

Intracerebral Mass and Medullary Compression Syndrome as Manifestation of HIV/AIDS

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1. Clinical Image

A 44-year-old woman was admitted to hospital with a history of fever, low back pain, paraesthesia and paresis with evolution to paraplegia, loss of esficter control. At the examination: Oriented in time and space, isocoric pupils, paraplegia level T12, hypoesthesia level T10, anesthesia level T12, positive Babinski. Positive HIV test. Magnetic resonance column (**Figure 1**): Osteolytic lesion vertebral body T1-T2, left pleural effusion; CT scan and magnetic resonance the brain (**Figure 2A and B**): Osteolytic expansive lesion 4.9 X 1.4cm left frontal affecting internal bone plate causing compression of the homolateral frontal turns, left parietal osteolytic lesion. CD4: 97 cell/mm³; VC: 257,734. Empirical treatment for tuberculosis (Rifampicin, Isoniazid, Pyrazinamide, Etambutol), neurotoxoplasmosis (sulfadiazine, pyrimethamine and folinic acid) had been initiated; dexamethasone for medullary compression syndrome and intracranial hypertension. After 2 weeks HART (TDF + 3TC + RAL) had been initiated. Craniectomy for the exeresis of the lesion, whose histopathology concluded by adenocarcinoma of mucosecretory pattern, being indicated radiotherapy. The patient presented respiratory and urinary infection culminating with death. Supportive therapy, prophylaxis of opportunistic infections, as well as HART, are already well established in the clinical practice of infectious and physician accompanying HIV/AIDS, however, early research for pre-malignant lesions and neoplastic diseases is important as it lacks of greater dissemination of knowledge and investment in SUS in screening programs especially for this population.



Figure: 1

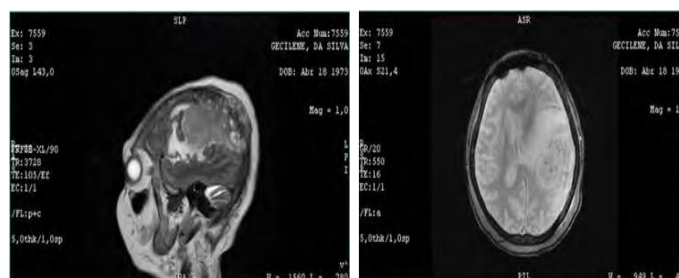


Figure: 2a

Figure: 2b

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