IMAGES IN CLINICAL MEDICINE

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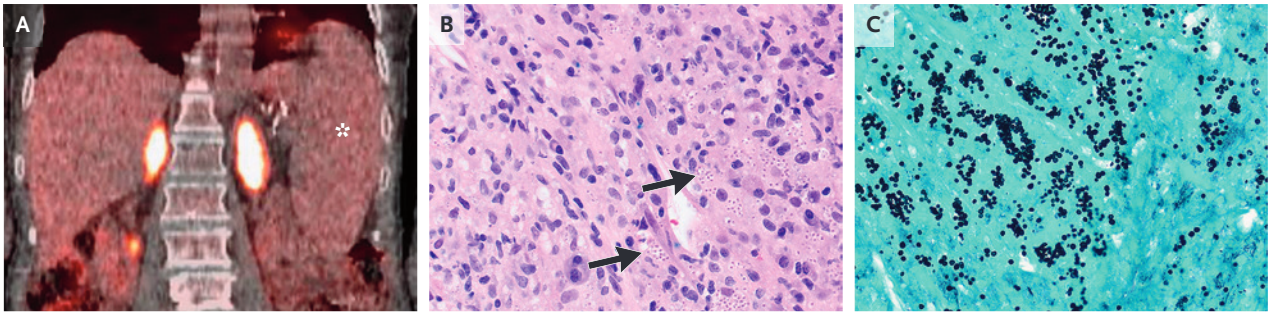
Adrenal Involvement in Disseminated Histoplasmosis



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An 82-year-old man presented to the emergency department with a 3-year history of progressive generalized weakness. Four months before presentation, a left adrenal mass had been identified incidentally on computed tomography (CT) that had been performed to evaluate an episode of chest pain. During the month preceding presentation, he had lost 8 kg of weight and had become unable to sit up in bed. The physical examination was unremarkable. Laboratory studies were notable for a white-cell count of 2700 per cubic millimeter (reference range, 3700 to 10,500), a normal adrenal axis, and negative testing for human immunodeficiency virus. Owing to concern for cancer, positron-emission tomography–CT of the whole body was performed and showed an adrenal mass on each side with fluorodeoxyglucose (FDG) uptake (Panel A shows a coronal view), a 17-cm-long spleen without FDG uptake (asterisk in Panel A), and no other abnormal findings. A subsequent biopsy of the left adrenal mass showed necrotizing granulomatous inflammation with intracellular fungal organisms (Panel B, arrows; hematoxylin and eosin staining) that stained positive with Grocott's methenamine silver (Panel C), a finding consistent with *Histoplasma capsulatum*. A diagnosis of chronic progressive disseminated histoplasmosis was made. Treatment with itraconazole was initiated. The patient died on hospital day 13 from hospital-acquired pneumonia.

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