

Zika Virus Encefalitis

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Clinical Image

A Male, 23 years old, pancreatitis and cholecystectomy 1 month ago, presented to our ED with a history of 6 days of fever, dizziness and confusion. He reported no headache, neck stiffness or seizures. Physical examination the patient was somnolent, with reactive isochoric pupils, quadriparetic with hyporeflexia. He became stuporous with shock and leukocytosis. Treatment with meropenem and vancomycin were initiated empirically. Magnetic resonance imaging (MRI) of the

brain revealed hyper intense lesions in the brain stem, fornix and bilateral thalamus (Figures 1A and 1B) with no midline shift. The CSF analysis results were non-specific with mild protein elevation. CSF molecular biology testing with PCR RNA for Zika virus was positive. A diagnosis of acute disseminated Zika virus encephalitis was made. Immunomodulatory therapy with IVIG was initiated. Follow-up MRI of the brain showed progression of lesions to midbrain, basal ganglia and brain cortex (Figures 1C and 1D). He had no response to 5 days of IVIG therapy and subsequently the patient died.

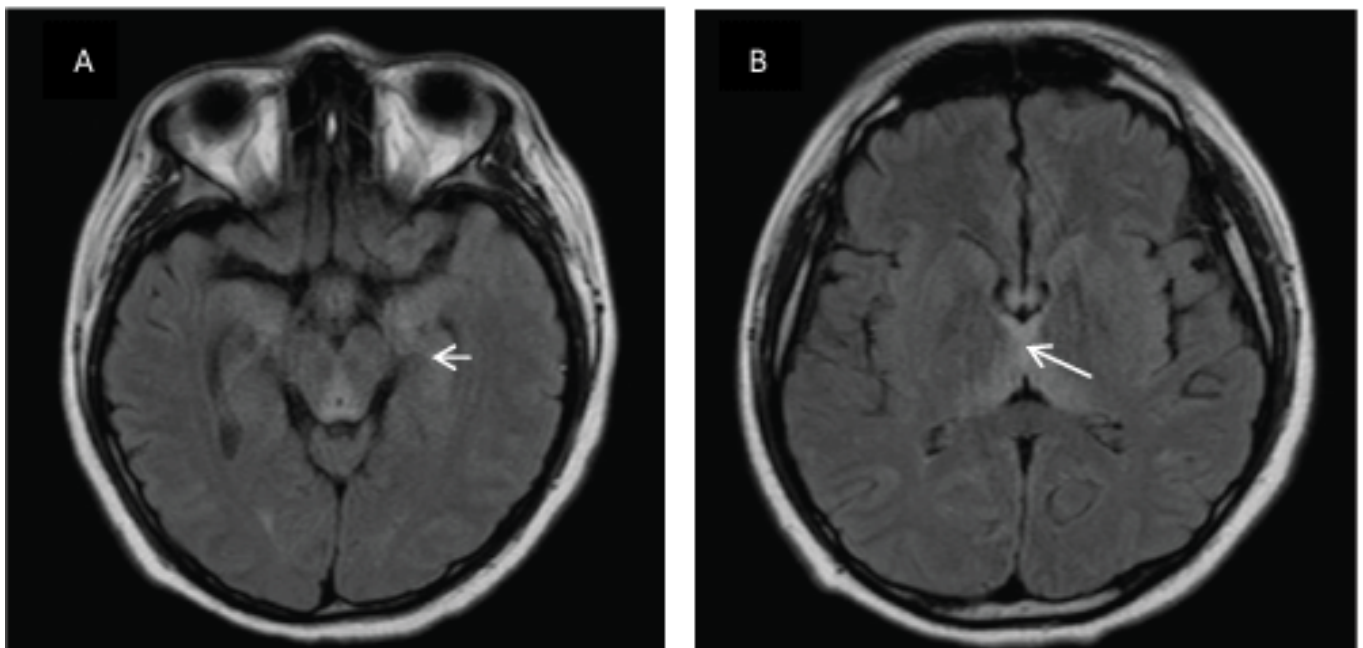


Figure 1(A,B): MRI brain (FLAIR) at beginning, there are bilateral simetri hyper intense lesions incuad rigeminal tuberculosi, periacue ductal gray matter and fornix.

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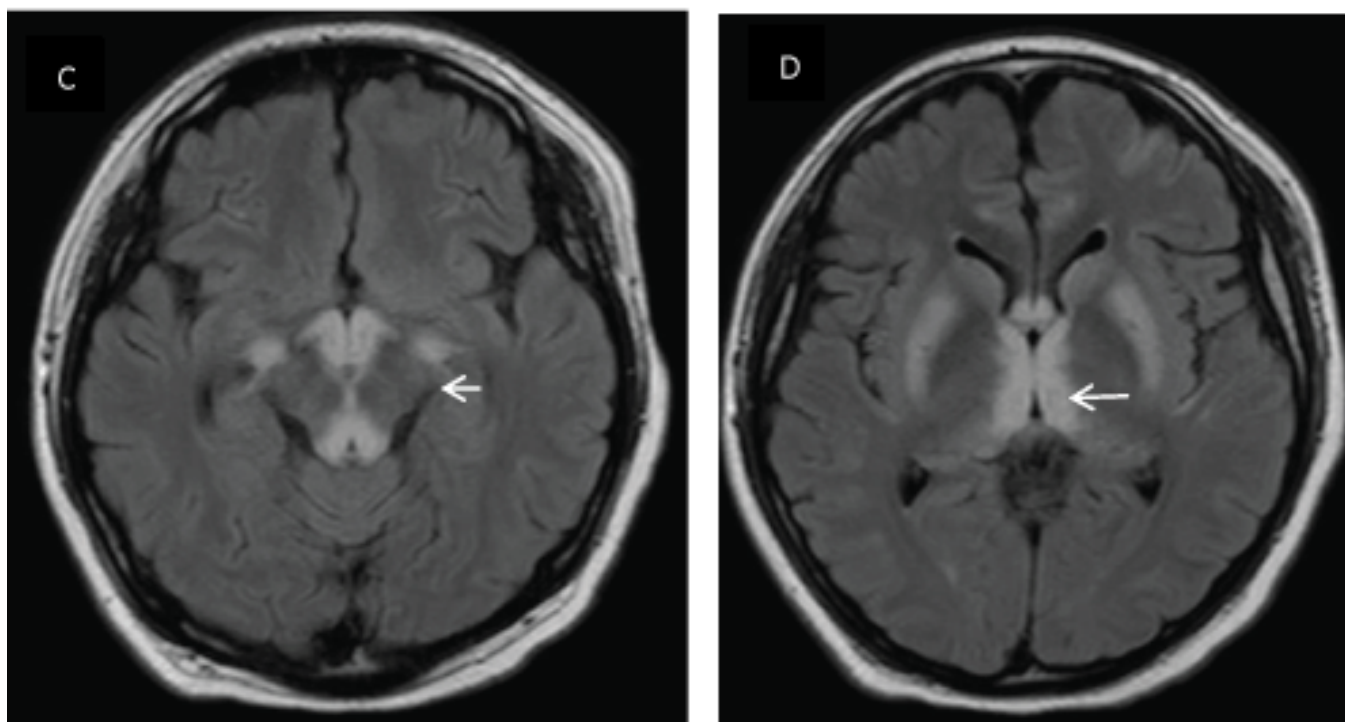


Figure 1 (C,D): Brain MRI follow-up at 4 days shows bilateral extending basal ganglia (putamen) and brain cortex hyper intense lesions with accentuation in cuadrigeminal tuberculosi and thalamus.