A 61-year-old woman presented with vomiting and progressive weight loss. Blood counts, and liver and kidney function tests were normal. Upper gastrointestinal endoscopy showed a grossly dilated stomach with food residue, thickened duodenal folds, and luminal obstruction in the second part of the duodenum. Abdominal computed tomography showed features suggestive of gastric outlet obstruction and head/uncinate process mass lesion of the pancreas causing duodenal obstruction (Fig. 1). An endoscopic ultrasound (EUS) was done, and revealed a hypoechoic lesion in the head of the pancreas, with loss of planes between the pancreas and the duodenal walls (Fig. 2). EUS-guided fine-needle aspiration (FNA) was performed, and subsequent periodic acid-Schiff staining showed thin-walled, round yeast forms with histoplasma morphology, suggestive of pancreatic histoplasmosis (Fig. 3). Test for human immunodeficiency virus was negative. The patient was treated with itraconazole. Her symptoms improved gradually over the next month. However, sudden cardiac death occurred at 3 months due to arrhythmia.

The natural habitat of histoplasma is fecal-enriched soil found in avian habitats. Clinical manifestations of histoplasmosis vary, from asymptomatic pulmonary infection (most common form) to disseminated disease [1,2]. Disseminated disease is rare in immunocompetent individuals [2]. Pancreatic histoplasmosis is an uncommon form of gastrointestinal histoplasmosis, and intestinal obstruction, which has been reported in immunocompromised patients, is a rare form of the disease [2,3]. This case illustrates the importance of performing FNA of pancreatic head lesions.

Competing interests: None

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