

**44<sup>th</sup> ANNUAL DIAGNOSTIC SLIDE SESSION 2003.**

Case 2003-8

SUBMITTED BY: Joshua D. Stephany, M.D and Gary S. Pearl, M.D., Ph.D.  
Department of Pathology  
Orlando Regional Medical Center  
1414 Kuhl Ave  
Orlando, FL 32806

**CLINICAL HISTORY:**

The patient was an 8 year old boy initially presented to the emergency room with fever (Tmax 103.4), headache, and vomiting for 2 days. Cerebrospinal fluid revealed 17 RBC/mm<sup>3</sup>, 13.1 WBC/mm<sup>3</sup>, 74% neutrophils, 24% lymphocytes, 2% monocytes, protein 58 mg/dL, glucose 56 mg/dL, and lactic acid 5.1 mg/dL. A CT scan of the head was negative for abnormalities. Treatment with ceftriaxone was begun.

He was subsequently transferred from the emergency room to another facility. Upon arrival he showed worsening decorticate posturing, asymmetric dilated unreactive pupils (right 4mm, left 3mm), absent corneal reflexes, absent doll's eyes reflex, and 2/4 deep tendon reflexes. Bacterial and viral antigens were not detected.

He was transferred to tertiary care center where he continued to slip in and out of consciousness. A repeat CT scan and magnetic resonance imaging were performed and were negative for acute changes. A ventriculostomy catheter was placed with an increased intracranial pressure of 28 mmHG. He became hypertensive and tachycardic and then proceeded to become hypotensive. He expired two days later.

**NECROSCOPY FINDINGS:**

The brain weighed 1050 grams, with diffuse leptomeningial clouding and edema.

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

**POINTS FOR DISCUSSION:** Diagnosis