CASE 2001-4

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Case reference number: A01-N8

Clinical History:

The patient was a 58 old lady, who lived in Massachusetts with her husband and three children. Her medical history was positive only for mild hypertension and obesity. She was in her usual state of health until 12/23/2000, when she developed right calf pain and low back discomfort. Three days later, she had flu-like symptoms including bifrontal headache, sinus pressure, chills and fever (107°) that responded to Advil. Of note, one of her sons, who was institutionalized due to cerebral palsy, had recently come home for the holidays and had a similar illness.

On 12/26, she developed right foot tingling and right leg weakness (12/26) for which she was seen in the Emergency Room of a local hospital. Her white count was 16.8, her erythrocyte sedimentation rate 72. She was thought to have sinusitis and was discharged on levofloxacin. On December 29th, she was admitted due to worsening symptoms. Her neurological exam at the time revealed sharp discs, supple neck, foot paresthesias bilaterally, brisk leg reflexes with up-going toes bilaterally. Strength, sensation and gait were intact. Head CT was unremarkable.

On 12/30 she was transferred to MGH due to progressive weakness, dysarthria and shortness of breath. On examination her mental status was intact with mild dysarthria. Right pupil was 4mm non-reactive, left pupil 2 mm reactive, bilateral VI nerve palsies, bilateral ptosis and facial weakness. Motor exam showed weakness in upper and lower extremities and decreased rectal tone. Sensory exam showed diminished light touch and temperature sensation throughout. There was areflexia in the lower extremities with up-going toes.

Lumbar puncture showed protein of 247, glucose of 45, 350 white blood cells (60% neutrophils, 40% lymphocytes) and no micro-organisms. Urine toxicology screen was negative.

Empiric antibiotic coverage for presumed meningitis was started. Unfortunately, the patient became hypotensive and bradycardic and was pronounced dead on 01/04/01, 14 days following her initial presentation.

Necropsy findings: At autopsy the brain was externally normal and weighed 1335 grams. The remainder of the autopsy was non-contributory.

Materials submitted: 1. H&E stained section of brain
2. unstained section

Points for discussion: 1. Diagnosis
2. Etiology