CASE 1993-4

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CLINICAL HISTORY:

The patient, a 13 year old male, presented to the hospital on 10/5/92 with a one day history of headache exacerbated by movement, fever, gastric pain and nausea. In the emergency room, he was lethargic, confused and his eyes appeared crossed. CSF had 339 WBC with 42% segs, 58% lymphs, protein 495 and glucose 93. Bacterial antigens were not detected.

The patient was transferred, where physical examination revealed him to be lethargic and inattentive, weak and unable to vocalize. Nuchal rigidity was present and he had positive Kernig's and Brudzinski's signs and an equivocal Babinski reflex on the right. Healed insect bites were noted on his legs. Repeat CSF studies revealed 430 WBC with 46% segs, 54% lymphs, protein 490 and glucose 90. Gram stains were negative. Blood and CSF were sent for further studies. Treatment was started with Claforan and Acyclovir.

During the following day, he had a tonic-clonic seizure followed by respiratory arrest. He became unresponsive, with an isoelectric EEG.

NECROPSY FINDINGS:

The general autopsy was non-contributory. The brain weighed 1470 grams, with leptomeningeal clouding, edema and early uncal and cerebellar tonsillar herniation present. On coronal sections, punctate hemorrhages were observed.

MATERIAL SUBMITTED: One H & E slide of basal ganglia.

POINTS FOR DISCUSSION: Diagnosis