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Miliary thoracic pattern in disseminated histoplasmosis: not always tuberculosis

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A 24-year-old woman with Crohn's disease who had been receiving maintenance therapy with adalimumab (40 mg every 2 weeks) for 4 years presented with fever, moderate respiratory distress, and weight loss. She had travelled to Costa Rica three months prior to presentation.

The patient had leucopenia (3.3 G/l) and moderately elevated liver enzymes. Thoraco-abdominal computed tomography revealed diffuse pulmonary micronodules with a miliary distribution, ground-glass opacities (figure 1), and hepatosplenomegaly (not shown). HIV testing was negative.

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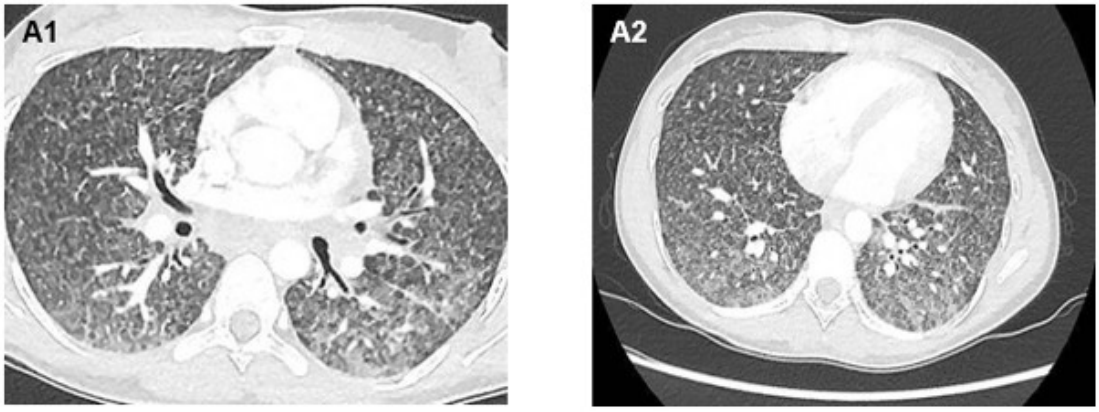


Figure 1: Thoracic computed tomography images illustrating multiple diffuse pulmonary micronodules with miliary/ haematogenous distribution and ground-glass opacities.

Antituberculous therapy was initiated, but the nucleic acid amplification test (NAAT) for *Mycobacterium tuberculosis* performed on bronchoalveolar lavage (BAL) fluid was negative. However, the NAAT, consisting of an in-house panfungal PCR targeting 26S rRNA, identified *Histoplasma capsulatum*. Histopathological examination of transbronchial biopsies revealed *Histoplasma* yeasts (figure 2).

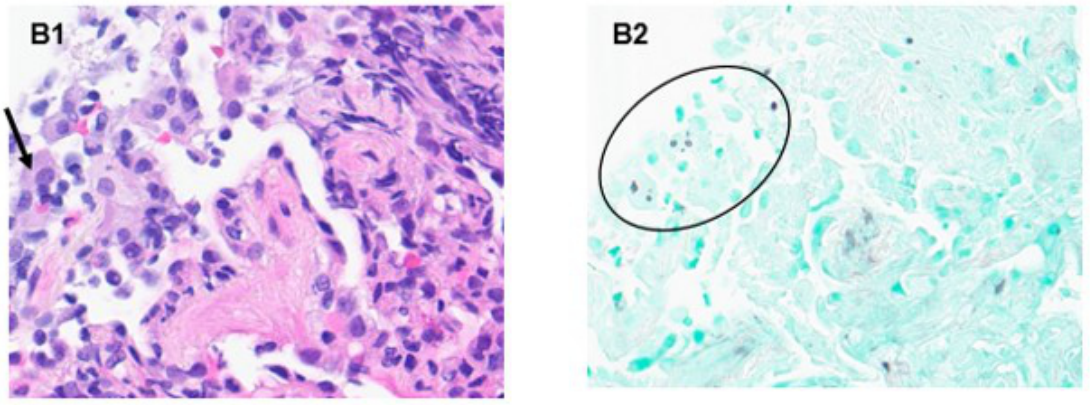


Figure 2: Histopathological examination of transbronchial biopsies on hematoxylin and eosin staining and Grocott methenamine silver staining, respectively (objective magnification ×40) indicating the *Histoplasma* yeasts (arrow and ellipse, respectively).

The patient was treated with liposomal amphotericin B (3 mg/kg/day for 12 days), followed by itraconazole (200 mg twice daily for 12 months) [1], resulting in improvement. Histoplasmosis may be fatal in patients receiving tumour necrosis factor-alpha inhibitors and may mimic miliary tuberculosis [2].

Notes

Informed consent: Written informed consent was obtained from the patient for the publication of the case report and the accompanying images.

Use of AI: The authors declare that no generative artificial intelligence (AI) tools or AI-assisted technologies were used in the drafting, writing or creation of this manuscript.

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Potential competing interests

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References

1. Arnold SR, Spec A, Baddley JW, Pappas P, Lentz RJ, Wolf J, et al. 2025 Clinical Practice Guideline Update by the Infectious Diseases Society of America on Histoplasmosis: Treatment of Asymptomatic Histoplasma Pulmonary Nodules (Histoplasmomas) and Mild or Moderate Acute Pulmonary Histoplasmosis in Adults, Children, and Pregnant People. Clinical Infectious Diseases. 2026 Jan 16;81(Supplement_3):i27-i32. doi:10.1093/cid/ciaf256
2. Davis JS, Ferreira D, Paige E, Gedye C, Boyle M. Infectious Complications of Biological and Small Molecule Targeted Immunomodulatory Therapies. Clinical Microbiology Reviews. 2020 Jun 17;33(3):e00035-19. doi:10.1128/cmr.00035-19