Bilateral Adrenal Histoplasmosis in an Immunocompetent Patient

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The Case

A 57 year old Muslim patient, farmer by occupation, admitted with a history of fever and productive cough for two and half months. Fever was low grade without any chill and rigor, evening rise and used to subside spontaneously within hours. Sputum was scanty, mucoid, occasionally purulent. Though no acid fast bacilli were detected on sputum examination, patient was put on ATD by local physician on the basis of findings of Chest X ray (Figure 1). But ATD was stopped after two months as there was no response and patient was referred to us. Physical examination revealed mild pallor without any cyanosis, jaundice, clubbing or lymphadenopathy. Blood pressure was 120/80. Bilateral scattered rhonchi and crepitations were detected on Chest examination. Other systems examination did not show any abnormality. Investigations revealed Hb-10.0gm/dl, WBC-6000/dl, N-50 %, L-42%, E-8%; urea-32mg/dl, creatinine 1.1mg/dl. Na-137.7, K-3.9. Fasting and post-prandial blood sugar were 87mg/dl and 124mg/dl respectively. Liver function test was within normal limit. Elisa for HIV I and II was non reactive. Ultrasonography of abdomen showed a hypoechoic space occupying lesion in upper pole right kidney. Impression was (?) hypernephroma. But C. T.Scan of Abdomen (Figure 2) detected bilateral adrenal enlargement-likely neoplastic. C.T. guided FNAC done and it showed plenty of budding yeast cells along with inflammatory cells and necrosis –suggestive of Histoplasmosis (Figure 3). Serum cortisol was within normal limit (4.6µgm/100ml).

Histoplasmosis usually occurs in immunocompromised patients.¹ But in immunocompetent patients it is rarely reported². Our patient presented with low grade fever, cough, weight loss. These features pointed to a diagnosis of tuberculosis by local physician. Later on Ultrasonography and C.T. scan of abdomen detected bilateral adrenal mass likely to be neoplastic. Finally FNAC gave the diagnosis of Histoplasmosis. This case emphasizes the fact that adrenal histoplasmosis does occur in immunocompetent patients and has to be considered in the differential diagnosis of fever with bilateral adrenal masses.

References