Submitted by: Kathleen S. Kagan-Hallet, M.D.
Department of Pathology, UTHSC - San Antonio - Audie Murphy
Veterans Administration Hospital, San Antonio, Texas

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Clinical Abstract:

This 57-year-old White Male window dresser was first seen at the outpatient surgical clinic 2 years before his death because of a two-month history of bilateral cervical and axillary lymphadenopathy, unaccompanied by systemic symptoms or unusual exposures, except for a history of syphilis treated in the last few years (FTA, VDRL positive.) A needle biopsy of a lymph node showed nonspecific changes. When adenopathy persisted at a follow-up visit, the patient was admitted and another node biopsied; the histologic changes were interpreted as consistent with toxoplasmosis (toxoplasmosis IHA titers 1:2048, IFA 1:1024.) The patient did recall, in retrospect, a brief febrile illness which occurred a few weeks before adenopathy first appeared. Four months passed and the patient was readmitted with a 3-4 month history of herpes zoster, gradually worsening sore throat, a 15-pound weight loss, spiking fevers, lethargy, and guaiac-positive stools. The patient stated he was homosexual and had had hepatitis B in the last eight years (core antigen +, surface antigen = at this admission.) He admitted to occasional amyl nitrite use ("poppers") but only recreational heroin use. After another four months, the patient was again admitted with a two-week history of anorexia, malaise, and intense headaches which did not respond to aspirin, and which wakened him from sleep. He had had a brief febrile illness following a trip to New York City a few months previously. The patient's skin was conspicuously "tanned." His sinuses were tender to palpation and there were numerous scabbing lesions over the buttocks and perineum. BP was 80/60mm Hg and temperature was normal. Laboratory values were consistent with panhypopituitarism. Skin tests for Candida, mumps, and PPD were all negative. A lumbar puncture showed normal opening pressure, normal protein, glucose of 44mg/100 ml (83mg/100 ml serum glucose), India ink preparation negative, and 4 WBC's. A day later the patient's temperature rose to 102°F and he was confused, and developed anisocoria and lethargy. A previously-unrecognized RUL calcified lesion was discovered (the patient did have a 50-pack/year smoking history.) A bronchial washing and brain CT were negative. Pyramethamine, trisulfapiramine and folinic acid were begun imperically. The patient improved somewhat and was discharged home with his friend to begin rehabilitation. Within 2 weeks fevers, headaches, and vomiting returned. The drugs, stopped because of lack of response, were begun again, but sulfa had to be discontinued because the patient developed Stevens-Johnson syndrome. With some improvement, plans for nursing home placement were begun, as was an immunodeficiency work-up. An absolute lymphocyte count was 336. The patient became abruptly lethargic, developed cogwheel rigidity, pillrolling tremor, and lapsed into coma. A brain CT scan showed a right-sided parieto-occipital lesion and a midpontine lesion. Bronchoscopy showed Candida species. Biopsy of a cerebral lesion was done 19 days before death. Seizures and further decline in his condition occurred. An immunologic work-up showed less than 50% normal T cells and decreased responsiveness to phytohemagglutinin.

At autopsy the brain candida and cytomegalovirus pneumonia, perianal herpes, and scattered cerebral cortical, thalamic, and midpontine tegmental microabscesses in an edematous brain were noted. The pituitary was infarcted (remote.)

Material Submitted: 1 H&E/LFB stained (double hematoxylin), 1 unstained section from a cerebral microabscess.

Points for discussion:
1. Diagnosis
2. Pathogenesis