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Histoplasma capsulatum sinusitis: Possible way of revelation to the disseminated form of histoplasmosis in HIV patients

Case report and literature review



R. Elansari*, R. Abada, S. Rouadi, M. Roubal, M. Mahtar

Departement 20 August Hospital Ibn Roched, University Hospital Center Casablanca, Morocco

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ABSTRACT

INTRODUCTION: *Histoplasma capsulatum* is rarely found in nose and sinuses in immunocompetent and even in immunosuppressed patients. A literature review revealed rare cases of *H. capsulatum* sinusitis and the case we describe in this paper is the first case of *H. capsulatum* sinusitis in Morocco. The purpose of our work is to present a rare case of *H. capsulatum* sinusitis and a literature review.

CASE REPORT: A male patient, at his 39 presented to the emergency with suffered from nasal congestion and yellow postnasal rhinorrhea, occasional headaches and epistaxis for over than two months. He had human immunodeficiency virus (HIV) infection for 6 years with failing treatment adherence and he had an opportunistic infection and unconfirmed pulmonary tuberculosis treated 3 years ago.

Computerized tomography from paranasal sinus revealed complete opacification of the ethmoid-maxillary sinuses in the right fossa, consistent with acute sinusitis.

The cultures of the sinus aspirate, skin biopsy, were positive for *H. capsulatum* and the histology of the nasal mucosa and skin biopsy specimen of the rash evoking a sinusitis and cutaneous histoplasmosis.

The patient was started a treatment with intravenous amphotericin B at a rate of 1 mg/kg/day with clear clinical and biological improvement.

DISCUSSION: Cultures and histopathologic study confirm histoplasmosis. Itraconazole and amphotericin B are the first line drugs.

CONCLUSION: Patients with progressive disseminated histoplasmosis and those with AIDS should be treated with amphotericin B, and the ENT should suspect of opportunistic agents in immunosuppressed patients with sinusitis.

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1. Introduction

Sinusitis is a common disease on both adults and children [1], and the most common pathogens cultured from sinus aspirates of patients with sinusitis are streptococcus pneumoniae and non typeable haemophilus influenzae.

Rhinosinusitis occurs from 25% to 30% of patients with AIDS [1]. On those patients we can easily find infections by *Pseudomonas aeruginosa*, fungi, virus, parasites and even mycobacteria. Aspergillus is the main etiological agent of fungal rhinosinusitis, while *Histoplasma capsulatum* is rarely found, in both immune competent and immune depressed patients. In this current study we found a rare case of rhinosinusitis by *H. capsulatum* and we would

like to discuss the aspects related to histoplasmosis pathophysiology, clinical manifestations, diagnosis and treatment.

2. Case report

A male patient, at his 39 presented to the emergency of hospital 20 August–Casablanca city of Morocco with suffered from nasal congestion and yellow postnasal rhinorrhea for over than two months. Symptoms were accompanied by occasional headaches and epistaxis. He also presented cacostmia, sudoresis in the afternoon, occasional fever with a weight of 10 kg within the same period. He complained of a cough which produced greenish sputum for several days and noted a skin rash which had been present for three months.

His past medical record was significant, as he had human immunodeficiency virus (HIV) infection for 6 years with failing treatment adherence.

* Corresponding author.

E-mail address: dr.elansari66@gmail.com (R. Elansari).

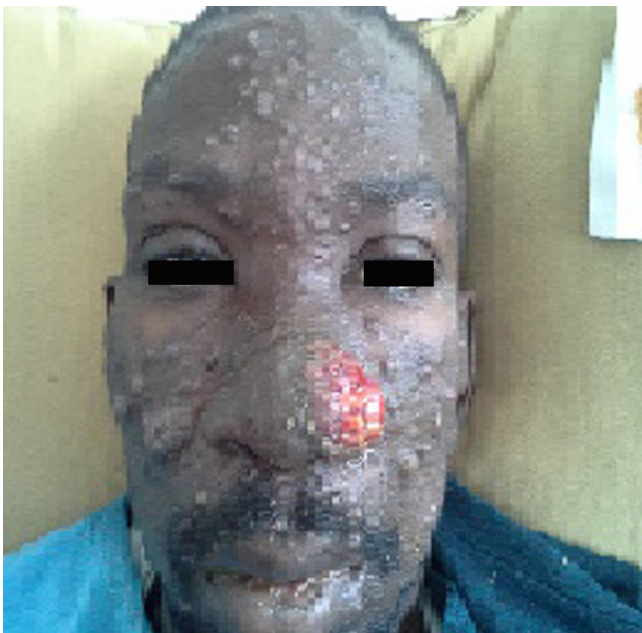


Fig. 1. Papular and nodular rash of the face.

He had an opportunistic infection and unconfirmed pulmonary tuberculosis treated 3 years ago, restraint on clinical arguments and currently he is taking antibacillare treatment.

Physical examination revealed a temperature of 38.5 °C, blood pressure of 86/54 mm Hg, and a pulse rate of 90/min. The respi-

ratory rate was 16/min while abdominal examination revealed a hepatosplenomegaly.

The skin examination was significant for papular and nodular rash of the face (Fig. 1), whose slightly raised edges. CD41 T-lymphocyte count was 120/ml and a virus charge was 310.410 copies. The endoscopic sinus examination was found polypoid and inflammatory nasal mucosa in the right nasal fossa, a stink of the middle meatus, and a bulging posterior wall of the nasopharynx.

Diagnosis discussion revealed: pulmonary tuberculosis, atypical mycobacterium infection, histoplasmosis, sarcoidosis, leishmaniasis or lymphoma.

A chest computerized tomography evidence of bilateral hilar and mediastinal lymphadenopathy and a diffuse reticulonodular infiltrate. There was a 1-cm pulmonary nodule in the superior segment of the right middle lobe (Fig. 2).

Abdominal ultrasound found a hydrocholecyste with expansion of the principal Bilaire way and a splenomegaly with micronodular splenic hilar training. Splenic puncture found a normal splenogramme, the leishmaniasis research was negative and the histological study was inconclusive.

Bone medullary biopsy has not been recovered infiltration of malignant cells. Leishmaniasis sérology was negative, no mark for a leishmaniasis found while doing myelogram and splenogramme.

Computerized tomography from paranasal sinus revealed complete opacification of the ethmoid-maxillary sinuses in the right fossa and partial opacification of both frontal sinuses, consistent with acute sinusitis (Fig. 3). Sinus aspiration and skin biopsy were performed as part of the diagnostic workup. Microscopic examination with gomori methanamine-silver staining showed organisms consistent with histoplasma in both specimens. The cultures of the sinus aspirate, skin biopsy, were positive for *H. capsulatum*. In addition, histology of the nasal mucosa and skin biopsy specimen of the

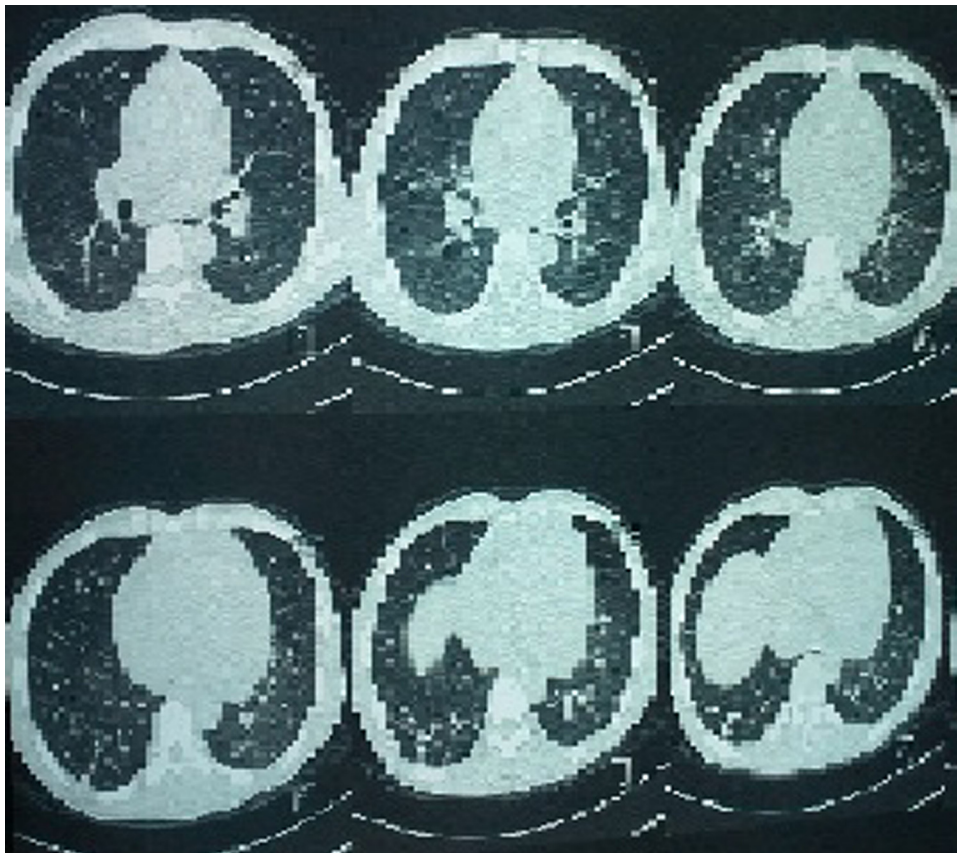


Fig. 2. Bilateral hilar and mediastinal lymphadenopathy and a diffuse reticulonodular infiltrate.

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