African histoplasmosis is geographically confined to Central Africa. Although it is established that the pathogen is also an exosaprophytic mould, the natural biotope remains unknown**.**

In the parasitic phase, *H. capsulatum var. duboisii* exhibits large, round spores of 10-15 µm. In the saprophytic phase, the two varieties are morphologically indistinguishable.

Patients with this chronic mycosis always exhibit polymorphous cutaneous lesions, bone and lymph node involvement and ultimately random deep localisations. When the disease follows an acute course (e.g. in AIDS patients), the yeast cells remain small and the infection is usually ascribed mistakenly to the variety *capsulatum*. In experimental infections also, cells exceeding the variety *capsulatum* in size are found only after a long time.

Histoplasmosis treatment

In the majority of immunocompetent individuals, histoplasmosis resolves without any treatment.

Antifungal medications are used to treat severe cases of acute histoplasmosis and all cases of chronic and disseminated disease. Typical treatment of severe disease first involves treatment with amphotericin B, followed by oral itraconazole. Alternatives to itraconazole are posaconazole, voriconazole, and fluconazole.