INTRODUCTION
Chronic meningitis has many causes, and both recent and remote exposures can be critical in identifying infectious etiologies. This case describes a rare cause of chronic meningitis in a recent immigrant from an endemic area.

INITIAL PRESENTATION

HISTORY OF PRESENT ILLNESS: A 67-year-old Nigerian man with chronic active hepatitis B and hypertension presented to the hospital with confusion, headaches, weakness, and nausea. His headaches and progressive confusion began three years earlier, and he immigrated to the United States four months prior seeking medical care. Two days prior to admission, he became less responsive and was brought to the hospital by his family.

PAST MEDICAL HISTORY: Chronic active hepatitis B, hypertension, benign prostatic hypertrophy

MEDICATIONS: Metformin, doxazosin

SOCIAL HISTORY: Retired 3 years ago as a small business owner in Nigeria. He lived in Lagos but frequently visited family in rural areas. He did not smoke, drink alcohol or use any drugs.

PHYSICAL EXAM: Vital signs were temperature 37.6°C, blood pressure 186/97, heart rate 105. He had a depressed level of consciousness and was disoriented, but followed simple commands. He had no photophobia and negative Kernig’s and Brudzinski’s signs, but did have moderate nuchal rigidity. He had no focal neurologic deficits with normal reflexes and absent Babinski’s sign.

INVESTIGATIVE STUDIES
Cultures of CSF for bacteria were negative. Herpes simplex virus PCR from CSF was negative. He had a positive tuberculin skin test and empiric therapy for possible Mycobacterium tuberculosis meningitis with isoniazid, rifampin, ethambutol, and pyrazinamide was started. Following his discharge, he continued to have intermittent severe headaches and cognitive deficits. CSF cultures did not grow acid fast bacilli. Repeat CSF analysis was essentially unchanged, with a lymphocytic predominance.

DIAGNOSIS
More than one month after discharge, fungal cultures from his first lumbar puncture grew Histoplasma capsulatum. The diagnosis of chronic Histoplasma meningitis was made. Treatment resulted in a marked improvement in his cognition and resolution of his chronic headaches.

DISCUSSION
Histoplasma capsulatum is endemic to rural areas of Nigeria. Central nervous system (CNS) involvement occurs in up to 20% of cases of disseminated histoplasmosis. Isolated CNS involvement is more rare, but can be seen in reactivation of latent disease, even years after the initial exposure. Chronic meningitis is a common presentation in these cases, with recurrent headaches occasionally the only notable symptom. Ventriculomegaly, as was seen on head CT scan two months prior to his decompensation, is another common but non-specific finding. One retrospective case series in an endemic area found occult Histoplasma meningitis in several patients who received ventricular shunts for idiopathic hydrocephalus, and normal pressure hydrocephalus is a frequent misdiagnosis. Culture of cerebrospinal fluid is low yield, with multiple large volume samples sometimes needed before a single positive culture is obtained.

CONCLUSIONS
This case emphasizes the importance of maintaining a broad differential for progressive headache and confusion. The battery of tests that led to his eventual diagnosis and treatment was undertaken due to his acute decompensation, but he had likely been symptomatic from the infection for years prior to his presentation.

REFERENCES