

2007 American College of Physicians Kansas Chapter Meeting

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Diagnostic Confusion: how a common problem delayed finding the correct diagnosis

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Introduction: Cryptococcus neoformans is a major cause of meningitis in immunocompromised patients and is an AIDS-defining illness. It commonly presents with headache, fever, and malaise. Occasionally, affected patients present with neck stiffness, vomiting and photophobia. Rarely, it presents with confusion, agitation or mania.

Case Report: A 45-year-old Hispanic man presented to the emergency department with confusion and agitation. His acquaintances stated that the patient went to a convenience store and returned confused, agitated and "flailing about." He had dilated but reactive pupils at admission.

The patient had a past medical history significant for mental illness and had undergone treatment for substance abuse with cocaine and alcohol. Admission laboratory studies revealed negative drug screen, acute renal failure and an anion-gap metabolic acidosis. The differential diagnosis included drug ingestion/toxicity, serotonin syndrome, and neuroleptic malignant syndrome. He had repeated drug screens for the next 24 hours as drug intoxication was the leading diagnostic consideration. His mental status did not improve and a physical exam later showed a right fixed, dilated, irregular pupil.

A cerebrospinal fluid analysis showed a white blood cell count of 281 with 96% lymphocytes, glucose of 28, and protein of 370. This modified the differential diagnosis to consider viral, fungal or tuberculous meningitis. He was started on empiric antifungal, antiviral, and antimycobacterial medications. The CSF cryptococcal antigen returned with titer of 1:256. HIV antibodies were positive. The CD4 lymphocyte count was 66 and the HIV quantitative load was 290,000.

Discussion: This patient shows how diagnostic confusion may occur when a rare diagnosis as cryptococcal meningitis is masked by H&P findings of the more common psychiatric history or IVDA. Since the patient presented with agitation and confusion but no fever, headache or weight loss, and was not known to be HIV antibody positive, the diagnosis was initially overlooked due to the initial similarity of symptoms. We discuss how such "no fault" errors may be prevented.

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