

Molluscum-like lesions in cryptococcal meningitis

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A 45-year-old man presented with fever and headache for 15 days. He had been reported to have an altered sensorium for 6 days prior to presentation. He did not have a known case of HIV/AIDS. There was no history of blood transfusions in the past. On physical examination, the patient had nuchal rigidity. The patient also had skin lesions on his eyelids (Fig. 1). The cerebrospinal fluid (CSF) examination revealed 10 cells, all lymphocytes, glucose level 28 mg/dL (normal 40–70 mg/dL) and a protein level of 88 mg/dL (normal 15–50 mg/dL). He was found to be positive for the AIDS virus (HIV1).

An India ink preparation of the CSF revealed capsulated yeast cells, and culture confirmed the etiology as *Cryptococcus neoformans*. The patient was started on amphotericin B, but he died 2 days post presentation.

Although the lesions seen in Fig. 1 are usually characteristic of a viral infection by Molluscum contagiosum, this would not explain the clinical features of meningitis. These viral lesions are common in HIV patients; however, Molluscum contagiosum does not usually result in meningitis, and therefore is unlikely to be the cause in this case. Infection with *Penicillium marneffeii* can also present with cutaneous lesions resembling Molluscum, but meningitis is rare [1].

Papular lesions with central umbilication resembling molluscum contagiosum are a rare manifestation of cryptococcal infection [2]. Such lesions can also be found

typically on the face, scalp and upper trunk. *Cryptococcus* is one of the leading infectious causes of meningitis, and can be accompanied by Molluscum-like lesions. The cutaneous biopsy confirmed the presence of cryptococcal organisms. These lesions are a late manifestation of cryptococcal infection. Early diagnosis can occur only if the diagnosis is considered, and therefore the clinician needs to consider cryptococcal infection as a possible cause of chronic and subacute meningitis. Most patients will lack any specific clue to cryptococcal infection [3]. The cases may be diagnosed early by making it a policy to do India ink staining and cryptococcal antigen testing on all CSF specimens. Complications of the meningitis may include elevated intracranial pressure, visual impairment and cerebral infarction [4]. This is important because cryptococcal meningitis can lead to a mortality of around 10–30% in HIV-related cases. Cryptococcal meningitis is treated with intravenous amphotericin B, at a dose of 0.7 mg/kg daily, with flucytosine, 25 mg/kg qid for the



Fig. 1 Molluscum like lesions on right eyelid

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initial 2 weeks. Following this the treatment is continued with fluconazole daily, 400 mg PO for 10 weeks. Fluconazole has to be continued at a dose of 200 mg/day until the CD4+ T-cell count remained above 200 cells/L for at least 6 months in response to HAART.

Conflict of interest None.

References

1. Supparatpinyo K, Khamwan C, Baosoung V, Nelson KE, Sirisanthana T (1994) Disseminated *Penicillium marneffei* infection in southeast Asia. *Lancet* 344:110–113
2. de Souza JA (2006) Molluscum or a mimic? *Am J Med* 119:927–929
3. Bicanic T, Harrison TS (2005) Cryptococcal meningitis. *Br Med Bull* 72:99–118
4. Day JN (2004) Cryptococcal meningitis. *Pract Neurol* 4:274–285