Molluscoid Lesions Over Face, Trunk and Bilateral Upper Limbs

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A 66-year-old female presented to our outpatient department with multiple itchy, tender, reddish-raised lesions over the face, trunk, and bilateral upper limbs for 1 month. Cutaneous lesions first appeared over the trunk in the form of discrete papules or nodules with some lesions featuring central umbilication. They slowly progressed to involve the whole back, face, and both upper limbs over a period of 15–20 days. The lesions were associated with mild-to-moderate pruritus and were tender to touch [Figure 1a and b]. She also complained of intermittent high-grade fever, loss of appetite, abdominal discomfort, generalized weakness, and cough without sputum for 3 months. She got relief from her fever and constitutional symptoms, but there was no relief from cough during the whole duration of her illness. A general physical examination revealed mild hepatosplenomegaly and generalized lymphadenopathy. Blood investigations showed raised parameters for liver function. X-ray of the chest revealed a single focal opacity in the upper lobe of the left lung. Serological testing for HIV was non-reactive. There was no history of visiting to caves or any exposure to birds.

Question

What is the diagnosis?

Answer

Disseminated cutaneous histoplasmosis.

Discussion

Histoplasmosis is a systemic mycosis caused by the dimorphic fungus *Histoplasma capsulatum*, which has two varieties: *H. capsulatum var capsulatum* and *H. capsulatum var duboisii*. *H. capsulatum* is endemic in some temperate and tropical countries like America, Africa, and Australia, and *H. duboisii* is only reported in Africa. In India, it is endemic in West Bengal and areas of Southern India. A few sporadic cases have also been reported from NorthIndia.[1] Histoplasma is a natural inhabitant of soil and has been recovered from soil enriched with bird and bat excreta. Humans acquire infection via inhalation of air-borne microconidia, which settle in the alveoli, leading to granuloma formation. In nearly 1% of cases, it may also disseminate to other organs, including the liver, lymph nodes, central nervous system (CNS), bone marrow, liver, adrenal gland, and skin.[2] The clinical presentation of histoplasmosis could be pulmonary, progressive disseminated, and primary cutaneous. Cutaneous lesions in the case of disseminated histoplasmosis can be papules, pustules, plaques, ulcers, warts, and rarely may present as erythema nodosum.[3]

Unlike in an immunocompetent host, widespread multiorgan involvement is seen in 95% of cases of acquired immunodeficiency syndrome (AIDS) who are infected with *Histoplasma capsulatum*.[3] Our patient was an immunocompetent host without any comorbidities. She presented to us with a complaint of multiple tender, itchy nodules resembling molluscum, which were discretely located over the face, trunk, and bilateral upper limbs.

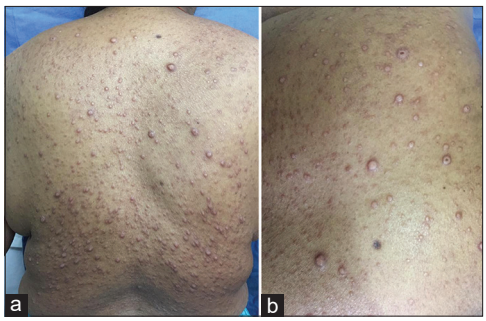

Figure 1: (a) Multiple papules to nodules over the trunk (b) Papules showing umbilication in center

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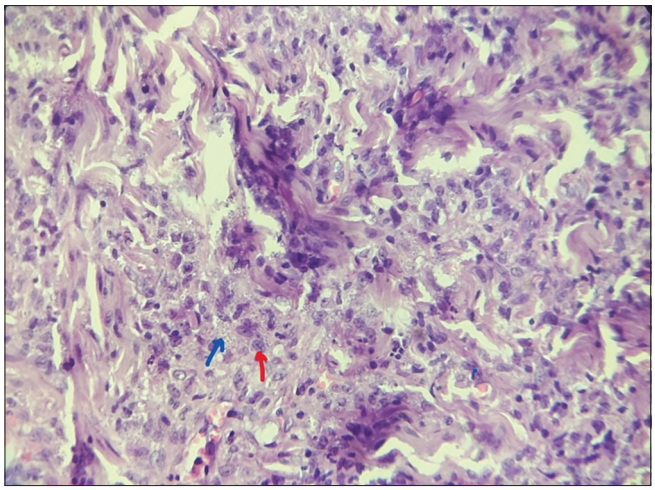

Figure 2: Multiple intracellular (red arrow) and extracellular (blue arrow) round to ovoid capsulated organisms (H&E, 40X)

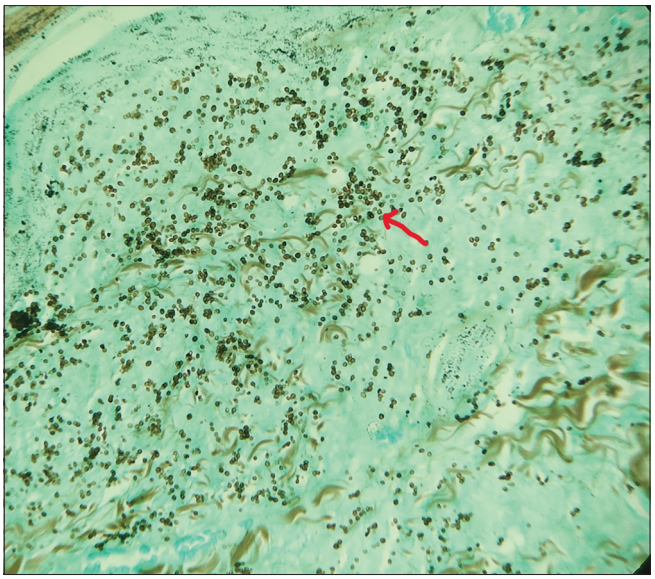

Figure 3: Gomori Methenamine silver (GMS) stain showing multiple capsulated organisms

The other differential diagnoses included cryptococcosis, leishmaniasis and penicilliosis. Spores of cryptococcus can be differentiated from histoplasma as they are larger and do not have well demarcated clear halo. Leishman Donovan (LD) bodies can be distinguished by a nucleus and bar-shaped kinetoplast within the amastigote, and it is negative for periodic acid–Schiff (PAS). *P. marneffei* replicates by binary division and has an septate appearance, whereas *H. capsulatum* divides by budding.[4]

Our patient's histopathology featured focal thinning of the epidermis. Dermis showed a dense mononuclear inflammatory infiltrate of histiocytes and few lymphocytes with multiple intra and extracellular round to ovoid-capsulated organisms [Figure 2]. PAS and Gomori methenamine silver stains confirmed the capsulated yeast form of histoplasma [Figure 3].

Mucocutaneous histoplasmosis is frequently seen in AIDS patients but rarely develops in immunocompetent hosts. It can be misdiagnosed as tuberculosis. We report a case of disseminated histoplasmosis with molluscum like morphology in an HIV-negative patient without any comorbities.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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