Disseminated Histoplasmosis

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A previously healthy 27-year-old El Salvadoran immigrant presented with a 2-week history of cough, fever, rigors, prostration, anorexia, weight loss, and scant hemoptysis. Physical examination revealed a thin, febrile, toxic-appearing man in respiratory distress with bibasilar rales and scattered wheezes. Laboratory data showed a sodium of 126 mEq/L, lactate dehydrogenase of 617 U/L, ferritin of 3570 ng/mL, and liver test abnormalities suggestive of cholestasis. Chest film (Fig. 1) and computed tomography (Fig. 2) demonstrated a diffuse miliary air space pattern. Sputum smears for mycobacterium tuberculosis were negative. A urine histoplasmosis antigen level was markedly positive (7.6 EIA units), and bone marrow cultures eventually grew Histoplasma capsulatum. The HIV test result was positive, and his CD4 count was 34 cells/mm^3. He was successfully treated with liposomal amphotericin B followed by itraconazole.

Histoplasmosis is the most prevalent endemic mycosis in Latin America. Most infections are asymptomatic or self-limited, but immunodeficient individuals may develop acute pulmonary or severe, progressive disseminated infection, usually from reactivation of latent disease. Although nonspecific, the serum lactate dehydrogenase and ferritin levels are often markedly elevated. Chest imaging may be normal or show a diffuse reticulonodular pattern (with nodules less than 3 mm in diameter), indistinguishable from miliary tuberculosis. In HIV-infected individuals, disseminated histoplasmosis usually develops when the CD4 count is less than 75 cells/mm^3. Treatment is generally lifelong.

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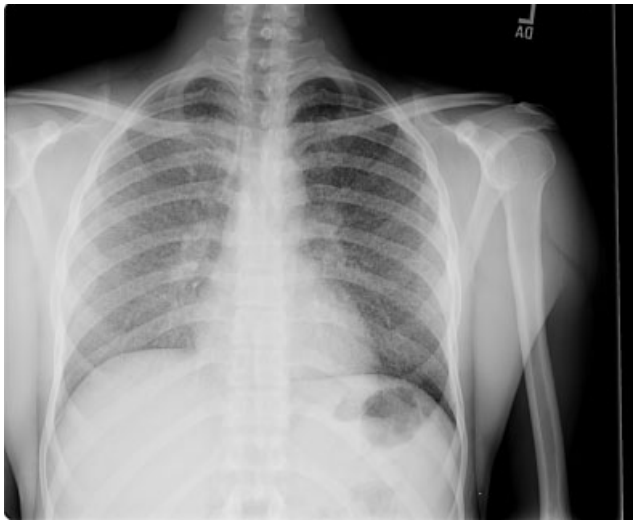

FIGURE 1. Chest radiograph.

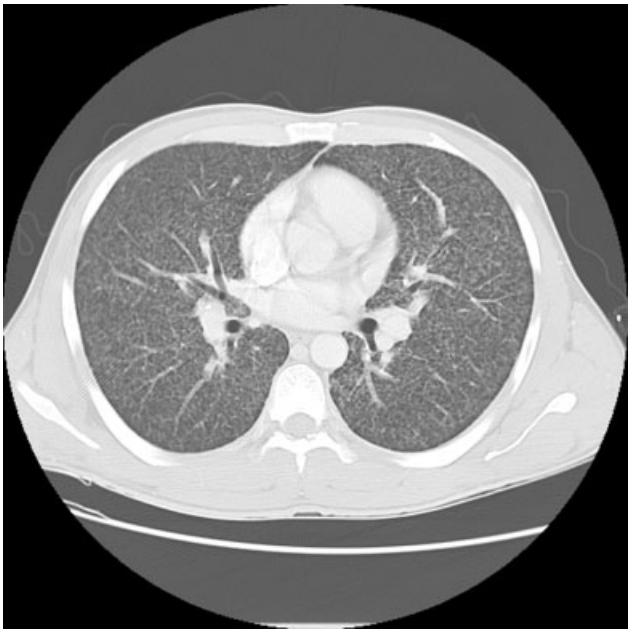

FIGURE 2. Thoracic CT.

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