CASE 1999-10

Submitted by: Saroja Ilangovan, M.D., Rajeswari Chandran, M.D., Reuben Cuison, M.D., Elena Koles, M.D., Marc G. Reyes, M.D. Section of Neuropathology, 627 S. Wood St., Cook County Hospital, Chicago, Illinois 60612

Clinical History: 42 year old right handed woman complained of headache of several months duration, altered mental status with gradual progression to nonverbal, disoriented state. Neurologic examination revealed intact cranial nerves, increased tone in all extremities, left side more than right with clonus in the left lower extremity. Deep tendon reflexes were hyperactive. Babinski sign was negative. Repeated CSF examinations showed pleocytosis and routine cultures for bacteria and fungi were negative. Angiogram performed four months before demise was non contributory. Diffuse slowing was noted on EEG. HIV testing was negative. Initial CT was normal. Three months after the onset of symptoms, basal ganglionic and periventricular white matter lesions were noted on MRI. Brain biopsy three months before terminal course was non specific. She expired in spite of broad spectrum antifungal, antibacterial and antiviral drugs.

Necropsy findings: At autopsy the brain weighed 1,050 grams. The leptomeninges were opaque and demonstrated subarachnoid purulent exudate. The pertinent findings were mild ventricular dilatation slight brown discoloration of the basal ganglia and white matter.

Material submitted: H&E stained and unstained section of basal ganglia.

Points for discussion: 1. Diagnosis, 2. Pathogenesis