CC: ,Headache.,HX: ,This 37y/o LHM was seen one month prior to this presentation for HA, nausea and vomiting. Gastrointestinal evaluation at that time showed no evidence of bowel obstruction and he was released home. These symptoms had been recurrent since onset.,At presentation he complained of mild blurred vision (OU), difficulty concentrating and HA which worsened upon sitting up. The headaches were especially noticeable in the early morning. He described them as non-throbbing headaches. They begin in the bifrontal region and radiate posteriorly. They occurred up to 6 times/day. The HA improved with lying down or dropping the head down between the knees towards the floor. The headaches were associated with blurred vision, nausea,vomiting, photophobia, and phonophobia. He denied any scotomata or positive visual phenomena. He denies any weakness, numbness, tingling, dysarthria or diplopia. His weight has fluctuated from 163# to 148# over the past 3 months and at present he weighs 154#. His appetite has been especially poor in the past month.,MEDS:,Sulfasalazine qid. Tylenol 650mg q4hours.,PMH:, 1)Ulcerative Colitis dx 1989. 2)HTN 3) occasional HAs since the early 1980s which are different in character and much less severe than his current HAs. They were not associated with nausea, vomiting, photophobia, phonophobia or difficulty thinking.,FHX:, MGF with h/o stroke. Mother and Father were healthy. No h/o of migraine in family.,SHX:, Single. Works as a newpaper printing press worker. Denies tobacco, ETOH or illicit drug use, but admits he was a heavy drinker until the last 1970s

when he quit.,EXAM: ,BP159/92 HR 48 (sitting): BP126/70 HR48 (supine). RR14 36.2C,MS: A&O; to person, place and time. Speech clear. Appears uncomfortable but acts appropriately and cooperatively. No difficulty with short and long term memory.,CN: Grad 2-3 papilledema OS; Grade 1 papilledema (@2 o'clock) OD. Pupils 4/4 decreasing to 2/2 on exposure to light. Bilateral horizontal sustained nystagmus on right and leftward gaze. Bilateral vertical sustained nystagmus on up and downward gaze. Face symmetric with full movement and PP sensation. Tongue midline with full ROM. Gag and SCM were intact bilaterally.,Motor: Full strength throughout with normal muscle bulk and tone.,Sensory: Unremarkable.,Coord: Mild dysynergia on FNF movements in BUE. HNS and RAM were unremarkable.,Station: Unsteady with and without eyes open on Romberg test. No drift in any particular direction.,Gait: Wide based, ataxic and to some degree magnetic and apraxic.,Gen Exam: Unremarkable.,COURSE:, Urinalysis revealed 1-2RBC, 2-3WBC and bacteria were noted. Repeat Urinalysis was negative the next day. PT, PTT, CXR and GS were normal. CBC revealed 10.4WBC with 7.1Granulocytes. HCT, 10/18/95, revealed hydrocephalus. MRI, 10/18/95, revealed ventriculomegaly of the lateral, 3rd and 4th ventricles. There was enhancement of the meninges about the prepontine cisterna and internal auditory canals, and enhancement of a scar or inflammed lining of the foramen of Magendie. These changes were felt suggestive of bacterial or granulomatous meningitis. The patient underwent ventriculostomy on

10/19/94. CSF taken on 10/19/94 via V-P shunt insertion revealed: 22 WBC (21 lymphocytes, 1 monocyte), 380 RBC, Glucose 58, Protein 29, GS negative, Cultures (bacterial, fungal, AFB) negative, Cryptococcal Antigen and India Ink were negative. Numerous CSF samples were taken from the lumbar region and shunt reservoir and these were consistantly unremarkable except for an occasional CSF protein of up to 99mg/dl. Serum and CSF toxoplasma titers and ACE levels were negative on multiple occasions. VDRL and HIV testing was unremarkable. 10/27/94 and 10/31/94 CSF cultures taken from the cervical region eventually grew non-encapsulated crytococcus neoformans. The patient was treated with amphotericin and showed some improvement. However, scarring had probably occurred by then and the V-P shunt was left in place.