In their Teaching NeuroImage, Dr. Trinh and colleagues share a case of a diabetic patient with cryptococcal meningoencephalitis. Other than diabetes, there was no reported evidence of immunosuppression. The authors concluded that certain features should raise one’s suspicion of Cryptococcus sp., such as meningeal enhancement, pseudocyst formation, and frank parenchymal abscesses/cryptococcomas. In a reader response, Drs. Feng and Zhang comment on the safety of invasive diagnostic testing in this case—particularly the risk of lumbar puncture, given the posterior fossa mass lesions—and inquire as to whether a brain biopsy was considered. The authors note that despite the posterior fossa lesions, there was no mass effect from the gelatinous pseudocysts and cryptococcomas. From a diagnostic and therapeutic point of view, the authors emphasize that it was considered safe to proceed with lumbar puncture in their case for antigen testing and that CSF withdrawal may also lower intracranial pressure. Ultimately, the patient improved after treatment with amphotericin B and flucytosine.

James E. Siegler, MD, and Steven Galetta, MD

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We read with interest this case by Trinh et al.1 regarding a 66-year-old diabetic patient with cryptococcal meningoencephalitis who had unusual brain magnetic resonance findings. We note that intracranial pressure would rise after cryptococcal infection, and the patient’s lesion is partially in the cerebellum, increasing the danger of brain herniation during lumbar puncture. How willing was the patient to take this risk? Why was not a brain biopsy performed because of the large number of lesions? Finally, we would like to know the prognosis of this patient after the treatment.


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Author Response: Teaching NeuroImage: Cryptococcal Meningoencephalitis With Cryptococcoma and Gelatinous Pseudocysts

Anderson Kuo (Midland, TX), Kelly Trinh (Lubbock, TX), and Duc Le (Lubbock, TX)

We appreciate the interest and comments posed by Drs. Feng and Zhang on our article.1 We agree that intracranial pressure often rises with CNS cryptococcosis. However, we note that the main mechanism underlying increased pressure is due to obstruction of the arachnoid villi, not from mass effect of the gelatinous pseudocysts and cryptococcomas.2 While the lesions in this case are sizable, there is no significant mass effect, ventricular obstruction, nor herniation that would preclude a safe lumbar puncture (LP). In fact, the World Health Organization (WHO) recommends (repeated) LP as mainstay treatment for intracranial hypertension in CNS cryptococcosis.3 Previous study showed therapeutic LP improved survival regardless of initial pressure.4 Rest assured, the patient was well informed. We also note that the WHO recommends LP with either antigen testing (if available) or the India ink test as first-line strategy of diagnosis.5 In this case, brain biopsy/evacuation would not have improved care because the lesions were not isolated to the cerebellum but could have resulted in additional complications. After induction therapy with amphotericin B and flucytosine, clinical improvement was noted. The patient was transferred to rehabilitation facility in stable condition on consolidation therapy.


CORRECTIONS

Should the Criterion for Brain Death Require Irreversible or Permanent Cessation of Function? Permanent

The UDDA Revision Series

Neurology® 2023;101:683. doi:10.1212/WNL.0000000000207862

In the Contemporary Issues in Practice, Education, & Research article “Should the Criterion for Brain Death Require Irreversible or Permanent Cessation of Function? Permanent: The UDDA Revision Series” by McGee and Gardiner,6 Andrew McGee’s degree should be listed as “PhD.” The publisher and the authors regret the error.

Reference

In the Research Article “Cutaneous α-Synuclein Signatures in Patients With Multiple System Atrophy and Parkinson Disease” by Gibbons et al.,1 in Figure 1, the arrows for panels B, C, and F were slightly adjusted for accuracy. The updated Figure 1 is below. The authors regret the errors.

Reference
Cutaneous α-Synuclein Signatures in Patients With Multiple System Atrophy and Parkinson Disease

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