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HIV with Opportunistic Neuroinfection

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CLINICAL HISTORY:

34 year old male with complaints of:

-Fever since 2 days, moderate grade, associated with chills and rigors

-Unresponsiveness since 2 days

Known case of HIV since one year, non-adherent to Anti-retroviral therapy medication

Known case of Miliary TB was treated with Anti-Tubercular therapy (ATT) 1 year back.

Known case of Seizure disorder on medication

(Tab. Levetiracetam)

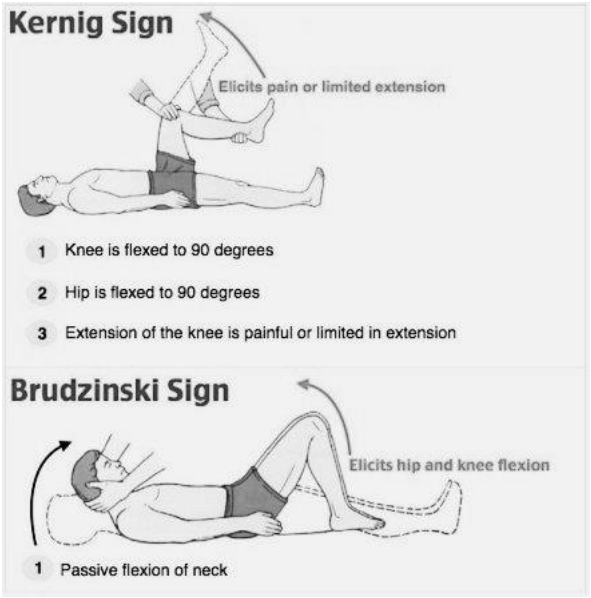
EXAMINATION AND INVESTIGATIONS:

CNS Examination:

-Patient was conscious, not oriented, was not obeying oral commands

-Neck Rigidity was present

-Kernig sign was positive



- Bilateral pupils are equal and reactive
- Cerebellar Signs – Not Elicited

CVS: S1 S2 heard. No Murmurs

Respiratory System: Bilateral normal vesicular breath sounds heard. No adventitious sounds

Per Abdomen: Soft, Non-tender, No organomegaly. Bowel sounds heard.

Fundoscopy: Normal

CSF Analysis:

Cell count: 42

98% Lymphocytes,

2% Neutrophils

CSF LDH: 223 U/L

ZN Staining:

Negative for AFB

Cryptococcal Capsular Polysaccharide Antigen: Positive in Serum and CSF

CD4 count: 63cells/mm3

HIV Viral Load: 36936 copies/mL

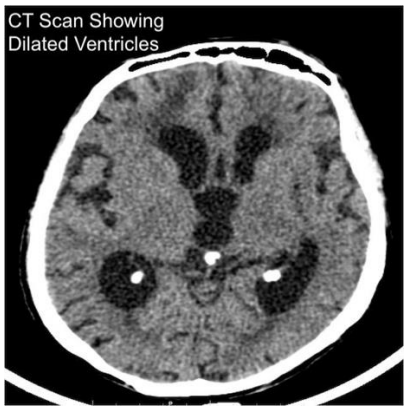
Sodium: 121mEq/L

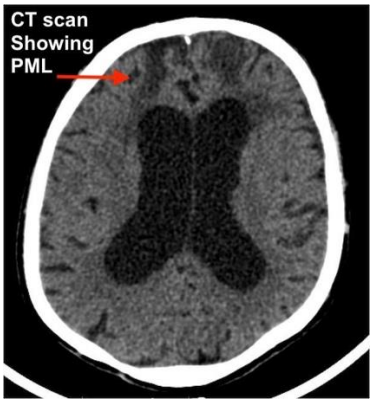
Potassium – 3.5mEq/L

Chloride – 85mEq/L

USG Abdomen and pelvis: Bulky Kidneys and Splenomegaly.

CT Brain: Bilateral ill-defined hypo-densities in the frontal, insular and temporal lobes suggestive of Progressive Multifocal Leukoencephalopathy (PML)





FINAL DIAGNOSIS:

- HIV with

  -TB Meningitis (TBM)

-Cryptococcal Meningitis

-Progressive Multifocal Leukoencephalopathy

- Hyponatremia probably due to SIADH.

DISCUSSION:

HIV positive patients are at an increased risk of opportunistic infections (O.I) like Tuberculosis. It can present as Pulmonary and Extra-Pulmonary manifestations.

Neuroinfections like TBM and Cryptococcal meningitis are common, predisposition to certain infection depends on CD4 count. These can give rise to complications with a high mortality rate. (1) Starting ART early prevents these complications. Resistance to drugs and failure to ART is mostly due to non- adherence to the treatment. It is important to monitor all patients regularly for clinical, immunological and virological failure. (2)

ACKNOWLEDGEMENTS: None

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