Letter to Editor

APALM

Primary Vocal Cord Histoplasmosis: A Rare Presentation Impersonating Laryngeal Malignancy

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Dear Sir,

A 53 year old male presented with gradual onset of hoarseness of voice. However there was no history of dyspnoea, dysphagia, haemoptysis, weight loss or fever. He was a diabetic and a chronic smoker since 20-25 years with no past history of tuberculosis. His general condition was good and local examination of oral cavity, oropharynx and neck was within normal limits.

Direct laryngoscopy was done and showed a growth on the free edge of right true vocal cord with retained mobility of the cord. The false vocal cords showed mild edema bilaterally, however the rest of larynx was within normal limits. MRI showed an altered signal intensity soft tissue thickening involving the entire length of right true vocal cord. No other lesion in any other organ was detected.

An incisional biopsy of the vocal cord lesion was taken and subjected to histopathological examination. Microscopic examination revealed ulcerated mucosa with dense myofibroblastic proliferation along with interspersed yeast forms resembling histoplasma capsulatum lying predominantly intracellularly. The basophilic cytoplasm of the fungal cells showed retracted appearance. Special stains with Gomori'smethanamine silver highlighted the fungal yeast forms (Figure 1-A). The unusual finding was absence of granulomatous response in an immunocompetent host. A diagnosis of vocal cord histoplasmosis was rendered and the patient was subsequently treated with amphotericin and recovered in 6 weeks

Histoplasmosis, a disease caused by the dimorphic fungus Histoplasma capsulatumis endemic in certain parts of the world including Asia.[1]It usually infects the lung however a disseminated disease may also occur with involvement of bone marrow, lymph nodes, adrenal glands

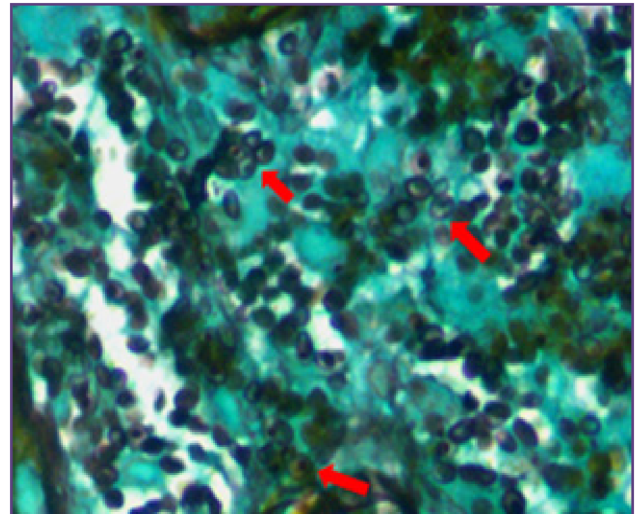

Fig. 1: Histoplasmacapsulatum (marked by arrows (Gomori'smethanamine silver, 1000X).

,gastrointestinal tract, tongue and oral mucosa.[2]The primary histoplasmosis of larynx with no lung involvement is extremely rare with no evidence of dissemination even a rarer phenomenon. Laryngeal involvement occurs in the mucocutaneous form of the chronic disease.[3]As per data histoplasmosis of head and neck is more common in adults and exclusively in males.[3]

Laryngeal histoplasmosis is a benign and easily curable disease. However due to the unusual location and deceptive clinical presentation, it may pose a few diagnostic challenges. It may clinically mimic a malignancy and microscopically resemble blastomycosis (due to similar morphology),tuberculosis(due to presence of necrosis and granulomas) and squamous cell carcinoma because of atypical epithelial response (pseudo-epitheliomatous

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hyperplasia).[4] Therefore an adequate history coupled with a proper histopathological as well as microbiological examination is a necessity.

Moreover all biopsy negative suspicious lesions of the upper airways should be always dealt with carefully keeping in mind a differential diagnosis of histoplasmosis.

Abbreviations and Symbols

MRI: magnetic resonance imaging

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Conflict of Interest

None

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Competing Interests

None Declared

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