A puzzling case of cryptococcal meningitis

To the Editor: We recently admitted a young immunocompetent man with cryptococcal meningitis. He presented alone, and a combination of language barrier and blunted cerebral function hampered history taking. He described 1 week of headache and fever, and gave a vague account of a penetrating head injury 6 months previously.

It was difficult to explain why this otherwise healthy young man, with no evident risk factors for poor T-cell function, had encapsulated yeasts growing in his cerebrospinal fluid. Multiple HIV rapid antigen tests were negative, and 2 weeks of intravenous amphotericin B and oral fluconazole did little to improve his condition.

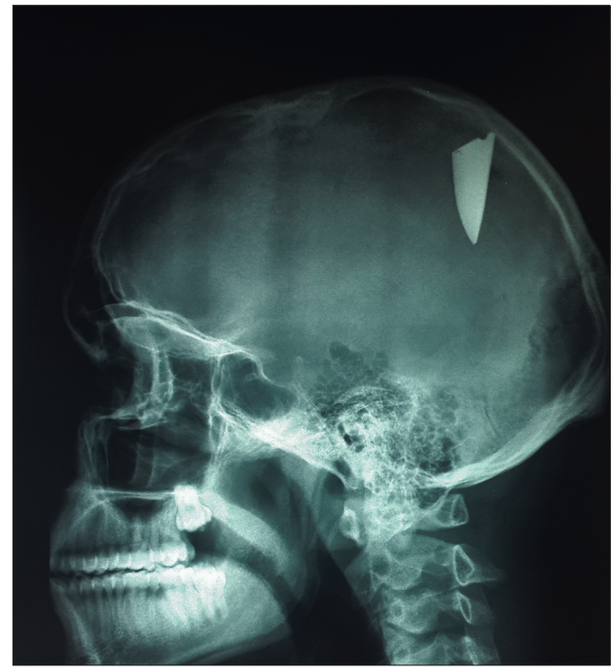

Fig. 1. Cryptococcal meningitis in an otherwise healthy young man – the puzzle solved.

We were poised to embark on the somewhat lengthy referral procedure for a computed tomography brain scan at our tertiary centre when our patient noticed a small amount of pus discharging from a scar on his scalp. A firm prominence was palpated just under the scar, and a subsequent X-ray solved the mystery (Fig. 1).

After surgical removal of the knife blade, the meningitis resolved within several days. The patient was then able to give a more detailed history, and it transpired that he had not come to hospital after the initial injury 6 months earlier because of transport and financial constraints.

A retained foreign body is an often-overlooked differential diagnosis in patients who present with atypical infection.[1] A good history is the single most useful tool in making the diagnosis. This has been well described in the context of inhaled objects in the paediatric population.[2]

Difficulty in obtaining a complete history can delay diagnosis and definitive treatment. Maintaining a high index of suspicion, and early use of simple imaging where there is any possibility of prior penetrating trauma, may assist in early exclusion of a retained foreign body. Making a delayed diagnosis by means of unnecessary and expensive investigations at tertiary referral centres can then be avoided.

Stewart James Brown
Simon George
Kate Braithwaite
Tintswalo Hospital, Acornhoek, Mpumalanga, South Africa
simongeorge@hotmail.co.uk

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