Disseminated histoplasmosis presenting as colonic pseudotumor

Gastrointestinal histoplasmosis may be a rare initial manifestation in immunocompromised patients. We present a case of colonic histoplasmosis in a patient with human immunodeficiency virus (HIV), disseminated disease, and an unusual presentation.

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Her laboratory data were notable because they showed pancytopenia, but an initial neurologist and infectious work-up was negative. A magnetic resonance imaging (MRI) scan of her brain showed no acute intracranial pathology. Blood, urine, cerebrospinal fluid (CSF), and sputum culture results were negative. A computed tomography (CT) scan showed diffuse bilateral ground-glass opacities in the lungs, splenomegaly, and thickening of the wall of the ascending colon. A bronchoscopy was performed, and bronchial washings and biopsies were negative for fungal organisms.

The patient underwent a colonoscopy, which demonstrated a large 10-cm ulcerated area of mucosa with heaped-up edges in the ascending colon, suspicious for malignancy (Fig. 1). Biopsies from this area showed prominent granulomatous reaction, but no dysplasia or malignancy was identified. Periodic acid–Schiff reaction (PAS), a fungal stain, revealed numerous intracytoplasmic and extracellular fungal organisms consistent with Histoplasma capsulatum (Fig. 2).

The patient was positive for HIV by enzyme-linked immunoassay (ELISA) and Western blot, with a CD4 count of 29, and was diagnosed with acquired immune deficiency syndrome (AIDS). She was treated initially with amphotericin B for disseminated histoplasmosis, which produced a clinical improvement, and was then changed to itraconazole as consolidation therapy.

Histoplasmosis is a common opportunistic infection in immunocompromised patients with HIV and has been an AIDS-defining illness. The causative organism H. capsulatum is the most common fungus in the USA and is endemic in the Mississippi and Ohio River Valleys. Disseminated histoplasmosis occurs from hematogenous spread of the inhaled fungal spores or reactivation of histoplasma granulomas. Gastrointestinal involvement in disseminated histoplasmosis is common (70%–90% in autopsy studies); however, it is rarely identified during life [1]. The ileocecal area is commonly affected, presumably because of the abundant lymphoid tissue in this region. In our patient, diagnostic work-up did not reveal extracolonic histoplasmosis.

Gastrointestinal symptoms in disseminated histoplasmosis are nonspecific and may include abdominal pain, diarrhea, fever, weight loss, bleeding, and obstruction [2]. Endoscopic findings may include erythema, ulceration, stricture, or mass lesion, and may be misdiagnosed as colitis or malignancy [3]. Definitive diagnosis can be obtained by endoscopic biopsy of a lesion that subsequently demonstrates intracytoplasmic organisms. Disseminated histoplasmosis should be included in the differential diagnosis in immunocompromised patients with abnormal gastrointestinal imaging or symptoms. It is usually fatal if not diagnosed early and treated rapidly.

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References

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