Histoplasmosis and AIDS co-infection *

Coinfecção histoplasmose e Aids

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Abstract: This report concerns an AIDS patient presenting systemic and cutaneous manifestations of histoplasmosis. A histopathological and mycological examination of the skin lesion confirmed the diagnosis. In AIDS patients histoplasmosis arises mainly when the T-CD4+ cell count is less than 50 cells/mm3. In such cases, histoplasmosis can be severe and if left untreated can lead to death, as occurred with this patient.
Keywords: AIDS-Related Opportunistic infections; Acquired immunodeficiency syndrome; HIV; Histoplasma; Histoplasmosis

Resumo: Apresenta-se um caso de coinfecção histoplasmose e Aids, com lesões cutâneas predominantemente papulosas e comprometimento sistêmico. O exame histopatológico e micológico de lesão cutânea confirmou o diagnóstico. Em doentes com Aids, a histoplasmose surge, principalmente, quando a contagem de células T-CD4-positivas é inferior a 50 células/mm^3. Nesses casos, a histoplasmose pode ser grave e, se não tratada adequadamente, levar ao êxito letal, como no paciente relatado.
Palavras-chave: HIV; Histoplasma; Histoplasmose; Infecções oportunistas relacionadas com a Aids; Síndrome de imunodeficiência adquirida

Histoplasmosis is caused by *Histoplasma capsulatum var. Capsulatum*. In patients with AIDS it occurs mainly when the T-CD4-positive cell count is less than 50 cells/ mm^3. In such cases,this mycosis can be severe and if left untreated can lead to a lethal outcome, as in the patient reported here. [2,3] Clinical symptoms may include fever, hepatosplenomegaly, lymphadenopathy, pulmonary manifestations, skin and mucosal lesions and central nervous system involvement. [3,4] Macular, purpuric, papular lesions (occasionally acneiform or molluscum contagiosum-like), plaques and ulcers can occur together or in isolation (Figures 1 and 2). Erosive lesions or ulcers can occur

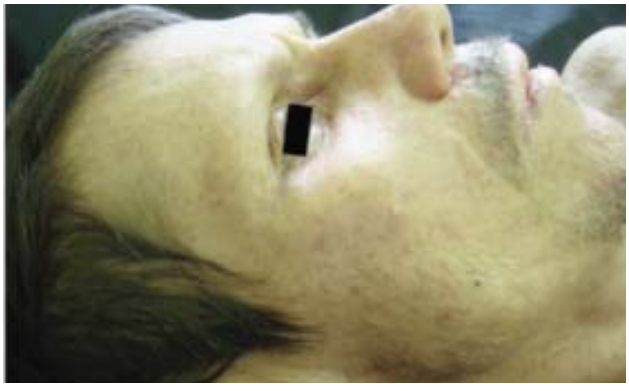

FIGURE 1: Male patient with newly-diagnosed AIDS without antiretroviral therapy, presented (one month ago) with papular, erythematous, confluent and isolated lesions on the face, trunk and upper and lower limbs. Close-up of face lesions

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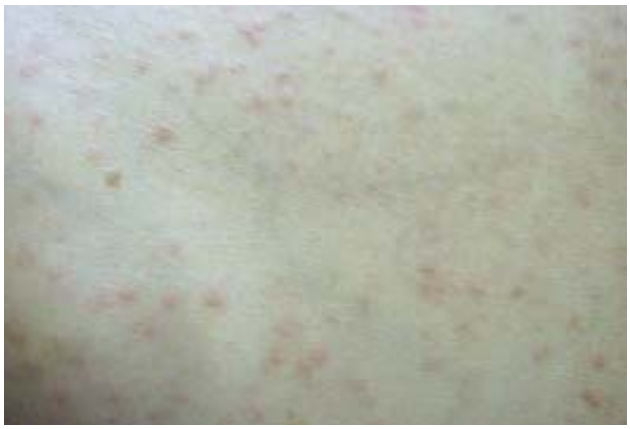

Figure 2: Close-up of the papular lesions of the trunk showing site of skin biopsy

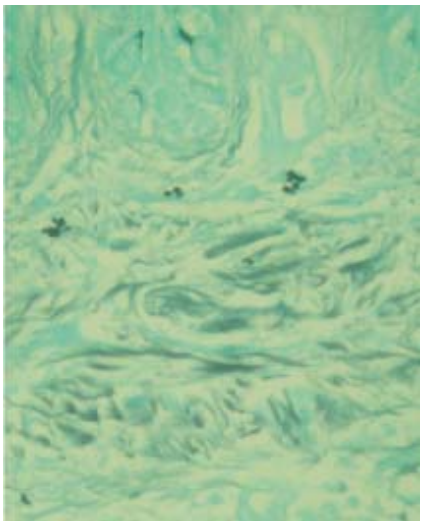

Figure 4: Silver staining reveals a few isolated and grouped parasites, (Grocott, 400x)

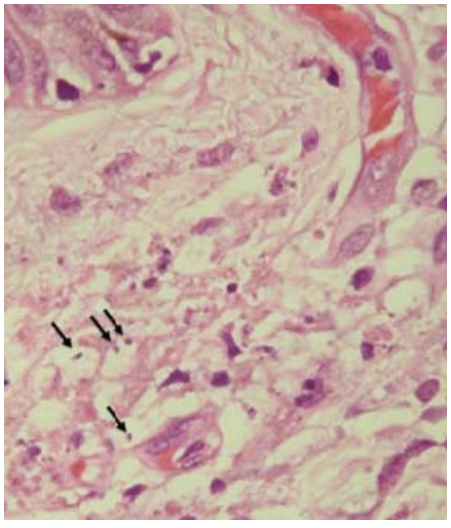

Figure 3: Histopathologic examination shows foamy histiocytes and round basophilic structures inside, some indicated by arrows (hematoxylin and eosin, 400x)

in the oral mucosa. [4-7] Diagnosis is made by direct examination, culture and histopathology (Figures 3 and 4). The treatment of severe cases (T-CD4+ counts of below 100 cells/ mm^3 and/or general state of health compromised) consists of amphotericin B (1mg/kg) until complete regression of clinical symptoms, followed by maintenance with fluconazole or itraconazole (200-300 mg/day) until the T-CD4+ count reaches 150 cells/mm^3.[1,4-7] ❑

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