**Introduction**

*Schizophyllum commune* is a ubiquitous basidiomycete fungus which is rarely causing infections in humans. But since recently, it is recognized as an emergent or misdiagnosed fungal pathogen in rhinology due to diagnosis of *Schizophyllum commune* causing rhinosinusitis in immunocompetent patients.

Here we present the 1st reported case of *Schizophyllum commune* rhinosinusitis with nasal polyposis in an immunocompetent child in Sri Lanka who was successfully managed with antifungal treatment and surgical intervention.

**Case history**

Twelve-year-old girl presented with nasal blockage, intermittent fever and blood-stained nasal discharge for one week duration. She has been on treatment for allergic rhinitis time to time for the past few years.

NCCT scan of the sinuses revealed that R/maxillary sinus was filled with soft tissue mass with calcifications, which extends through the widened infundibula to the oropharynx. Sinus cavity was expanded. No bone destruction or sclerosis were seen. There was soft tissue thickening with calcification in the depending part of the L/maxillary sinus.

She underwent B/L FESS with B/L middle meatal antrostomy and B/L maxillary sinus clearance. Fungal like material was seen during this procedure and samples were sent for histopathology and it revealed only inflammatory cells and fungal stain was negative. She was treated with co-amoxiclav and betamethasone nasal drops.

After 1 month, FESS was repeated due to recurrence of nasal obstruction. R/S large nasal polyp was seen with caseous material filling the maxillary antrum. Polyp was sent for fungal studies and histopathology. KOH direct smear of the specimen was negative for fungal elements but fungal culture isolated *Schizophyllum commune*. Histopathology revealed only inflammatory cells, had no necrosis or granuloma.

Due to persistence of symptoms, child was started on oral itraconazole 200mg twice daily. Though she had some clinical response to treatment, she again developed recurrent nasal blockage. Therefore, after 2 months of treatment she underwent middle meatal antrostomy and maxillary sinus clearance. Multiple polyps were noted filling the right maxillary antrum with yellowish caseous material. Middle meatal antrostomy was enlarged and specimen was sent for fungal studies and histopathology.

Histology revealed necrotic tissue with abundant neutrophils and fungal stain was negative. But direct KOH smear was positive for thin fungal filaments and culture again isolated, *Schizophyllum commune* further enhancing its clinical significance. Antifungal susceptibility was performed with MIC E strips and it was sensitive to voriconazole and showed higher MIC to itraconazole. Therefore, the child was started on oral voriconazole 200mg twice daily after a loading dose of 400mg twice daily to which she showed a remarkable improvement after 4 months of treatment.

**Conclusion**

This case elaborates on successful management of a child with *Schizophyllum commune* rhinosinusitis with nasal polyposis with voriconazole treatment combined with surgical intervention.

*Schizophyllum commune* is a rare cause of rhinosinusitis and due to difficulty in morphological diagnosis it could often be misdiagnosed. Therefore, awareness and clinical suspicion of this emergent pathogen in rhinology is important to obtain good clinical response in patients.