



The Brazilian Journal of INFECTIOUS DISEASES

www.elsevier.com/locate/bjid



Clinical image

An exuberant form of disseminated histoplasmosis



Débora Mânica Rockenbach*, Lia Natalia Diehl Dallazem, Raíssa Londero Chemello, André Avelino Costa Beber

Dermatologia da Universidade Federal de Santa Maria, Santa Maria, RS, Brazil

ARTICLE INFO

Article history:

Received 6 February 2018

Accepted 24 May 2018

Available online 22 June 2018

A 37-year-old man with AIDS on antiretroviral therapy, from south of Brazil, was admitted to the hospital with dyspnea and fever. He exhibited umbilicated papulonodular lesions, resembling molluscum contagiosum lesions, scattered in the face, trunk, and lower and upper limbs, associated painful ulcers in the oral cavity and genital region. A direct mycological exam identified fungal elements suggestive of *Histoplasma*. Histopathological examination demonstrated a granulomatous inflammatory process with massive presence of fungal structures compatible with *Histoplasma capsulatum*. A fibrobronchoscopy was also performed revealing small and round leveduriform structures with morphological characteristics consistent with *Histoplasma* in a patient with CD4 T-lymphocyte count of 77/mm³. Treatment with Amphotericin B was initiated. The patient progressed with favorable clinical recovery after five weeks, when treatment was switched to Itraconazole. This case illustrates an exuberant form of disseminated histoplasmosis. The systemic mycosis caused by *H. capsulatum* is endemic in central and South America. The infection occurs by direct inhalation of fungal spores

that are present in soil contaminated with excrements of birds and bats. The clinical manifestation varies according to the immune status of the host and load of exposure. The acquired immunosuppression due to HIV is the major risk factor for disseminated histoplasmosis, which includes pulmonary disease, systemic endothelial-reticular involvement and skin lesions. Cutaneous lesions occur in a wide variety of forms, none of which characteristic of the infection, and result from hematogenic dissemination. Diagnosis can be performed by a biopsy of mucosal or cutaneous lesion (the most rapid method to specific diagnosis), with direct mycological examination and culture. Treatment consists of an induction phase with amphotericin B (standard treatment) followed by 12 months of Itraconazole (maintenance phase) (Figs. 1 and 2).

Conflict of interest

The authors declare no conflicts of interest.

* Corresponding author.

E-mail address: dederockenbach@yahoo.com.br (D.M. Rockenbach).

<https://doi.org/10.1016/j.bjid.2018.05.008>

1413-8670/© 2018 Sociedade Brasileira de Infectologia. Published by Elsevier Editora Ltda. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).



Figure 1 : patient's pre-treatment

Figure 1 – Patient's pre-treatment.



Figure 2 : after 5 weeks of use of Amphotericin B, followed by Itraconazole

Figure 2 – After 5 weeks of use of Amphotericin B, followed by Itraconazole.

REFERENCES

1. Doughan A. Disseminated histoplasmosis: case report and brief review. *Travel Med Infect Dis.* 2006;4:332-5.
2. Khambaty MM, Hsu SS. Dermatology of the Patient with HIV. *Emerg Med Clin North Am.* 2010;28:335-68.
3. Mehta A, Desai S, Desai N, Mookerjee A. Disseminated histoplasmosis: missed opportunistic infection in a HIV-infected patient. *BMJ Case Rep.* 2013.
4. Marques SA, Silvares MRC, Camargo de RMP, Marques MEA. Cutaneous histoplasmosis disclosing an HIV-infection. *An Bras Dermatol.* 2013;88:420-3.