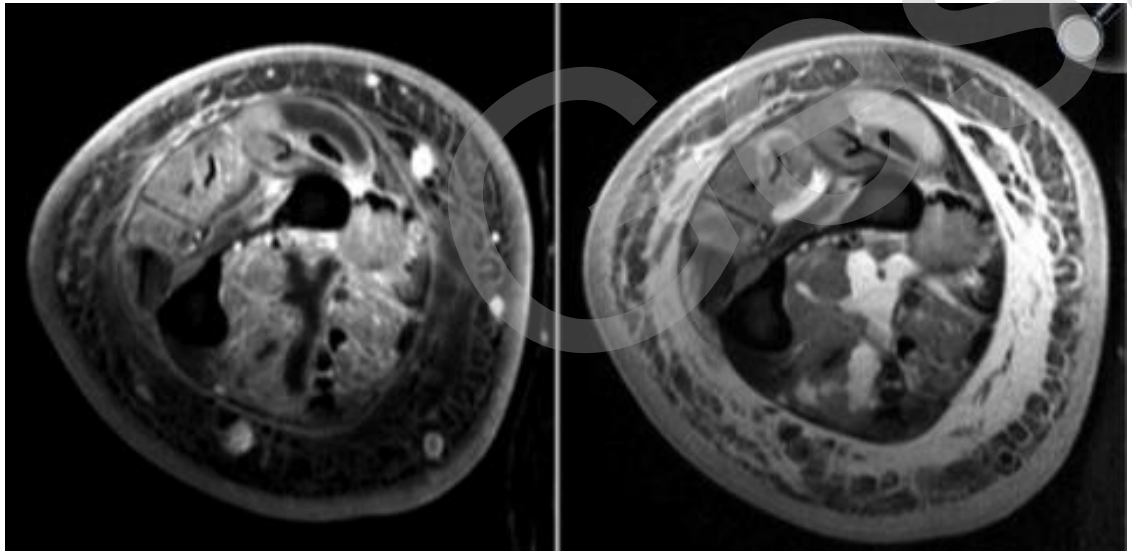
Varón 34 años, India
Tx renal hace 9 años
Dolor gluteo izdo subagudo. Lesión hiperintensa en RM
PAAF: BAAR (GenXpert+)

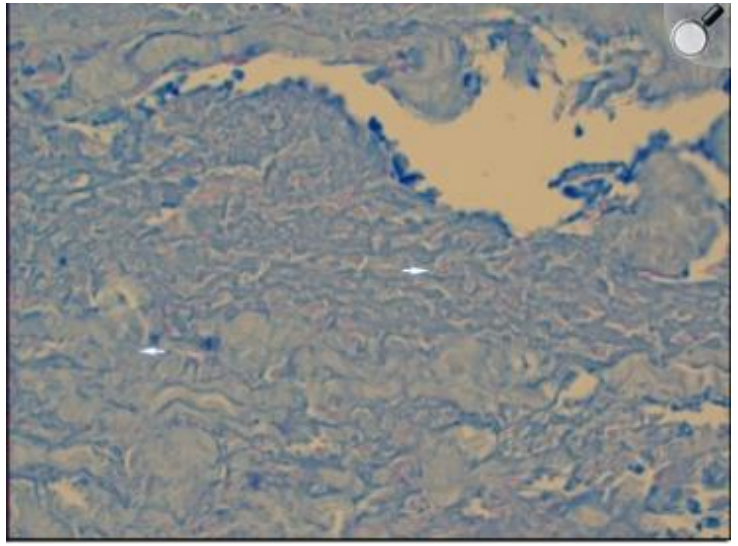
Open Forum Infect Dis. 2022 Jul 29;9(8):ofac385.

Disseminated *Mycobacterium avium* Complex Myositis in a Patient With Graft-Versus-Host Disease

Kathryn Grace Kompa [1], Caitlin A Trottier [2,✉], Charles L Hyman [3], Rakhi Kohli [4,2]

Varón 59 años
Alo TPH hace 19 años (LLC). EICR esteroides y Ruxolinitib
Dolor, hinchazón brazo desde caida hace 3 meses
15.000 LEUC, CPK normal (36 UI/L).





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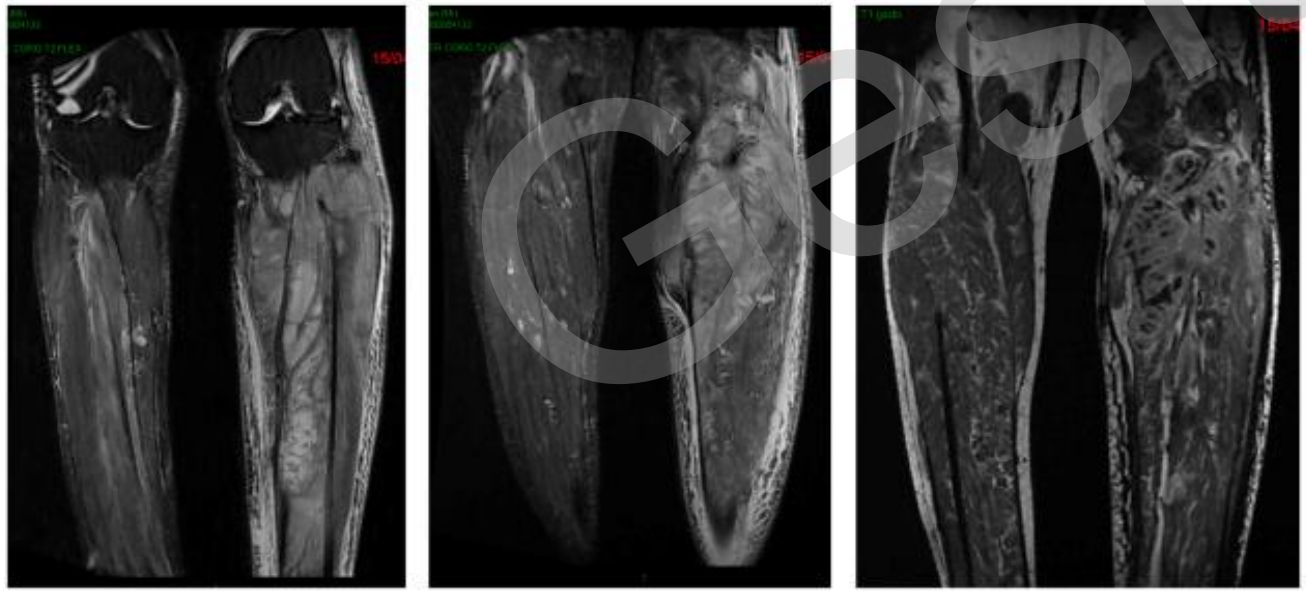
Kumar P, et al. Best Practice & Research Clinical Reumatol 2025;29(2):102041

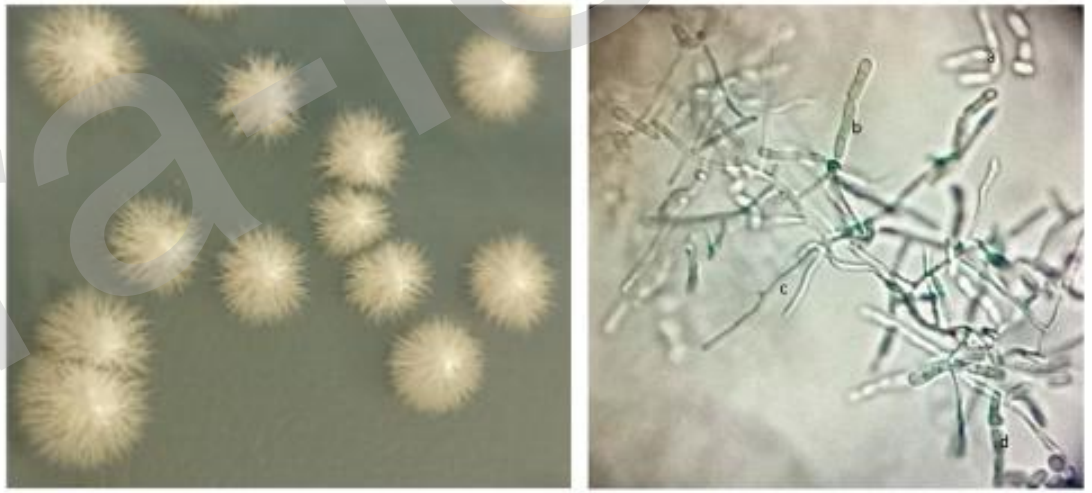
Uncommon fungal pyomyositis in a kidney transplant recipient

Yanis Tamzali[1] | Jeanne Bigot[2] | Yaye Senghor[2] | Christophe Hennequin[2] | Hélène François[3]

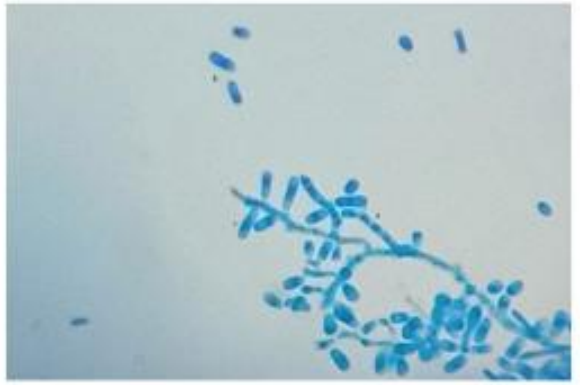
Trasp Inf Dis 2023;25 e14060

Varón, 60 años. Natural de Milán
Tx renal. Glonerulonefritis
Mes +18:
- Dolor en piernas
- Sudoración nocturna





(A) (B)



Nannizziopsis obscura
(Like: Tchicophyton
Tricosporon
Geotrichum
BDG >500 ng/ml

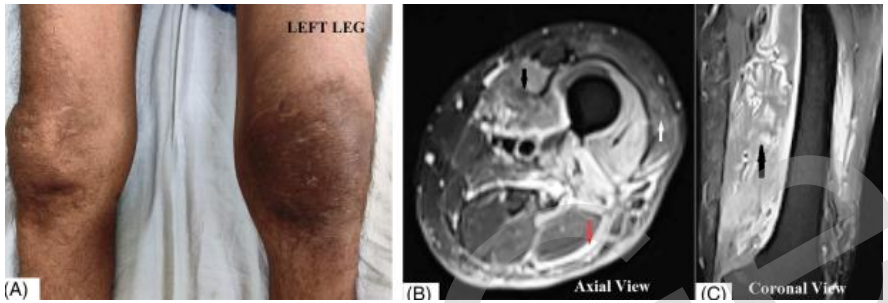
Tto: cirugía y posaconazol

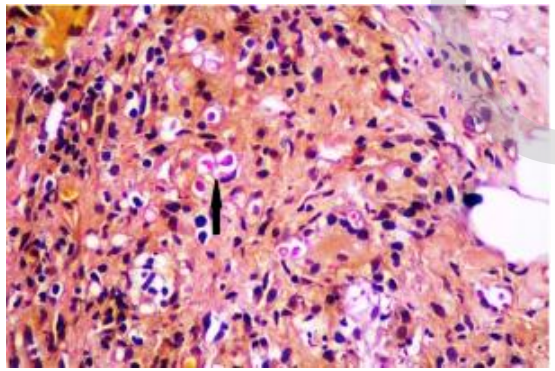
Cryptococcal myositis and monoarthritis in a failed renal allograft recipient

Varadharajan V et al. Transpl Infect Dis. 2023;25:e14092.

Varón, 38 años, India
Tx renal en 2017 (Nefrop IgA)
-TAC, MMF, Est (Basiliximab induc)

En 2023: dolor rodilla y muslo





Unilateral leg pain caused by cryptococcal myositis: An unusua presentation of disseminated cryptococcosis in a kidney transplant recipient

Lier AJ et al. Transpl Infect Dis. 2021;23:e13491.

Mujer 43 años. DM. 3º Tx renal. Sensib 98%
Timoglobullna
Disfunción crónica. Suspension tacrolimua
-Belatacept, MMF, Est

A los 4 años del 3ª Tx:
-Dolor e hinchazon rodilla izda
-Dificultad respiratoria
HC y biopsia muscular: Criptococo neoforrmans
-Ambisome
DRA, vidrio deslustrado
-BAL: Criptococ + P. Jirovecci
-Ambisome + Soltrim
Reingreso: deterioro neurológico
-Meningitis criptocócica
-Exitus

Miositis criptocócica en trasplantados y no trasplantados

Age, gender	Transplant history, medical comorbidities	Immuno-suppression regimen	Time since transplant	Myositis symptom duration	Muscles involved	Other sites	Treatment	Outcome
51M[7]	Amyloidosis OHT, CKD, DVT	Dexamethasone Bortezomib Tacrolimus Mycophenolate	6mo	n/a	Left biceps femoris	CSF	Amphotericin B, Fluconazole, Micafungin, Voriconazole	Survived
28M[8]	KT	Methyl-prednisolone	3y	14d	Right rectus femoris, vastus intermedius	CSF	5-flucytosine, Amphotericin B	Expired
67M[9]	OHT, CKD, HTN, NIDDM, cutaneous squamous cell carcinoma	Azathioprine Prednisone Cyclosporine Isosorbide	11y	3d	Left upper thigh	None	Fluconazole	Expired
43F[a]	KT x 3, HTN, NIDDM	Tacrolimus Mycophenolate Belatacept Prednisone	4y	30d	Left gastrocnemius, soleus	CSF	Amphotericin B, Fluconazole	Expired
32F[10]	HIV/AIDS	n/a	n/a	3d	Right vastus medialis, vastus intermedius, adductor longus	None	Amphotericin B, Fluconazole	Survived
53F[11]	HCV, hepatic cirrhosis, IDDM	n/a	n/a	n/a	Right and Left gastrocnemius	Ascites	Amphotericin B, Fluconazole	Survived
84F[12]	HTN, dementia, hemolytic anemia, CKD, prosthetic mitral valve, osteoarthritis, hypothyroidism	n/a	n/a	n/a	Right thigh	None	Fluconazole, Surgical debridement	Expired
48F[13]	CLL, splenectomy, oral candidiasis, *Aspergillus fumigatus* pneumonia	Prednisone Chlorambucil	n/a	30d	Myocardium, biceps, esophagus, diaphragm	None	Ketoconazole, Amphotericin B, Flucytosine	Expired
35M[14]	Large B cell lymphoma	Anti-neoplastic therapy	n/a	21d	Right erector	None	Fluconazole	Survived

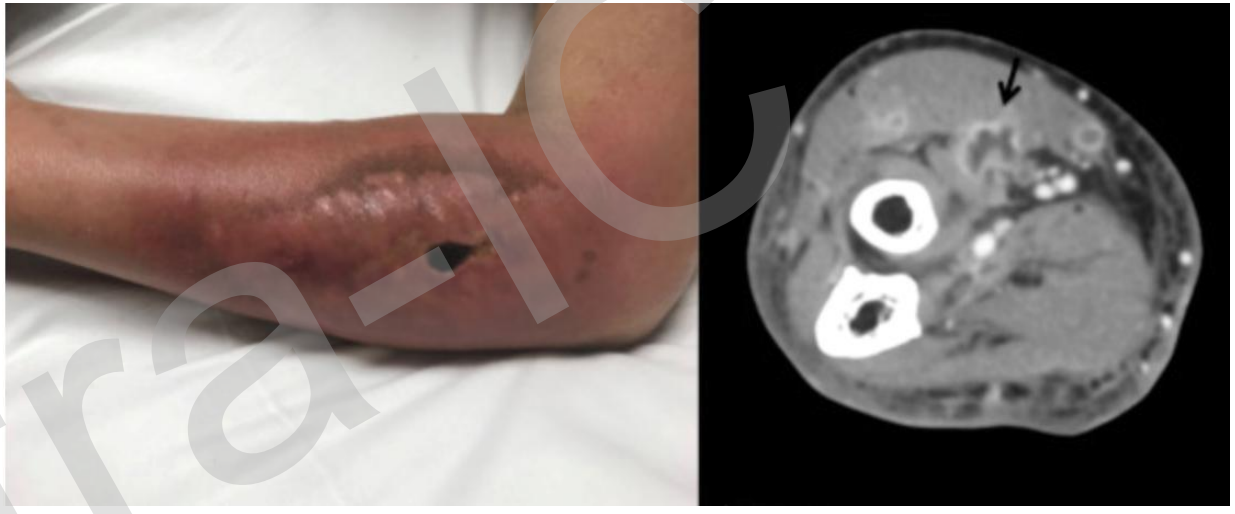
Necrotizing soft tissue invasive aspergillosis in a cancer patient treated with immunosupressants due to checkpoint inhibitor-induced hepatitis

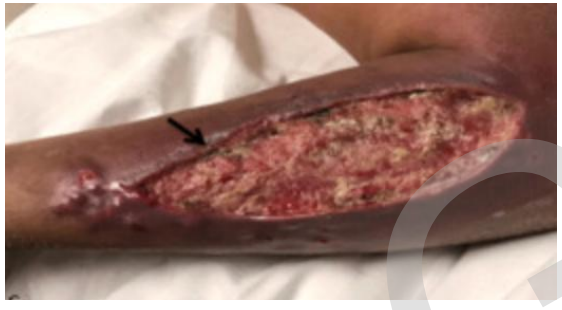
Malek AE, et al. . Infection 2019;80(2)

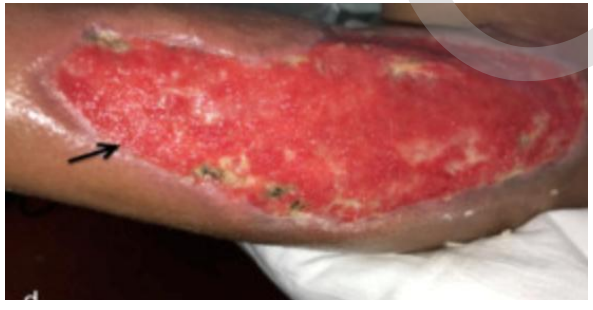
Varón 62 años, DM. Cáncer renal
Nivolumab-Ipilimumab.
Hepatitis mediada: CE altas dosis, MMF. RTM

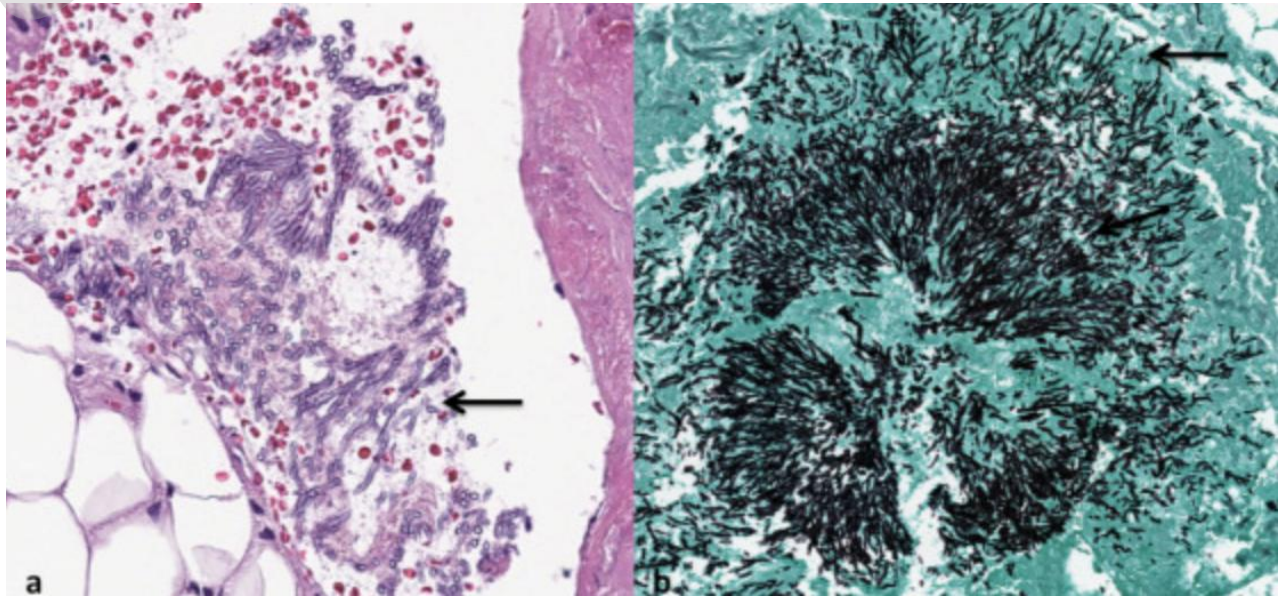
+1 mes: dolor brazo, hinchazón, placa negra, dolor
refractaria a cefalexina
leuc 3300/ul. CPK normal

Brazo: eritem piel, escara negra, nódulos
TAC Fascitis necrotizante y necrosis muscular







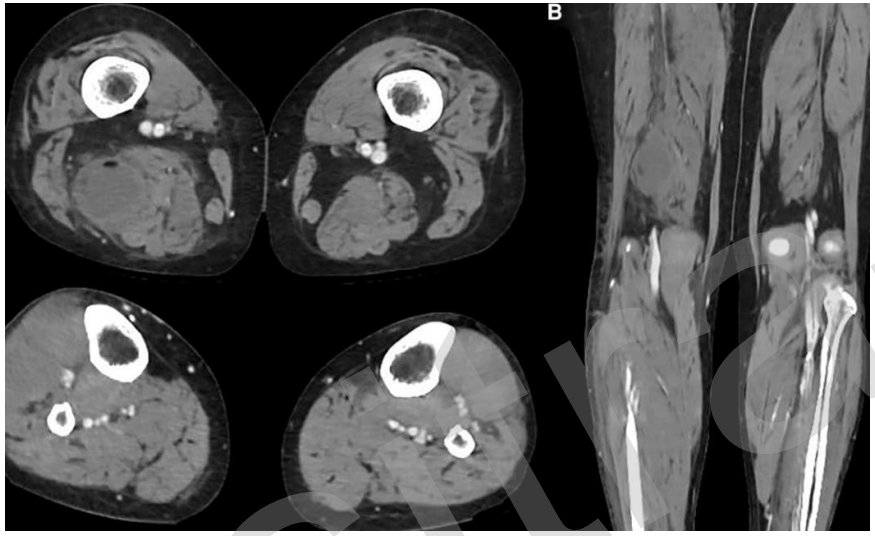


Skin and Soft Tissue Mucormycosis in Patients Receiving Bruton Tyrosine Kinase Inhibitors: Case Report and Literature Review

Aparicio-Minguijon E et al.
Open Forum Inf Dis 2025;12(12):ofaf691

Varón 72 años, LLC.
Fascitis necrotizante y miositis por *Lichtheimia* spp
- -tras 4 meses de tto con BTKi zanubrutinib (previo: ibrutinib, RTM y venetoclax, 4 años)
- - evolución fatal

Revisión literatura: 8 casos
- - mortalidad 37%
- - 2/3 con trauma o herida previa



Inflamacion grasa sbc y músculo, fascitis, colecciones

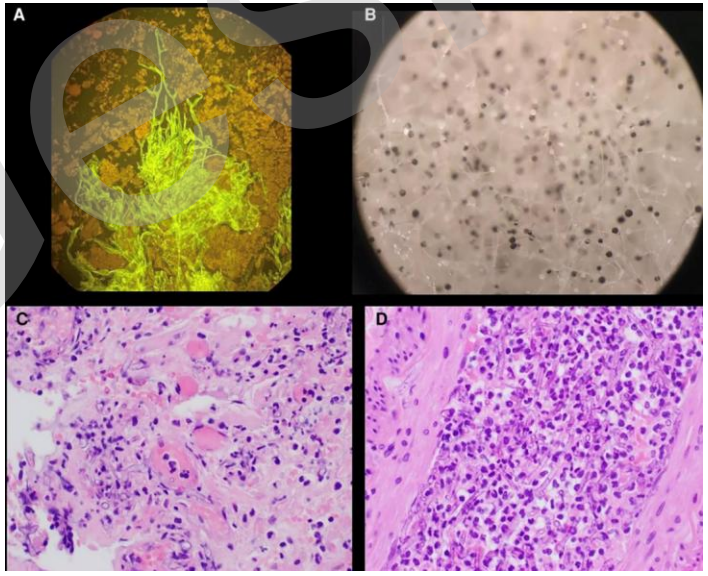


Table 2. Demographics, Clinical and Microbiological Characteristics, Treatments, and Outcomes of the Reported Cases of Skin and Soft Tissue Mucormycosis in Patients Receiving BTKi Therapy (n = 8)

Variable	Median (IQR) or No. (%)
Age, y	72 (68–74)
Male gender	7 (87.5)
BTKi agent	
Ibrutinib	6 (75.0)
Zanubrutinib	2 (25.0)
Concomitant immunosuppressive therapy	3 (37.5)
Corticosteroids	2 (25.0)
Rituximab	1 (12.5)
Fungal identification	
Rhizopus spp	1 (12.5)
Apophysomyces spp	1 (12.5)
Lichtheimia spp	1 (12.5)
Mucor spp	1 (12.5)
Not reported	4 (50.0)
Time to infection onset from BTKi initiation, mo	20 (2.5–36)
Previous trauma or skin lesion	5 (62.5)
Pulmonary symptoms	3 (37.5)
Antifungal therapy	
L-AmB	7 (87.5)
Triazole	7 (87.5)
Length of antifungal therapy, d	45 (30–90)
Surgical debridement	3 (37.5)
Outcome	
Clinical cure	6 (75.0)
Attributable death	3 (37.5)

Disseminated toxoplasma infection after hematopoietic stem cell transplantation with myositis and encephalitis

Asensi P et al. Transpl Infect Dis. 2023;25(4):e14067

Mujer, 54 años. Mes +90 aloTPH (SMD)
EICR, sirolimus

Pérdida peso >25% y sdme confusional
-Ataxia, debilidad EEII
Aldolasa y PCR ligeramente elevadas
EEG: encefalitis difusa
RM cerebral: cerebelitis y talamo. No LOE anillo

EMG: patrón miopático y ausencia actividad
RM corporal: miositis en EEII

HC y LCR: PCR Toxoplasma+
Biopsia muscular: (ver figura)

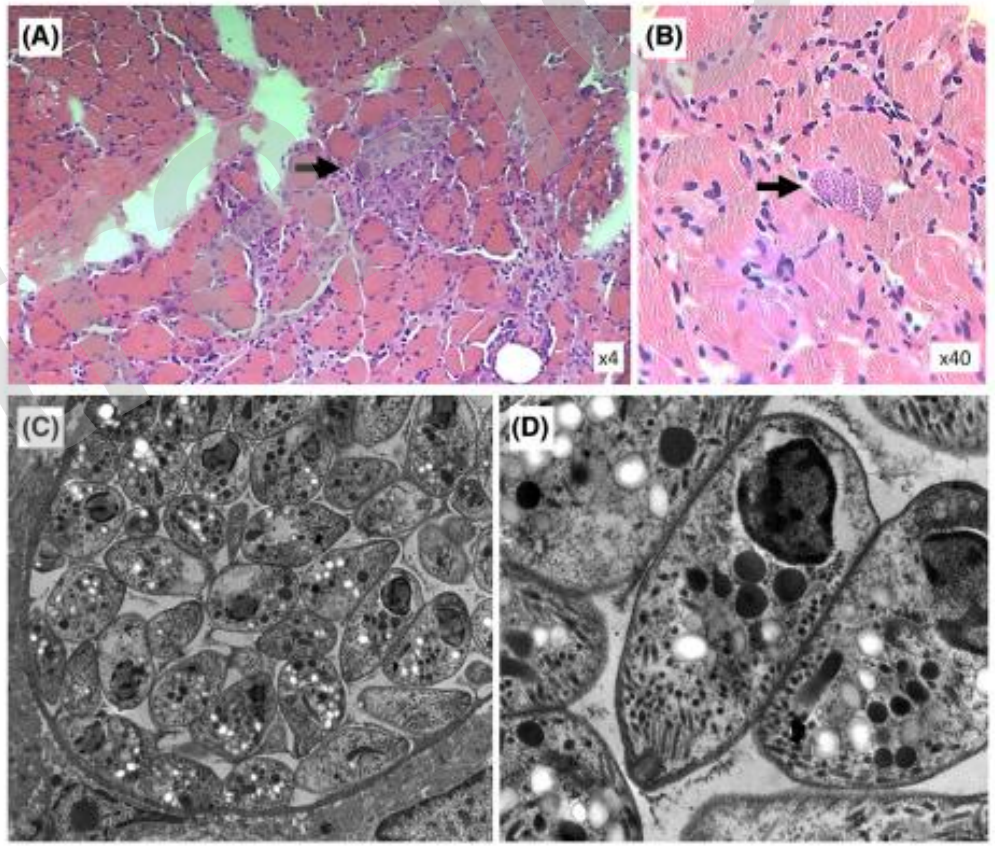


FIGURE 1 Morphological findings in a vastus lateralis muscle biopsy. Panel A. Hematoxylin and eosin (H&E) stain transverse cryostat section 4x: inflammatory myopathy with extensive inflammatory infiltrates in perivascular, perymisial, and endomysial locations forming necrotizing granulomas (arrow). Panel B. H&E stain, 40x: tissue cyst is distinguised (arrow). Panel C. Electronic microscopy (EM) scan, 18.000x. Protozoon-containing cyst. Panel D. EM scan, 62.000x. Ultrastructure of the pathogen.

European Journal of Pediatrics (2021) 180:577–584
https://doi.org/10.1007/s00431-020-03835-w

Influenza-associated myositis: a single-centre, 5-year retrospective study

James Kerr [1] · Kristine Macartney [2,3] · Philip N. Britton [3,4]

Miositis asociada a influenza:
- Edad 5-9 años
- Influenza B
- Dolor piernas bilateral, CPK >3.500 U/L, no afectación renal
- Estacional
- Benigna

Myonecrosis: A Rare Presentation of Cytomegalovirus Disease

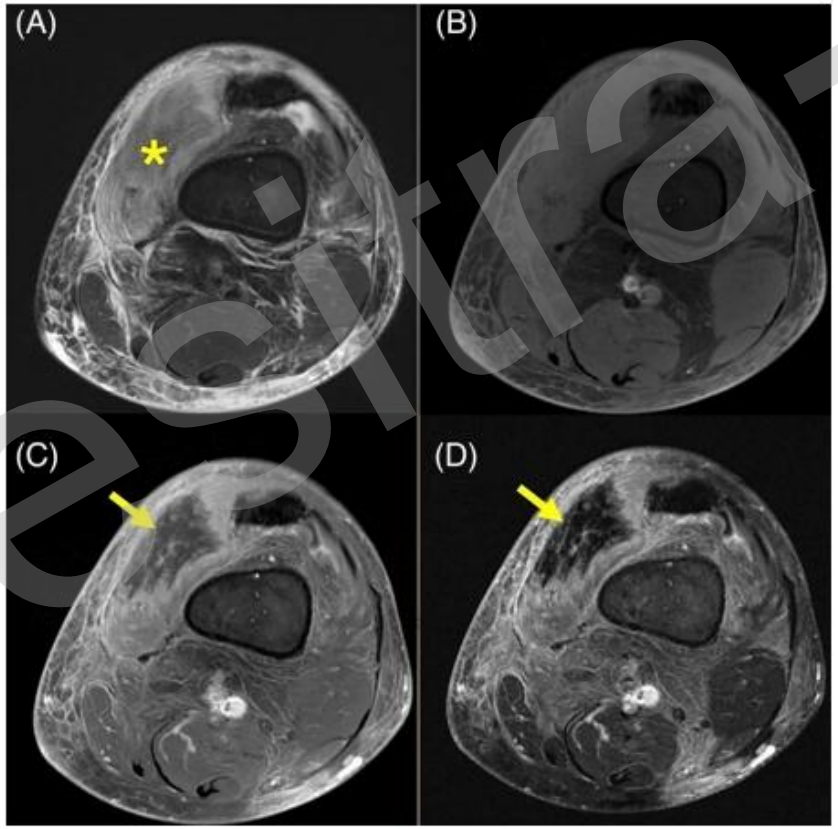
Traspl Inf Dis 2025;27(6)e70109

Karim A. Elyamany[1] | Ravi V. Durvasula[2] | Sammer M. Elwasila[1] | Matthew M. Crowe[3] | Daniel E. Wessell[4] | Jennifer G. Katsolis[1]

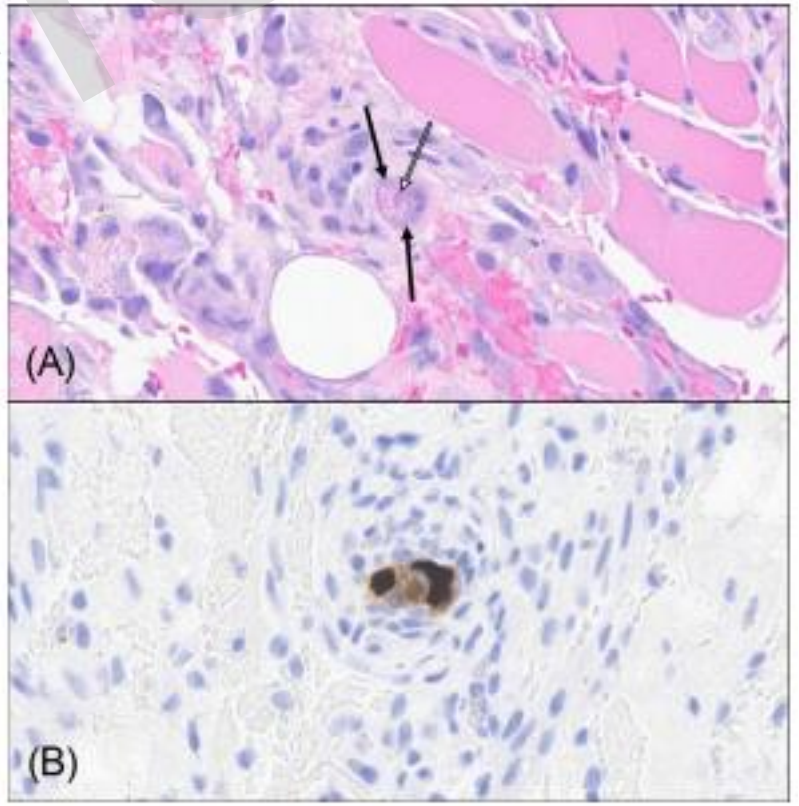
Varón 53 años. Hepatitis AI
2ª Tx Hepático, R-D+
-6 meses profilaxis VGCV

Mes +8: colitis y viremia CMV
-6 semanas VGCV

- viremia tras suspensión
- dolor hinchazón en rodilla
- CPK 720 UI/l



RM: Miositis vasto interno. Sinovitis



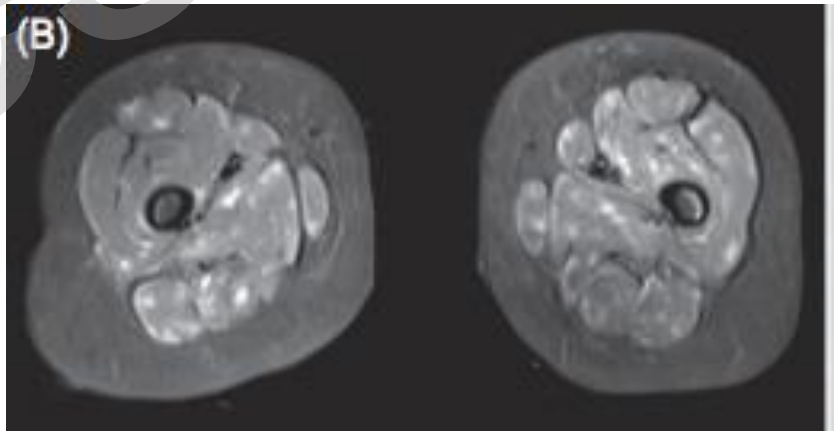
Inmunohistoquímica CMV: +

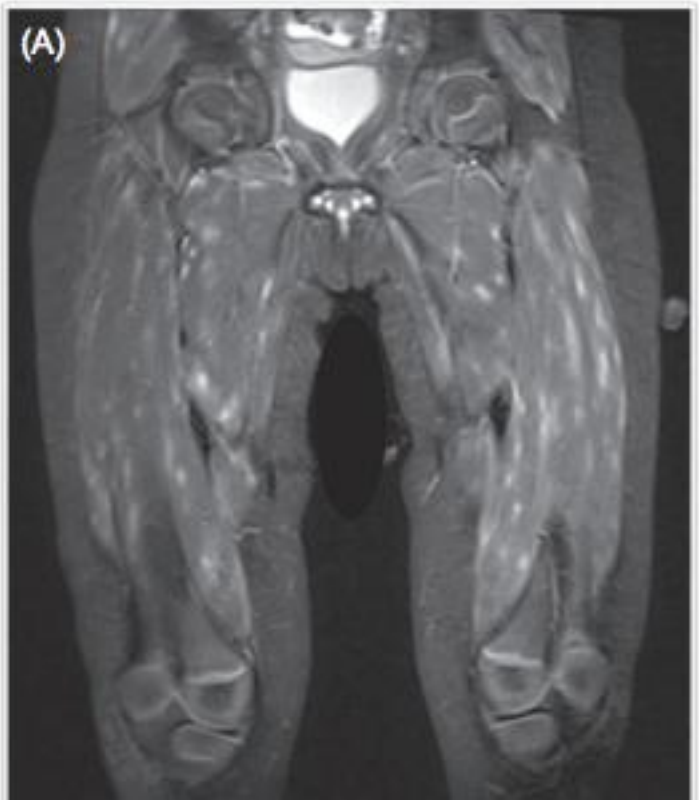
Necrotizing enterovirus myositis in a pediatric renal transplant recipient

Pediatr Transplant. 2022 Aug;26(5):e14275. doi: 10.1111/petr.14275.

Kristen G Valencia Deray [1], Margaret G Taylor [1], Melissa M Blessing [2], Claire E Bocchini [1], Erica K Schallert [3], Daniel Ruderfer [1], Poyyapakkam R Srivaths [4], Rossana Malatesta Muncher [4]

Niño, 3 años
Tx renal hace 7 meses
Debilidad en musculatura prroximal
Distres





CAUSAS NO INFECCIOSAS

- Causas vasculares: Trombosis venosa profunda (TVP) gemelar
- Rotura fibrilar / desgarro muscular
- Miositis tóxica o farmacológica (Tacrolimus, estatinas...)
- Síndrome compartimental (dolor intenso, tensión).
- Vasculitis (si contexto autoinmune).
- Miositis autoinmune post-trasplante (menos probable).

Case Reports > Case Rep Transplant. 2022 Mar 25:2022:7323755.
doi: 10.1155/2022/7323755. eCollection 2022.

Azole-Induced Myositis after Combined Lung-Liver Transplantation

Sofie Happaerts [1], Michiel Wieërs [1], Ward Vander Mijnsbrugge [2], Laurent Godinas [1], Dirk Van Raemdonck [3], Laurens J Ceulemans [3], Robin Vos [1], Geert M Verleden [1]

DIAGNÓSTICOS SUGERIDOS

1. Infección por Nocardia

2. Infección fúngica
    1. Mucor
    2. Aspergillus
    3. Hongos raros (incluido Criptococo)

3. S. aureus y otras bacterias (incluido Pseudomonas spp)

PRUEBAS URGENTES RECOMENDADAS

- RMN de pierna (gold standard para miositis/absceso)
- Eco-Doppler venoso
- CK, PCR, procalcitonina
- Hemocultivos
- Aspiración/biopsia si colección
- TC torácico

1. PIOMISITIS BACTERIANA PRIMARIA

Muy probable en este contexto.

- Suele ser por **Staphylococcus aureus** (incluyendo **MRSA**).

También considerar:

- **Streptococcus pyogenes**

- **Bacilos gramnegativos** (más en inmunodeprimidos)

El traumatismo previo favorece siembra hematógena.

Puede coexistir con neumonía como foco primario o bacteriemia.

👉 En inmunosuprimidos puede progresar rápido a absceso o sepsis.

2. FASCITIS NECROTIZANTE

Dolor desproporcionado al examen físico.

Edema, eritema, progresión rápida.

Puede ser **polimicrobiana** o por **estreptococo grupo A.**

Urgencia quirúrgica.

⚠️ Clave: dolor intenso + toxicidad sistémica.

3. MIOSITIS POR AGENTES OPORTUNISTAS POST-TRASPLANTE

En este paciente con hipogammaglobulinemia considerar:

- **Nocardia** (recuente en trasplante pulmonar).

  neumonía + abscesos musculares.

  Diseminación hematógena.

- **Micobacterias no tuberculosas**

  Mycobacterium abscessus (más frecuente en trasplante pulmonar).

- **Infección fúngica invasiva**

  Aspergillus (diseminación desde pulmón).

  Mucorales (si diabetes o neutropenia).