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Mucocutaneous Histoplasmosis in an Immunocompetent Patient: A Case Report from Non-Endemic Region in North India

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Abstract

Histoplasmosis is a disease caused by the fungus Histoplasma capsulatum. Symptoms of this infection vary greatly, but the disease affects primarily the lungs. Occasionally, other organs are affected; called disseminated histoplasmosis, Histoplasmosis is common among AIDS patients because of their suppressed immunity. Pulmonary histoplasmosis and disseminated histoplasmosis involving the skin can be a major cause of morbidity and mortality in patients with advanced acquired immunodeficiency syndrome and in patients with lymphoma. A 45 year old male, farmer by occupation, presented with multiple, painful nodules and ulcers over the tongue, angle of mouth and lips and dysphagia for 6 months. He also had numerous painful papulo nodular eruptions on head, trunk, and extremities for 5 months. The lesion on the palate started as a small swelling which gradually increased in size and then ulcerate. After appropriate analysis the patient was treated with Itraconazole because of its easy availability and lesser cost.

Keywords: Antifungal; Immunocompetent; lymphoma

Introduction

Histoplasmosis/Darling's disease is a deep mycotic infection caused by two species of dimorphic saprophytic fungi Histoplasma capsulatum; Histoplasma capsulatum var. capsulatum found in the Americas and the tropics; also known as small form histoplasmosis, and Histoplasma capsulatum var. Duboisii prevalent in Africa, also known as large form histoplasmosis/African histoplasmosis [1]. In India, endemic in eastern part of India particularly West Bengal and in southern India [2,3]. Further reports of histoplasmosis in nonendemic regions are very rare [4].

The spores are found in soil, contaminated with chicken feathers and droppings of bird like starling and bat [1]. Pulmonary histoplasmosis and disseminated histoplasmosis involving the skin can be a major cause of morbidity and mortality in patients with advanced acquired immunodeficiency syndrome and in patients with lymphoma [1]. Although histoplasmosis occurs most commonly in immunocompromised patients, only a few case reports of this disease in immunocompetent hosts [5]. Due to rarity of this disease in immunocompetent individuals and in non-endemic region, we report a case of disseminated mucocutaneous histoplasmosis in an immunocompetent individual from a nonendemic region of North India.

Case Report

A 45 year old male, farmer by occupation, presented with multiple, painful nodules and ulcers over the tongue, angle of mouth and lips and dysphagia for 6 months. He also had numerous painful papulo nodular eruptions on head, trunk, and extremities for 5 months. The lesion on the palate started as a small swelling which gradually increased in size and then ulcerate. Later he developed painful eruptions, started from the forehead and gradually spread to other parts of body with occasional purulent discharge from some of the lesions.

He had a persistent low grade fever, weight loss, productive cough and shortness of breath for last one month. He had to travel different parts of India for occupational purposes. He had no history of unprotected sexual exposure, hypertension, diabetes, epilepsy, chronic obstructive pulmonary disease or tuberculosis.

On general physical examination he was undernourished, poorly built man with severe pallor and cervical lymphadenopathy. Cutaneous examination revealed multiple, well defined, discrete, skin coloured to hyper pigmented, umbilicated, indurated, papules and nodules with haemorrhagic crust in centre or purulent discharge from some lesion, size ranging from 2 mm to 1.5 × 1 cm, distributed over the face, neck, chest, abdomen, back, and both extremities (**Figure 1**). Oral mucosa showed multiple, well defined, discrete to confluent, erythematous, tender papulonodular lesions, sized 3 mm to 1.5×1.5 cm, over the dorsum of tongue and angle of mouth. Multiple, well defined,

erosions with haemorrhage over the buccal mucosa, hard palate and inner surface of lips (**Figure 2**). Other systemic examinations were unremarkable. Routine laboratory investigations revealed severe anaemia with 5.3 gm/dl haemoglobin and 2.51 × 10^6/mm3 RBCs. Marked leukocytosis and thrombocytosis with 25,900 and 6.66 lakh/mm3 total counts and platelet respectively. ESR was raised (50 mm in 1st hour). Other laboratory investigations including HIV serology were unremarkable. Skiagram of chest was unremarkable except bilateral hilar lymphadenopathy.

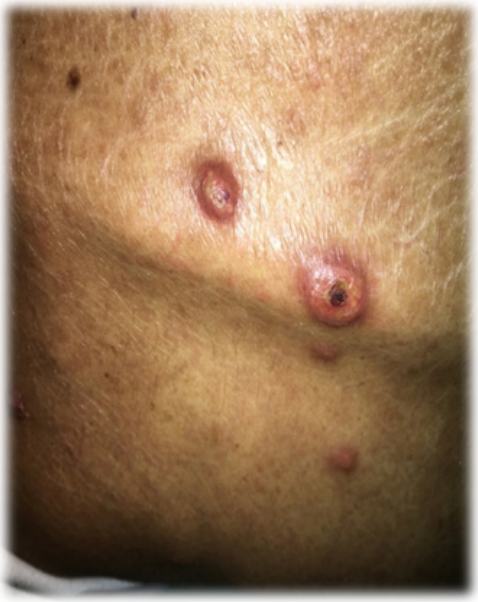

Figure 1 Cutaneous examination of face, neck, chest, abdomen, back, and both extremities

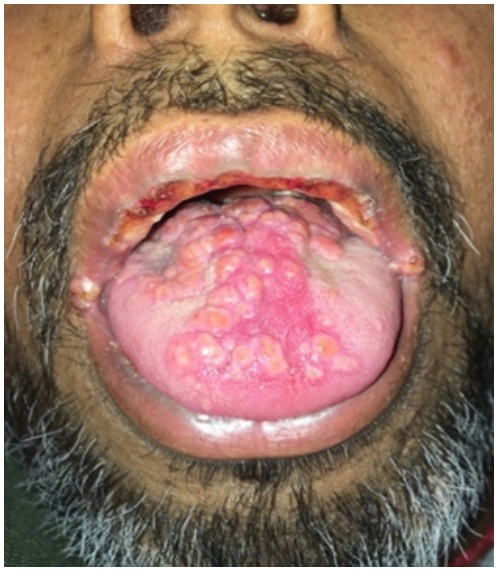

Figure 2 Multiple, well defined, erosions with haemorrhage over the buccal mucosa, hard palate and inner surface of lips

Histopathology revealed epidermal necrosis and acute inflammatory infiltrate in dermis with fungus histoplasmosis (**Figures 3** and **4**). Dermis was filled with multiple tiny intracellular round yeasts surrounded by a halo on PAS and GMS staining. Tissue culture grew cottony white colonies suggestive of Histoplasma capsulatum. A test for dimorphism was conclusive for histoplasmosis.

Treatment given

Itraconazole 100 mg twice daily for 8 weeks with topical application of Clotrimazole over mucosal lesions.

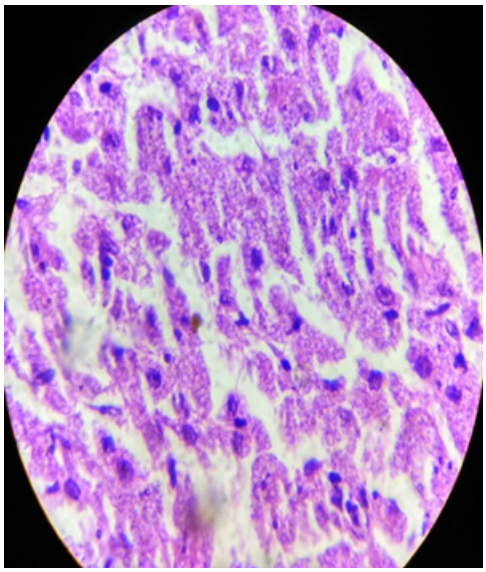

Figure 3 Fungus histoplasmosis

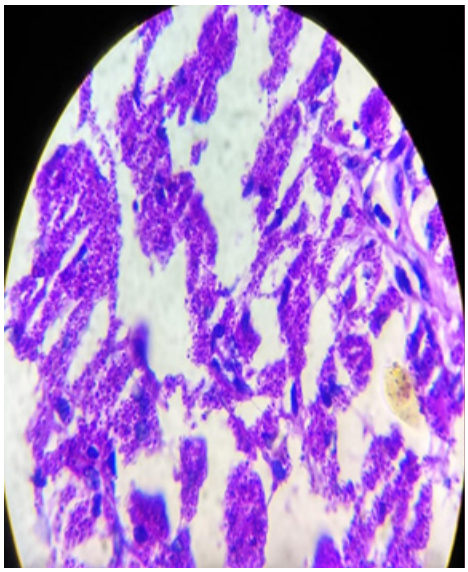

Figure 4 Histoplasmosis

Discussion

Disseminated mucocutaneous histoplasmosis is rare in immunocompetent host and from a nonendemic region. This patient was a resident of a non-endemic region of North India but frequently travelled to different parts of country [1]. We believe

that our patient contracted the disease via inhalation of conidia from contaminated soil.

Inhalation of microconidia is the main mode of transmission, after inhalation these microconidia, small enough to reach the terminal bronchioles and alveoli, they translocated to local draining lymph nodes [6] and spread throughout the reticulo endothelial system by blood Primary pulmonary histoplasmosis in the vast majority (~90%), is asymptomatic or subclinical [1]. Symptomatic hosts with primary pulmonary histoplasmosis often present with nonspecific self-limiting symptoms of fever, chest pain and cough. Immunocompetent hosts are able to control and limit infections with development of cell-mediated immunity. However, hosts with defective CMI, including patients with malignancies, organ transplants, AIDS and patients on chemotherapeutic and immunosuppressants, are at risk of developing progressive disseminated histoplasmosis involving the reticuloendothelial system, including the liver, spleen, kidney, lymph nodes, bone marrow and mucocutaneous tissues [1].

Disseminated mucocutaneous histoplasmosis in an immunocompetent is rarely described around the world [7]. We report a case of acute disseminated histoplasmosis in an immunocompetent host. Frequently, in such cases, oral lesions, such as ulcers, erythematous or vegetative indurated nodules or wart like growths, mainly over the palate, gingiva, and oropharynx are initial manifestations [1,7]. The common cutaneous lesions include papules, nodules and ulcers, and rarely granulomas, abscesses, fistulae, scars and pigmentary changes the noduloulcerative oral lesions may mimic squamous cell carcinoma, lymphoma, and other systemic mycoses like cryptococcosis.

Fungal culture remains the gold standard for diagnosis though it can often be negative [6]. Body fluids like, sputum, peripheral blood, bone marrow, tissue specimens and lymph node aspiration sample can be used for culture [1]. The culture yield white to light tan colonies on SDA culture.

Routine histopathology shows the budding yeast forms within histiocytes as a clear space or artifactual “halo” due to the retraction of the basophilic fungal cell cytoplasm from the poorly stained cell wall, confirmed by Gomory methenamine silver stain and PAS positivity, [6] and also by serology for histoplasma antigen in body fluids by immunodiffusion and complement fixation test, but not easily available and expensive hence not widely used [6].

Conclusion

Disseminated mucocutaneous histoplasmosis is not rare as it is assumed in non-endemic and immunocompetent host. Treatment of histoplasmosis in present era of advance antifungals like Itraconazole, terbinafine and voriconazole is easy. We used Itraconazole because of its easy availability and lesser cost.

Competing Interest

We assert that there is not any competing interest in this case report..

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