Sir,

Fungal invasive infections are more frequent in individuals with immunodeficiency related to HIV infection, chemotherapy, and bone marrow or solid organ transplants, and approximately 80% of cryptococcal infections occur in immunocompromised individuals [1, 2]. Carniato et al. described two apparently immunocompetent Caucasian male patients with meningoencephalitis by Cryptococcus neoformans, and their immunological condition was evaluated in the acute phase of infection, which did not rule out eventual previous immunodeficiency [1]. These infections were well controlled by amphotericin B, 5-flucytosine and fluconazole. Interestingly, the authors questioned if the current state of partial or substantial immune competence of those individuals might be related to the lack of more ominous outcomes [1]. De Rosa et al. reported invasive aspergillosis in a young female with immunosuppression after brief use of metilprednisolone in high-dose for autoimmune thrombocytopenia [2]. Pulmonary and central nervous system lesions were well controlled by voriconazole and caspofungin. The authors emphasized the variability of host susceptibility to invasive fungal infections depending upon either transitory or permanent immunosuppressive conditions [2].

Recently, we read the very interesting review by Cheon et al. about disseminated aspergillosis in a young female with immunosuppression after brief use of metilprednisolone in high-dose for autoimmune thrombocytopenia [2]. Pulmonary and central nervous system lesions were well controlled by voriconazole and caspofungin. The authors emphasized the variability of host susceptibility to invasive fungal infections depending upon either transitory or permanent immunosuppressive conditions [2].

We would like to comment two prostatic cryptococcal infections in Brazilian patients, and two Italian patients, immunocompetent and immunocompromised, with fungal infections. A 32-year-old man had AIDS and widespread infection by Mycobacterium avium-intracellulare, which was not controlled by antimicrobial treatment, and the patient died [5]. Necropsy revealed unsuspected cryptococcoma measuring 2 cm of diameter characterized by the finding of abundant yeast-like fungi of uniform volume, unique gemmulation, and “tear drop” pattern. The fungi were surrounded by mucinous matter without inflammatory reaction, and the capsules stained by mucicarmine [5]. In spite of the advanced grade of immunosuppression, the infection by C. neoformans was restricted to the prostate, and without eliciting local immune reactions.

Keywords: disseminated mycosis, immunocompetent host, immunosuppression.
inflammatory response. The authors emphasized the role of necropsy to evaluate the prevalence of silent foci of fungal infection in immunosuppressed individuals [5]. A 54-year-old man with unremarkable morbid antecedents developed post-renal kidney insufficiency and underwent trans-vesical prostatectomy. Histopathologic and culture exams performed in surgical specimens revealed the diagnosis of prostatic cryptococcosis [6]. Approximately three weeks after the surgical procedure, the patient was admitted with clinical features of acute meningoencephalitis and C. neoformans was identified in samples of urine, blood and cerebrospinal fluid, evidencing the dissemination of this cryptococcal infection [6]. The main hypotheses included the prostatic surgical manipulation playing a role in systemic dissemination of the fungus; and an overlooked non-symptomatic meningoencephalitis [6]. The authors emphasized the incidental detection of fungi in necropsy and surgical tissues, and the underestimated prostatic cryptococcosis in apparently immunocompetent individuals [6]. A common feature of these last commented case studies was the discrepancy between the immunosuppressive status and the degree of dissemination of the respective infections [3,4]. The presence of Aspergillus in active lung lesions gives origin to invasive infection, whereas the prostatic localized cryptococcosis can be a focus of disseminated infection [3-6]. We believe that the findings of the case reports herein commented might contribute to the knowledge about clinical features of invasive fungal infections in immunocompetent patients, but controlled studies should be performed to better clear the involved mechanisms.

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**REFERENCES**