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Disseminated Histoplasmosis

Comment 1

I read with interest the case report on Disseminated Histoplasmosis by Joshi et al. The case is not the first culturally confirmed case of disseminated histoplasmosis in AIDS patients in India. Although the disease is under-diagnosed and under-reported from India, such a case was reported from Calcutta School of Tropical Medicine, along with four other chronic disseminated histoplasmosis in non-AIDS patients. Those were detected between February 1996 and September 1997 and all were culturally confirmed.

In the past, maximum number of this rare fungal disease were reported from this centre, including the first reporting of an Indian case of histoplasmosis in 1954 and the only report of isolation of causal fungus from Indian soil in 1975. In spite of under-reporting, at least 38 cases have been documented from India up to 1992. In view of the rising incidence of AIDS in India, the alarm of appearance of histoplasmosis as an emerging opportunistic infection in eastern India was given with first reported histoplasmosis as an emerging case infected with HIV. The apprehension has now come to a reality after detecting nine more cases of disseminated histoplasmosis in HIV-infected cases who attended Calcutta School of Tropical Medicine from 2000 to 2006 (S. Basak, Personal communication). Thus, the Indian scenario of histoplasmosis in AIDS patients is changing very rapidly and is not confined to three or four reported cases only. Since Maharashatra is not as endemic an area for histoplasmosis as West Bengal, the information about travelling to any high-endemic locality is also important for epidemiological purpose. The authors have very rightly pointed out the need of a countrywide survey on skin sensitivity to histoplasmin, as well as to develop a high degree of clinical suspicion for this rare disease whenever a clinical indication is there.

As the disease is very rare in India, most microbiologists may have no practical experience in isolation and identification of *H. capsulatum*. Bedside inoculation of bone marrow aspirate into multiple tubes of Sabouraud dextrose agar slant and incubation up to six weeks is almost always rewarded with success in disseminated histoplasmosis cases. It is preferred because no other clinical material can be collected in sufficient quantity to provide sufficient parasite-laden macrophages than bone marrow and its collection is relatively easier. Sometimes, scanty growth is overlooked. Any floccose white fungal growth should be observed for conidiogenesis by slide culture. Typical macroconidia sometimes appear late and most of these may be initially without tuberculate processes. After long-term observation or subculture, typical morphology may appear. Microscopic examination of smears or histopathological sections sometimes creates confusion with leishmaniasis whose clinical presentations, morphological appearance and therapeutic responses are very much similar to histoplasmosis. This should be considered particularly for areas like West Bengal where both the diseases are endemic.

References


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