following transplantation (e.g., prednisone, mycophenolate, calcineurin inhibitors), and the use of methotrexate, anti-TNF-α agents, and other biologic response modifiers for autoimmune disorders. PDH may also occur in healthy individuals, some of whom may have rare undiagnosed genetic immunodeficiencies—workup for these conditions should be considered in healthy subjects with PDH.

The clinical spectrum of PDH ranges from an acute, rapidly fatal course—with diffuse interstitial or reticulonodular lung infiltrates causing respiratory failure, shock, coagulopathy, and multiorgan failure—to a subacute or chronic course with a focal organ distribution. Common manifestations include fever, weight loss, hepatosplenomegaly, and thrombocytopenia. Other findings may include meningitis or focal brain lesions, ulcerations of the oral mucosa, gastrointestinal ulcerations and bleeding, and adrenal insufficiency. Prompt recognition of this devastating illness is of paramount importance in patients with severe manifestations or with underlying immunosuppression, especially that due to AIDS **(Chap. 202)**.

Chronic cavitary histoplasmosis is seen in smokers who have structural lung disease (e.g., bullous emphysema). This chronic illness is characterized by productive cough, dyspnea, low-grade fever, night sweats, and weight loss. Chest radiographs usually show upper-lobe infiltrates, cavitation, and pleural thickening—findings resembling those of tuberculosis. Without treatment, the course is slowly progressive.

Fibrosing mediastinitis is an uncommon but serious complication of histoplasmosis. In certain patients, acute infection is followed for unknown reasons by progressive fibrosis around the hilar and mediastinal lymph nodes, encasing mediastinal structures with potentially devastating consequences. Major manifestations include superior vena cava syndrome, obstruction of pulmonary vessels, and airway obstruction. Patients may experience recurrent pneumonia, hemoptysis, or respiratory failure. Fibrosing mediastinitis is fatal in up to one-third of cases.

In healed histoplasmosis, calcified mediastinal nodes or lung parenchymal nodules may erode through the walls of the airways