Cryptococcal meningitis and cerebral toxoplasmosis in AIDS: another case report.

Sirs: We were very interested in the short report of Bahls and Sumi on the association of cryptococcal meningitis and cerebral toxoplasmosis in a patient with Acquired Immune Deficiency Syndrome (AIDS) and we would like to document a further case.

A 34-year-old homosexual male was admitted with a 4-months history of slight cough, fever with occasional haemoptysis and weight loss. Three months later he developed a headache. One day before admission the patient became less alert. Neurological examination showed a comatose patient with nuchal rigidity and left facial paralysis.

The diagnosis of AIDS and cryptococcal meningitis was made by clinical and laboratory evaluation and was treated with amphotericin B and 5-fluorocytosine. After 2 months he developed progressive hemiparesis and CT scan showed multiple, ring-enhancing, low-density lesions. Slightly increased serological titres against Toxoplasma gondii were detected and therapy with pyrimetamine and sulfonamides was subsequently started. In the next week the patient quickly improved, the CT lesions disappeared and he soon became asymptomatic. Unfortunately, after one and a half months, therapy was discontinued because severe pancytopenia had developed, and he progressively experienced again right limb weakness and aphasia. Later, he died of pneumonitis from Pseudomonas aeruginosa.

Pathological findings in the central nervous system revealed cryptococcal meningoencephalitis, multiple necrotising abscesses for Toxoplasma gondii and medulla and spinal cord infection by cytomegalovirus.

In our opinion, taking into account that cryptococcus and toxoplasma are both common causes of infection in patients with AIDS, their association may frequently occur. Consequently, we suggest the immediate onset of therapy with pyrimetamine and sulfadiazines if the diagnosis of toxoplasmosis is suspected in patients with cryptococcal meningitis and AIDS. Brain biopsy should be reserved for cases with poor response to treatment because its use is limited by its potential morbidity and the presence of false-negative results.

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Cryptococcal meningitis and cerebral toxoplasmosis in a patient with acquired immunodeficiency syndrome.

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