Adrenal histoplasmosis: an uncommon presentation with an ulcer of the tongue

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DESCRIPTION

We report the case of a 73-year-old man who presented with a history of intermittent, episodic fever and of decreased appetite, citing a weight loss of 5 kg over a 6-month period. This was also associated with a central lesion over the posterior part of the tongue, appearing 6 months before. He also has a history of having experienced intermittent dizziness and dyspepsia. There were no other known comorbid chronic illnesses or history of tuberculosis. Besides confirming the presence of a nodular lesion on the posterior part of the tongue (figure 1), examination also revealed prominent lingual tonsils and hepatosplenomegaly. Biochemistry showed that he had hyponatraemia (130 mEq/dL) with an inappropriately low cortisol response under stress (13 µg/dL) with high plasma adrenocorticotropic hormone levels (159 pg/mL; normal: 5–46). A CT scan of the abdomen demonstrated bilateral hypodense lesions with heterogeneous contrast enhancement replacing the adrenal glands (figure 2). An MRI of the abdomen confirmed bilaterally enlarged, heterogeneously hypointense adrenal lesions measuring 30×22 mm on the right gland and 36×21 mm on the left gland, respectively. A biopsy from the lesion on the tongue demonstrated macrophages containing intracellular, round-to-oval capsulated small-sized (3–5 µm) yeast-like fungus that resembled *Histoplasma capsulatum* (figure 1), confirming the diagnosis. He was initiated on oral prednisolone, fludrocortisone and itraconazole and continued to be asymptomatic during the remainder of his stay at the hospital. He was subsequently discharged and remains on follow-up. Histoplasmosis, caused by *H. capsulatum*, is usually asymptomatic, but may occasionally present as severe illness. Despite the sparseness of literature that hinders an accurate estimate of worldwide prevalence, previous reports have suggested that it may be endemic to parts of eastern India.[1 2] A recent review has shown increased reporting of identified cases from India.[3] Future prospective studies may aid better understanding of the epidemiology. Although pulmonary histoplasmosis is the most common type of presentation, chronic haematogenous dissemination frequently takes place in immunocompromised states.[4] The adrenal glands are commonly involved; however, overt adrenal insufficiency is uncommon. Oropharyngeal involvement is reported in at least 30% of cases.[5] These lesions have clinical significance and early biopsy can prevent diagnostic delay.[6 7]

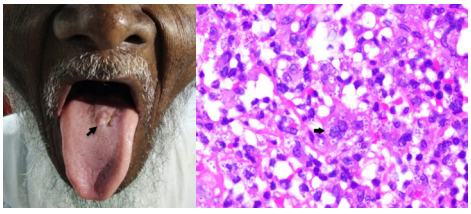

Figure 1 (L) An elevated, nodular central lesion seen on the tongue (indicated with an arrow); (R) histopathology of which demonstrated macrophages containing intracellular, round-to-oval capsulated small-sized (3–5 µm) yeast forms (seen at the arrow) that resembled *Histoplasma capsulatum* (H&E, 400×).

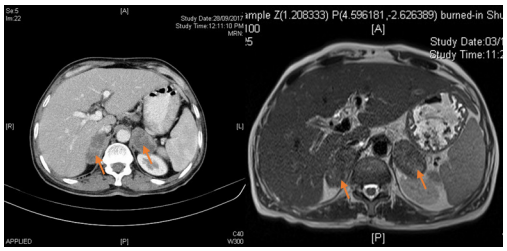

Figure 2 (L) A CT scan of the adrenal glands showing bilateral hypodense lesions with heterogeneous enhancement (shown with arrows); (R) MRI of the abdomen showing bilaterally enlarged, heterogeneously hypointense adrenal lesions (shown with arrows), measuring 30×22 mm and 36×21 mm on the right and left sides, respectively.

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Competing interests None declared.

Learning points

- In the presence of bilateral adrenal enlargement, it is important to consider histoplasmosis as a potential differential diagnosis.
- While the disseminated form of histoplasmosis has been described commonly in patients in immunocompromised states, it does not rule out its occurrence in others without this predisposition.
- Early biopsy of a suspect oropharyngeal lesion may prevent diagnostic delay.

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