

LETTER TO THE EDITOR

(*J Bangladesh Coll Phys Surg 2012; 30: 58-59*)

To

Editor in Chief

Journal of Bangladesh College of Physicians and Surgeons

Sir,

I had gone through the case report of your valuable journal (Vol . 29, No. 4, October 2011) title with “Chronic Disseminated Histoplasmosis in an Immunocompetent Man Presented as Bilateral Adrenal Masses with Partial Adrenocortical Insufficiency- A Rare Condition” by ABM Sarwar-e-Alam et al with keen interest and have few observations.

- a. The case report was well written and the contents and illustrations were nice.
- b. Disseminated Histoplasmosis involving adrenal gland is a rare disease and under diagnosed and underreported but it is not the first case in Bangladesh as there was another report published in Journal of Medicine 2011;12:81-85. Adrenal involvement is seen in disseminated disease but sometimes it may be the only site of demonstrable disease.¹
- c. Pure form of dissemination of a disease need involvement of two or more than two sites, but in this case only one site is mentioned.
- d. Serological diagnosis (antigen and antibody based)² is important for diagnosing chronic disseminated histoplasmosis. In this paper no such diagnostic tool was used.
- e. The recommended treatment is amphotericin B for critically ill hospitalized patients³. Less severe cases can be treated with oral Itraconazole which is the first line drug. In this case Amphotericin was given as first line drug though it was not severe form of disease. Among patient without AIDS, amphotericin B is effective in 68-72% of the cases, itraconazole is effective in 100% of the cases, ketoconazole is effective in 56-70% of the cases and fluconazole is effective in 86% of the cases.⁴

The authors have rightly pointed out that high degree of clinical suspicion for this rare disease should be developed.

1. Vyas S, Kalra N, Das PJ, Lal A, Radhika S, Bhansali A, Khandelwal N. Adrenal histoplasmosis: An unusual cause of adrenomegaly. *Indian J Nephrol.* 2011 Oct;21(4):283-285
2. Wheat LJ. Improvements in diagnosis of histoplasmosis. *Expert Opin Biol Ther* 2006;6:1207-21.
3. Adderson E. Histoplasmosis. *The Pediatric Infectious Disease Journal* 25: 73-74, 2006. [Links]
4. J. bras. pneumol. vol.35 no.11 São Paulo Nov. 2009 <http://dx.doi.org/10.1590/S1806-37132009001100013>

Dr Rukhsana Parvin

Assistant Professor

Department of Medicine

Enam Medical College, Savar

Author's Reply

To

Editor-in-Chief

Journal of Bangladesh College of Physicians and Surgeons.

Dear Sir,

I have got the following reply of the comments mentioned by Dr Rukhsana Parvin:

- a. Thanks for her kind remarks,
- b. We submitted our case report to your office on 06/10/2010 prior to the publication mentioned by her which was published in Journal of Medicine 2011; 12:81-85.
- c. The literal meaning of “Disseminated histoplasmosis” is progression of histoplasmosis beyond the initial focus in the lung (usually) or skin (rarely) to other organs. In other word we can say, disseminated histoplasmosis is a progressive extrapulmonary infection. So there was no doubt about disseminated histoplasmosis in our case. Involvement of two sites or more sounds the diagnosis anatomically and clinically as

disseminated form. In our case, two adrenals were involved.

- d. We agree that the specific diagnostic laboratory tests are –detection of antigen of *H. Capsulatum* in urine and serum, histopathology, antibody to *H. Capsulatum* in serum, culture of blood or tissue samples. There is no doubt, culture or biopsy is the definite tool for diagnosis of disseminated histoplasmosis. Both the tests were done in our case. Tests for antigen and antibody may be falsely +ve or –ve in good number of cases. Moreover In non-AIDS patients with disseminated histoplasmosis, serological test is of limited value.
- e. Our patient was an elderly man (75 years) with fever and symptomatic postural hypotension (lying

100/62→standing 70/55 mmHg) which was due to adrenal involvement. So we chose step-down therapy i.e., initially Injection amphotericin-B followed by oral itraconazole because itraconazole does not eradicate fungemia as rapidly as amphotericin-B (we followed the clinical practice guidelines for the management of patients with histoplasmosis updated in 2007 by the infectious diseases society of America).

Dr. A B M Sarwar-e-Alam ,
Professor Zahidul Hasan,
Professor Md. Aminul Islam Khan,
Square Hospitals Limited, Dhaka