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Neuro*Images*

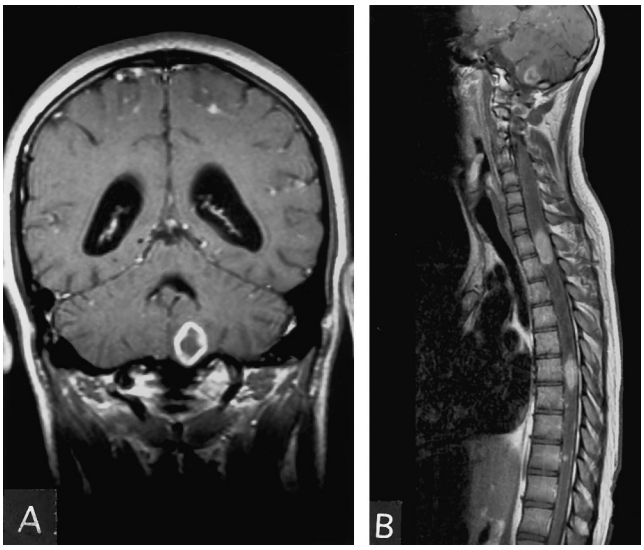

Figure. MRI at admission (postcontrast T1-weighted). (A) Ring-enhancing left cerebellar lesion and meningeal contrast enhancement. (B) Multiple intramedullary lesions.

Cerebellar and medullar histoplasmosis

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A 16-year-old Surinam boy presented with a 3-month history of progressive paraparesis and periods of fever and neck stiffness. Neurologic examination demonstrated a severe spastic paraparesis, Babinski signs, and sensory disturbance under level T4. The patient was not taking immunosuppressants, was HIV-seronegative, and had normal $CD4^+$ lymphocyte counts. Postcontrast T1-weighted MRI of brain and spinal cord revealed a ring-enhancing left cerebellar lesion, meningeal contrast enhancement, and multiple intramedullary lesions (figure). CSF examination showed a lymphocytic pleocytosis, elevated total protein, lowered glucose, and negative Gram staining and cultures. Biopsy of one intramedullary lesion disclosed granulomatous lymphohistiocytic inflammation with giant cells and necrosis; cultures were positive for *Histoplasma capsulatum*. Some neurologic improvement occurred after sequential treatment with amphotericin B and itraconazole.

Primary neurologic presentation of histoplasmosis is extremely rare, especially in young, nonimmunocompromised hosts. Tan et al. reported a case of disseminated histoplasmosis in a 72-year-old man, which was the first report of histoplasmosis presenting as a myelopathy.[1] Tabbal and Harik recently reported cerebral histoplasmosis in a 60-year-old man, presenting as a bilateral pyramidal syndrome.[2]

To our knowledge, this is the first case of cerebellar, meningeal, and medullar histoplasmosis reported in a young, nonimmunocompromised host. The severity of the neurologic presentation, lack of systemic manifestations, and extensiveness of CNS lesions on MRI are exceptional.

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