

# Fulminant toxoplasmosis presenting as isolated myelitis

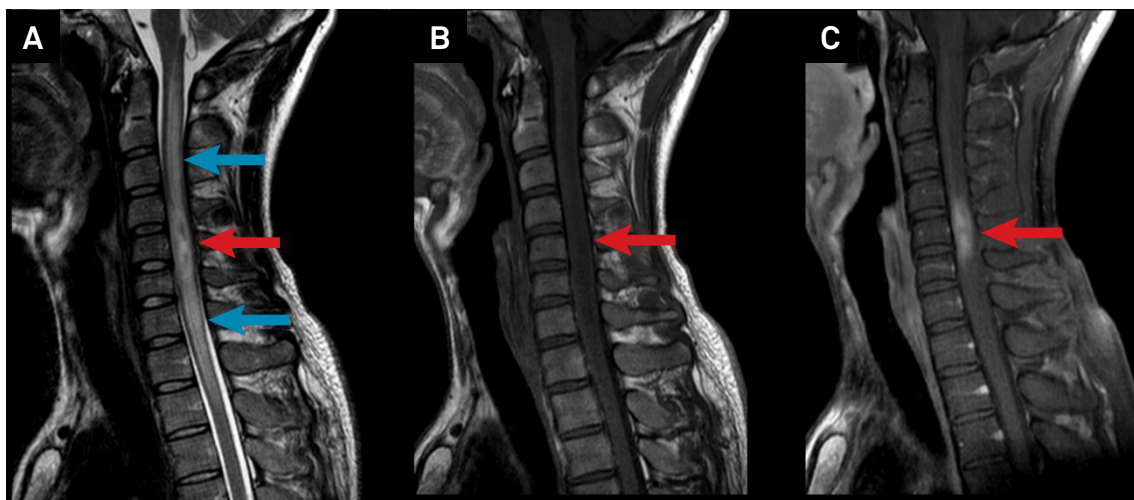
## Toxoplasmose fulminante se apresentando como mielite isolada

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A 29-year-old male patient with an untreated HIV infection for seven years presented with a two-month history of neck pain, progressive left-hand weakness and numbness. Physical examination showed C5-C6 territory hypoesthesia and urinary bladder retention. A spinal MRI (Figure 1) showed a single contrast-enhanced lesion at C4-C6 level, cerebrospinal fluid analysis showed 3.6

white blood cells/mm<sup>3</sup> and a positive IgG for toxoplasma. Despite empiric treatment, the disease progressed locally and to the brainstem. Autopsy (Figure 2) showed disseminated CNS toxoplasmosis.

Toxoplasmosis is the most common CNS infection in patients with AIDS, but isolated spinal cord involvement is rare<sup>1</sup>. Prompt empiric treatment for toxoplasmosis should be considered in all patients<sup>2</sup>.











**Figure 1.** (A) Sagittal T2-weighted cervical spine MRI showing a heterogeneous mass-occupying lesion in the spinal cord (red arrow) with longitudinal edema from the medulla to T2 (blue arrows). The same lesion in T1-weighted MRI without (B) and with contrast (C). Note the heterogeneous contrast enhancement of the lesion (red arrows on B and C).

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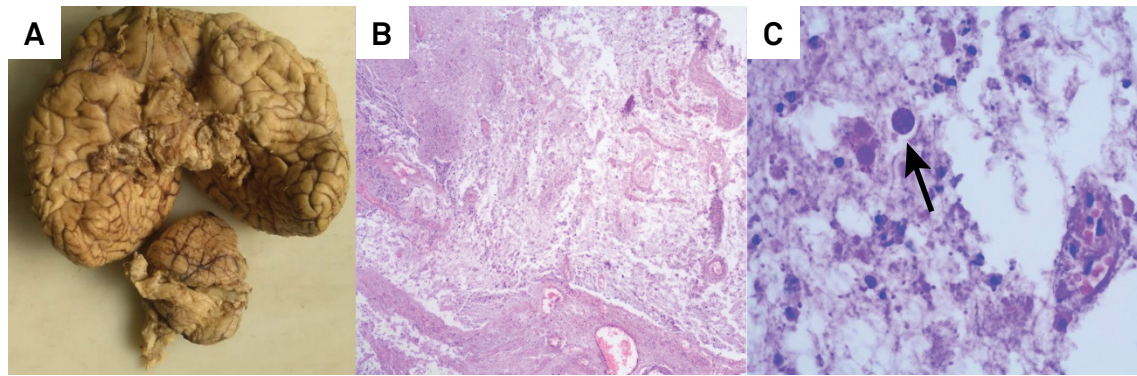
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**Figure 2.** Autopsy findings showing: (A) macroscopic brain appearance with necrosis of brainstem and loss of connection between it and cerebellum. Histological evaluation with hematoxylin and eosin stain showed vast areas of liquefactive necrosis (lower magnification, B) and some *T. gondii* bradyzoites at higher magnification (arrow, C).

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