

CASE 1996 - 10

Submitted by:

Meena Gujrati, M.D.; John M. Lee, M.D., Ph.D.; Keith Izban, M.D.;
Chinnamma Thomas, M.D.
Section of Neuropathology
Loyola University Medical Center and Hines VA Hospital
2160 South First Avenue
Maywood, IL 60153

Case reference number:

A95-7

Clinical History:

A 45-year-old male, intravenous drug abuser, presented to West Side VA Hospital in Chicago, IL with a two week history of intermittent nausea, vomiting and inability to tolerate oral fluids. He was HIV seropositive for two years and had a previous history of Herpes zoster, oral candidiasis, and a thirty pound weight loss.

Upon admission, the patient was cachectic but afebrile with normal vital signs. The remainder of the physical exam was unremarkable except for prominent oral thrush. Routine laboratory tests, including blood and biochemical analysis were within normal limits. Both chest and abdominal x-rays were interpreted as unremarkable. The patient was hydrated with intravenous saline and administered compazine and nystatin. Initially he had a partial improvement; however on day three, he developed severe nausea, vomiting, and vertigo, accompanied by headache, fever, and nuchal rigidity. A repeat chest x-ray demonstrated bilateral, apical pleural thickening without evidence of infiltrates, mass lesions, or pleural effusion. Cerebral spinal fluid analysis revealed an opening pressure of 460mm Hg, a white blood cell count of 256,000/ul (neutrophils - 63%, lymphocytes - 32%, and monocytes - 4%), a protein of 162 mg/dl, glucose - 14 mg/dl and numerous gram positive cocci and bacilli. However, VDRL, CIE and Cryptococcal antigen tests were negative. Intravenous mannitol, dexamethasone, ampicillin, ceftriaxone, and empiric amphotericin B were administered. A CT scan demonstrated diffuse cerebral edema, hydrocephalus, and a mass lesion obstructing the fourth ventricle. Despite aggressive therapy, the patient developed respiratory failure requiring intubation and hyperventilation. Subsequently, the patient was referred to VA Hospital, Hines, IL for intracranial shunt placement.

During the transfer, the patient became completely unresponsive and markedly hypotensive. The following day, a perfusion scan showed no cerebral blood flow consistent with brain death.

Material submitted:

One H&E and one unstained section of cerebellum