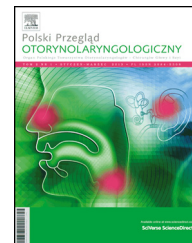


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Case Report/Kazuistyka

Disseminated histoplasmosis with oral and cutaneous manifestation in an immunosuppressed patient – A case report

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ABSTRACT

Histoplasmosis is a granulomatous fungal disease caused by *Histoplasma capsulatum*. This microorganism is found in soil rich in excreta of bats and birds. Histoplasmosis has variable clinical features. It is usually self-limiting or localized in immunocompetent individuals. On the other hand, it occurs in the disseminated form in 95% of patients with HIV/AIDS. This article describes a case of oral histoplasmosis in an immunosuppressed patient. A 39-year-old male was admitted to the Hospital Oswaldo Cruz complaining of oral soreness. Several ulcerations were observed on the lips, soft palate, tongue, and skin. The patient reported weight loss, appetite loss and fever. A biopsy was realized and microscopic examination showed chronic inflammatory infiltrate, collections of macrophages, and *H. capsulatum*. Itraconazole and Amphotericin B were used in the treatment and all lesions disappeared three months later. Oral manifestations of histoplasmosis may be exacerbated in patients with HIV/AIDS. Thus, the examination of the mouth and oropharynx should be performed in patients suspected of histoplasmosis.

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Introduction

Histoplasmosis is a chronic granulomatous infectious disease caused by *Histoplasma capsulatum*, a thermally dimorphic fungus. This fungus has been found in soils with high nitrogen concentrations, especially those associated

with bats and birds feces [1]. *H. capsulatum* reaches the human host by the inhalation of mycelial fragments of the fungus. Infection typically occurs after inhalation of these structures, which settle in airways followed by the thermally regulated transition to the parasitic yeast phase [2].

From the lungs, it can disseminate to several organs, giving rise to different clinical signs. Most infections caused

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by *H. capsulatum* are asymptomatic or subclinical. Symptomatic cases usually manifest as self-limiting respiratory tract infections [3]. However, the severity of the illness depends on the intensity of exposure and the immunity of the host [4]. One of the early and more evident manifestations of the disease is the presence of ulcers with irregular margins on the oral mucous membranes, especially on the tongue, palate and buccal mucosa. Histoplasmosis is one of the most important systemic mycosis in United States, and has also been reported in Latin America, Africa, Asia, India, and Australia [6-9]. In Europe, most cases of HIV-associated histoplasmosis occur in residents or travelers from South America. Several cases of histoplasmosis have been notably diagnosed in France, Spain, and Italy. Many cases are diagnosed late because clinicians are not familiar with this "endemic" disease [10-12].

In general, disseminated histoplasmosis occurs in debilitated patients with advanced age or immunosuppressed [13]. Histoplasmosis is controlled effectively by antifungal therapy, but recurrences are frequent and may cause sequels or death. This manuscript describes a case of disseminated histoplasmosis in a HIV-positive patient.

Report of case

A 39-year-old white male was admitted to the Hospital Oswaldo Cruz (Curitiba, PR, Brazil) complaining of bleeding and oral soreness. During the anamnesis, the patient related that oral lesions initially appeared on inferior lip. Three days before, he had tried to stop the bleeding by using a topical medication. However, no improvement in oral bleeding was observed and the patient decided to look for medical attention.

Chronic cough, weight loss, appetite loss, fever, and spontaneous oral and nasal bleeding were reported during clinical examination. Three months ago, he had been tested for tuberculosis(-) and HIV(+) quick test. The patient was initially treated with sulfamethoxazole 400 mg and trimethoprim 80 mg.

Oral examination revealed ulcers covered with crusts on the vermillion of the upper and lower lip (Fig. 1) and blood



Fig. 1 – Ulcerated lesions covered with hemorrhagic crusts on the lower lip vermillion and the skin

clots on the tongue. However, it was not possible to perform a complete oral examination due to bleeding of the lips. According to these findings, two hypotheses of diagnosis were issued: erythema multiforme and HSV infection. Thus, acyclovir (500 mg, 8/8 h) was prescribed.

Hemogram, blood platelets counting, hemossedimentation rate, serology (HIV, HCV, HBV, CMV, HSV, cutaneous leishmaniasis, and mononucleosis), VDRL, viral load, and CD4 counting were performed. These laboratory exams showed the following changes: anemia, leukopenia, thrombocytopenia, liver dysfunction, renal failure, and an elevated hemossedimentation rate (110 mm/h). The patient presented with fever (37.8 °C) and continued with pallor and prostration. However, all serological tests were negative, except for HIV.

Two weeks later, one of the crusts came loose and was submitted to histopathological examination. This examination revealed a crust of fibrin associated with colonies of bacteria and some fungi. Thus, the lip lesions were associated with thrombocytopenia. The patient received Kanakion® (phytomenadione 10 mg EV), blood and platelet transfusion. The lesions on the lip had completely repaired and there was no bleeding seven days later. This fact allowed a more detailed examination of the mouth after removal of the dentures. A nodular reddish lesion, suggestive of Kaposi's sarcoma, was observed on the hard palate. Thus, an incisional biopsy was scheduled. However, the lesion had completely disappeared after one week and the biopsy was canceled. Then, the diagnosis of nodular lesions in the palate was also associated with thrombocytopenia.

PCR for *Mycobacterium tuberculosis*, MAC and Cytomegalovirus were made. All results were negative. A chest CT scan was performed and showed scattered nodular opacities.

Ulcerative lesions appeared covered by crusts on the skin of the face and lip forty-five days after hospitalization (Fig. 2). In this same period, ulcerated and nodular lesions also appeared on the dorsum of the tongue (Fig. 3). Simultaneously, the ulcerated lesions showed granulomatous areas



Fig. 2 – Aspect of the lesions at the skin

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