from the fourth to sixth month. The antifungal treatment lasted for six months. He is under our follow-up for the past one year and he made complete neurological recovery.

Fungi are common in the environment, but only a few are pathogenic. In general, fungi are organisms of low pathogenicity, emerging as opportunistic organisms thriving in a compromised host, however, some will infect even normal hosts.[1-3] In the nervous system, the infection can be found in the cerebral parenchyma, the meninges or the vascular system.[1]

Fungal infection as an etiology of brain abscess is common in immunosuppressed patients either due to systemic illness or due to drugs.[4] Aspergillus fumigatus is the most common human pathogen in the genus Aspergillus. It has branching septate hyphae varying from 4-12 mm in width, which show dichotomous branching and produce numerous spores on the tips of long conidiophores.[1]

Aspergillosis is diagnosed on direct examinations and culture, however, the diagnosis of aspergillosis of the central nervous system (CNS) is difficult. In purulent lesions, pus is seen in the center of the abscesses with abundant polymorphs at the periphery. Granulomas consist of lymphocytes, plasma cells and fungal hyphae.[1]

Aspergillus is cultured optimally on Sabouraud’s agar and demonstrates characteristic conidiophores. However, blood and cerebrospinal fluid cultures, even in disseminated disease, are frequently negative.[1]

Fungal abscess can be managed medically by antifungal drugs provided the organism is known, size of the abscess is small and source of the infection is located. Liposomal amphotericin has been demonstrated to be safe and efficacious in the management of CNS aspergilloma.[1] If the abscess is not amenable to medical management stereotactic aspiration or excision of abscess is the treatment of choice.[4] Radical surgical debridement can be curative in Aspergillus brain abscess if the extent of resection extends into uninvolved tissue.[9]

This is the first report of cerebellar tonsillar abscess due to fungal etiology.

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Cryptococcal meningitis unmasking idiopathic CD4 lymphocytopenia

Sir,

A 50-year-old gentleman presented with fever of 8 months' and abnormal movements of the right upper
This time, CSF examination was normal. The seizures were attributed to parenchymal scarring. Repeat CD4 cell count was 151/µl. Repeat serology for HIV-1 and -2 was negative. The patient is doing well for the past 24 months.

This patient was suffering from cryptococcal meningitis, and the underlying immune-deficient state was idiopathic CD4 lymphocytopenia (ICL). Idiopathic CD4 lymphocytopenia was defined in 1992 by the US Center for Disease Control as low CD4 cell count (<300/µl) or a percentage of CD4 cells <20% of total T cells on at least two occasions (6 weeks apart) without any immunodeficiency or therapy associated with T cell depletion. This syndrome was termed severe unexplained HIV seronegative immune suppression (SUHSIS) by the World Health Organization. Its incidence varies from 0.3-1.5% in voluntary blood donors. The demographic and clinical features of these patients differ from those of HIV infection, and CD4+ T cell count remains stable over a period of time. Though the exact cause of CD4 lymphocytopenia is not known, it has been suggested that decreased T cell

The interesting aspect of our patient was that he had presented with prolonged pyrexia, an uncommon presentation of cryptococcal meningitis, and was diagnosed as ICL incidentally. His seizures resembled coarse tremors. In the absence of clear guidelines regarding management of opportunistic infections in patients with ICL, we managed our patient with prophylaxis as described for HIV-infected patients.

Our case merits consideration as it highlights the need of increased awareness and consideration of ICL in the setting of cryptococcal meningitis.

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