CASE 10

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Examination of this 45-year-old white male showed residual particulant matter in the left anterior chamber as the result of uveitis, so that the retina could not be seen. There was no generalized lymphadenopathy. The cardiovascular findings were normal. The left tendon reflexes and the biceps, triceps, and patellar reflexes were increased over those on the right. The left Hoffmann was positive and the left Babinski equivocal. His WBC was 15,900 with 3% non-segmented cells, 46% segmented cells, 21% lymphocytes, 21% eosinophils and 90/4 monocytes. Sedimentation rate was 15 mm. per hour and there was noted on the slide moderate anisocytos with several macrocytes and slight hypochromia. Hemoglobin was 13.8 gms. and hematocrit was 44%. A trichinella agglutination test was negative.

The next day, EEG suggested a mass in the right cerebral hemisphere. Spinal fluid showed 38 mgm. protein and 11 white cells all eosinophils. Carotid arteriogram confirmed the right cerebral mass. The patient developed a progressive right hemiparesis and he was readmitted one month later. Arteriogram showed increased size of the right hemisphere. Right parietal biopsy revealed meningoencephalitis with a predominance of eosinophils in the exudate. He was confused and psychotic post-operatively, then he responded to steroid therapy. Viral complement fixation studies were positive 1:64 for influenza B, positive 1:1.6 for mumps (viral) and positive.1:8 for mumps (soluble). He deteriorated slowly, was readmitted and died shortly therafter, two months later with signs of increased intracranial pressure.

Autopsy revealed no evidence of trichinella in multiple sections of muscle. The eyes were not removed. The brain weighed 1700 gms. At the site of biopsy in the parietal lobe was a 1.5 cm. abscess filled with purulent material. Multiple yellowish-brown nodules were scattered throughout both hemispheres (in gray and white matter) and in the tegmentum and base of midbrain and pons. No organisms could be found with special stains.