

CASE 1995-3

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Clinical History

This 60 year-old man was last admitted for loss of consciousness. He was a heavy drinker since adolescence but this worsened when he became a widower 13 years ago. He lived alone and refused contact with his family. He was noisy and troublesome to neighbours who frequently saw him lying for hours in the garden.

According to his children, his mental status deteriorated in the year prior to his death but he always refused medical evaluation. On the day of admission, he was found unconscious in the garden. In the emergency room, he was very drowsy with poor hygiene. Ocular fundi, cranial nerves and tendon reflexes were normal. Laboratory data showed increased total and conjugated bilirubin but no other significant abnormalities. The ammonia level was normal. His evolution was stormy with delirium tremens and he died two days after admission.

Necropsy findings :

The brain only was sent for consultation. It weighed 1,280 g. There was moderate to severe atrophy of cerebral hemispheres and mild atrophy of the cerebellum.

Material submitted : HPS section of the temporal lobe

Points for discussion : 1- Differential diagnoses.
2- Physiopathology.