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Histoplasmosis in Patient with 23 Years Untreated HIV/AIDS

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CASE REPORT

43 year old African American Female with PMHx of HIV (diagnosed in 2002 during first and only pregnancy), cervical dysplasia, s/p colposcopy, and recurrent sinusitis s/p adenoidectomy (2021) seen in the outpatient setting for acute complaints of chills, malaise, body aches, decreased appetite, weight loss, nausea, fever, and diarrhea for three weeks. Patient had workup done in the clinic which revealed a HIV viral load of 327,000 vc/ml and CD 4 count of 8 cell/cmm. She endorsed been told she had HIV in 2002, when she was pregnant with her only child, but never received any treatment nor followed up with infectious disease specialists because of her fear of stigmatization and possible harm of the medicine to her then yet to be born child. She was admitted to a community hospital and started on bictegravir-emtricitabine-tenofovir alafenamide (Biktarvy) 50-200-25 mg tablet and sulfamethoxazole-trimethoprim (Bacrim DS) 400-80 mg both once daily. She also underwent a Computerized Tomography (CT) Scan of the abdomen which demonstrated enteritis, pathologically enlarged mesenteric and retroperitoneal lymphadenopathy, with discrete 2.1 cm left para-aortic retroperitoneal node. Her vital signs were significant for fever (101.9^0f), and elevated heart rate (105/min) with labs additionally positive for hyponatremia (125 mmol/L), enteropathogenic E. Coli (on stool culture), and elevated liver function levels (AST – 224 IU/L; ALT – 94 IU/L). Patient was started on intravenous antibiotics (piperacillin/Tazobactam and vancomycin) and underwent a CT guided biopsy of the retroperitoneal lymph node. Histopathology results from the retroperitoneal lymph node biopsy were positive for caseating granuloma with extensive histiocytic inflammation containing intracellular fungal organisms most consistent with Histoplasma. The results were negative for malignancy and patient was started on intravenous amphotericin B infusion 300mg once daily for 14 days, and then continued afterwards on oral Itraconazole once daily for twelve months. Upon discharge, patient has been compliant with her medications (including Biktarvy, Bactrim DS, and itraconazole) and has seen her HIV viral load reduced to 50 vc/ml and her CD4 count increased to 166 cell/cmm. She has also returned to work at a nearby factory (as a forklift operator), and denies any active sexual relationships.

DISCUSSION

Disseminated histoplasmosis is very common in Acquired Immunodeficiency Syndrome (AIDS) patients,[1] with some studies noting prevalence of 5% among AIDS Patients in the Ohio/Mississippi valley and other reports noting a global incidence of approximately 100,000 cases in 2017.[2] It is caused by the *Histoplasma capsulatum* fungus, and in the United States

of America (USA) is most commonly seen among those living in the surroundings of the Ohio and Mississippi river valleys.[3]

There are two types of histoplasmosis in HIV/AIDS patients. These include acute cases which present with fever, body aches, malaise, headaches, chest pain, or cough alongside pulmonary, dermatological, or rheumatological findings.[3] The other type is disseminated histoplasmosis which presents in elderly and immunosuppressed patients with more widespread systemic involvement (including bone marrow, liver, lymph nodes, spleen, and Gastrointestinal tract).[4]

Our patient had gastrointestinal and reticuloendothelial systems involvement and as a result we diagnosed her with disseminated histoplasmosis. She required aggressive treatment using intravenous amphotericin B and is now on oral itraconazole for the following twelve months.

Her lack of HIV treatment, post-diagnosis in 2002, most likely resulted in her disseminated histoplasmosis condition, and her case highlights the need to connect every patient diagnosed with HIV to linkage of care and adequate follow up.[5] She stated during her clinical visits that the stigma of entering an office dedicated to managing HIV/AIDS, and the fact that one of the principal staff knew her brother dissuaded her from attending to her health at that particular office.

The need to destigmatize HIV treatment in our medical system cannot be over emphasized. Our patient was infected by her child's partner and their inability to connect to care inadvertently resulted in the increased costs of care (as seen from our index patient's admission costs), and complications such as disseminated histoplasmosis arising in our patient.

The urgent need to use offices that are less stigmatizing, and easier for the general population to access without been profiled is a task the Infectious disease community must identify and address. Many patients, including our index patient, suggest the need to have a more incognito approach to HIV patient visits. They believe that making medical offices more open access to all-comers and less restricted to one disease will ward off their fear of stigmatization and improve patient compliance with treatment protocols.

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