Disseminated histoplasmosis in a patient with acquired immunodeficiency syndrome (AIDS): a case report

Abstract:

A 27 year old female with AIDS and disseminated histoplasmosis is presented. The clinical features include fever, weight loss, productive cough, splenomegaly and moderate pallor. The initial working diagnosis was pulmonary tuberculosis. The diagnosis of disseminated histoplasmosis was made terminally from bone marrow aspirate examination. Disseminated histoplasmosis with its varied clinical picture is likely to be missed in a patient with AIDS, and therefore a high index of suspicion is necessary for diagnosis. PIP: A 27-year old female from Nairobi was admitted to the medical wards of the Kenyatta National Hospital in May 1991. She presented with a 4-week history of productive cough, fever, weight loss, and night sweats. She acknowledged a history of contact with a patient known to have pulmonary tuberculosis. She has never received a blood transfusion. She was single and para 3 + 0. Examination revealed a sick patient, with moderate pallor, fever of 38 degrees Celsius, and who was wasted with moderate dehydration and oral thrush. There was no finger clubbing, lymphadenopathy, or pedal edema. Chest examination revealed bilateral basal pneumonia. The spleen was palpable 4 cm below the costal margin; the liver was not enlarged. The rest of the examination was normal. On admission, complete blood count showed a haemoglobin of 5.4 g/dl, total white cells were 12.5 x 10-9/L, with 82% polymorphonuclear cells and 18% lymphocytes, erythrocyte sedimentation rate (ESR) was 85 mm/hour, and platelet count was normal. The anemia was normocytic, normochromic, and no malaria parasites were seen. Urea and electrolytes and liver function tests were normal. Sputum showed no acid fast bacilli on Ziel-Neelson Stain. HIV-1 antibodies were positive by enzyme-linked immunosorbent assay (ELISA) and Western blot. Bone marrow aspirate revealed a hypercellular marrow with reversed M:E ration, dyserythropoesis, reticulum cell hyperplasia, plentiful golden yellow pigment, and clumps of Histoplasma capsulatum. Chest X-ray showed bilateral basal pneumonia. She was treated with antibiotics and intravenous fluids, but she remained febrile, her general condition progressively deteriorated, and she died a week after admission. Treatment for histoplasmosis had not been commenced, and no postmortem examination was carried out