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A severe serotonin syndrome induced by therapeutic range of antiparkinson drugs and antidepressants.

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Introduction: Serotonin syndrome is a disease which can occur from interaction between multiple drugs, such as anti-parkinsonism drugs, *serotonin receptor uptake inhibitor* **(SSRI)**,*tricyclic antidepressant* **(TCA)** and pain killers, acting on serotonergic receptor in central nervous system. It can occur not only in overdose, but in therapeutic dose range and often be life-threatening disease. **Case:** A 77-year-old female presented with a history of fever and myoclonous acitivity, who was on antiparkinsonism drugs and **SSRI**, **TCA** which was in therapeutic dosage for her parkinsonism and deppressive disorder. Her autonomic symptoms and fever got worse after using *tramadol*and *meperidine* that is commonly used in pain control. After stopping suspected drugs and administering *cyproheptadine* for severe serotonin syndrome, her autonomic symptoms & fever were subsided. **Conclusions:** Antiparkinsonism drugs, pain killer and antidepressant drugs including **SSRI**, **TCA**can cause severe serotonin syndrome and should be using with caution, even if in therapeutic dosage.

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Function-sparing effect of combination antifungal therapy in a patient with mucormycosis

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Background: Mucormycosis is a rare and aggressive fungal infection associated with high mortality in immunosuppressed patients. As response rates to antifungal agents are suboptimal, surgical resection is required. Wide excision often causes serious functional defect, which depends on the infected sites. Recently, the efficacy of combination antifungal therapy has been studied, but majority of data are based on case reports. Here we present a case of invasive mucormycosis involving perimandibular area successfully treated with combination therapy and could save his masticatory function. Case: A 57-year-old man with acute myelomonocytic leukemia presented a neutropenic fever and severe perimandibular pain during induction chemotherapy. Swelling and pus-like discharge were observed around the left lower wisdom tooth. Despite empirical antibiotics, fever and pain persisted. The symptoms were controlled by subsequent liposomal amphotericin B (3 mg/kg/day) administration and salvage granulocyte transfusions. After recovery of cytopenia, infected tooth was extracted. The biopsy result of surrounding necrotic tissue was consistent with invasive mucormycosis. MRI showed increased enhancement and soft tissue infiltration involving alveolar process of left mandible and retromolar, buccal, submandibular, and masticator spaces. To avoid wide excision, the dose of amphotericin was increased to 5 mg/kg/day and oral posaconazole 300 mg/day was added. His symptom did not aggravated during 2 more cycles of intensive chemotherapy for leukemia. After 9 weeks, the infiltrative enhancement disappeared without new lesions on follow up MRI. Finally the patient underwent simple debridement, and the pathology confirmed that fungal hyphae were disappeared. After discontinuation of antifungal agents, he is tolerable without recurrence of mucormycosis so far. **Conclusions:** The presented case shows that combination therapy with posaconazole and liposomal amphotericin B is highly effective and it might be helpful to reduce the morbidity associated with wide surgical resection.