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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.

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 a region for histoplasmosis as West Bengal, the information about travelling to any high-endemic locality is also important for epidemiological 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


Comment 2

I have read the case report on “Disseminated Histoplasmosis” published by Joshi et al. This is to draw your attention to the article “Disseminated Histoplasmosis” published from our institution by Subramanian et al. The article refers to diabetes mellitus and HIV being the most common co-morbid conditions. This is the single largest series on disseminated histoplasmosis from India including culture-proven disseminated histoplasmosis.

The figures published have been transposed and do not correspond to the text. The yeast cell in the picture is not clear

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to the uninitiated eye and the arrow pointing to this would greatly improve the quality of this publication. The “numerous” microconidia mentioned in the text is not evident in the figure that has been published.

References

Commercial radiation has been used to sterilize medical products for more than 40 years.1,2 Evidence from the literature clearly demonstrates that domestic microwave energy can be used for sterilization.3,5 The equipment in routine use for the sterilization of surgical materials is moist heat sterilizer, i.e., autoclave. The main purpose for using

Authors’ Reply

Dear Editor,

The case report of disseminated histoplasmosis in a patient with AIDS was published with the idea of increasing awareness of this condition and we are happy with the response we have received. Acute disseminated histoplasmosis is considered an AIDS indicator disease and yet reports from this country are very few. This is in spite of the fact that India is one of the major foci of the AIDS pandemic. One of the reasons for this as aptly brought out by Goswami et al.1 is that Histoplasma culture is difficult unless the appropriate sample is collected and there is a high index of suspicion by the microbiologist. Though the disease is more commonly reported from the Eastern parts of India, it is by no means restricted to these parts of the country as amply demonstrated by the article by Subramaniam et al.2 and an earlier review by Randhawa et al.3 Increased travel within the country has made the prevalence of the disease more widespread than it was previously believed to be and is at present still under-reported.

Though our culture showed abundant microconidia, the picture published with the article attempted to demonstrate the macroconidia as these are more characteristic of the organism. The photograph also shows many macroconidia without the characteristic tubercles and one in which these tubercles are just appearing. This has been aptly brought out in the comments by Goswami et al.,1 who have described that typical macroconidia may sometime appear late and most of these may be initially without tuberculated processes. An arrow was placed in the photograph pointing to the yeast phase of the organism.

By the time this article was submitted for publication, the series of Subramaniam et al.2 mentioned above had not been published. However, in spite of an extensive review of available literature, we missed the single culture positive case in the study by Goswami et al.1 Therefore, the credit for the first culture of Histoplasma from a patient with disseminated histoplasmosis in an AIDS patient must go to them.

References

Microwave Disinfection of Gauze Contaminated with Bacteria and Fungi

Dear Editor,

Commercial radiation has been used to sterilize medical products for more than 40 years.1,2 Evidence from the literature clearly demonstrates that domestic microwave