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MENINGITIS CAUSED BY CRYPTOCOCCUS GATTII IN A PERSON LIVING WITH HIV: A CASE REPORT OF REFRACTORY INTRACRANIAL HYPERTENSION AND LIMITED ACCESS TO NEUROSURGICAL MANAGEMENT IN THE BRAZILIAN PUBLIC HEALTH SYSTEM

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Cryptococcal meningoencephalitis due to Cryptococcus gattii is classically associated with immunocompetent individuals; however, its epidemiology in Brazil and clinical course in people living with HIV require further investigation. A 28-year-old cisgender woman, diagnosed with HIV two years earlier and not previously on antiretroviral therapy, was admitted with severe holocranial headache for seven days, diplopia, vomiting, and fever. Physical examination showed neck stiffness, positive Kernig sign, and bilateral sixth cranial nerve palsy. Admission head CT was unremarkable. Laboratory tests showed a reactive serum cryptococcal antigen (LF-CrAg), HIV viral load of 68,300 copies/mL, and CD4 count of 72 cells/mm^3. Lumbar puncture revealed an opening pressure of 38 cmH_2O and CSF analysis with 510 cells (97% mononuclear), protein 52 mg/dL, normal glucose, reactive LF-CrAg, and culture growth of C. gattii. Workup for other opportunistic infections was negative. She developed refractory intracranial hypertension, requiring 26 therapeutic lumbar punctures during the initial hospitalization. Induction therapy with liposomal amphotericin B plus flucytosine lasted four weeks, followed by fluconazole consolidation. Although early CSF diversion was indicated, it was not performed due to structural limitations in the health system. The patient stabilized transiently, started antiretroviral therapy, and was discharged. Ten days later, she was readmitted with recurrent intracranial hypertension, requiring nine additional therapeutic lumbar punctures until pressure stabilization, without mycological evidence of relapse, totaling 35 procedures since diagnosis. At one-year outpatient follow-up, she remains on fluconazole maintenance without complications or relapse. Notably, there was clinical–radiological dissociation, as follow-up CT scans did not show signs of intracranial hypertension, consistent with the “frozen brain state” described in the literature, attributed to deposition of C. gattii capsular polysaccharide. Guidelines recommend CSF diversion if intracranial hypertension persists for more than seven days despite therapeutic lumbar punctures, contrasting with the more than 60-day persistence in this case. Intracranial hypertension management in cryptococcal meningitis is directly associated with reduced mortality, and pharmacologic treatment offers no benefit. This case highlights the limitations of exclusive clinical management and reinforces the importance of early neurosurgical intervention.

Keywords: Cryptococcus gattii, Meningitis, HIV, Intracranial Hypertension, CSF Diversion.

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CUTANEOUS MUCORMYCOSIS IN A DIABETIC PATIENT AFTER A SPIDER BITE: DIAGNOSTIC AND THERAPEUTIC CHALLENGE

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Cutaneous mucormycosis is a rare fungal infection caused by fungi of the order Mucorales, occurring more frequently in immunosuppressed patients or in those with uncontrolled diabetes. Although less lethal than rhino-sino-orbital and pulmonary forms, it can be severe, especially when diagnosis is delayed. We report the case of a 68-year-old woman with poorly controlled diabetes who developed an ulcerated lesion on the back after a spider bite. Initially, the lesion progressed with erythema, pain, and local edema, and she was evaluated and treated symptomatically. The lesion progressively worsened, became associated with daily fever, and the patient was hospitalized. On admission, she had an extensive ulceration with necrotic borders and intense pain, and broad-spectrum antibiotic therapy was initiated. Computed tomography showed an ulcerated lesion involving the skin, subcutaneous tissue, and trapezius muscle, measuring $11 \times 11 \times 2.9$ cm. Surgical debridement was performed, and samples were collected for culture. Despite therapy and the procedure, lesion necrosis recurred and the patient clinically deteriorated, requiring further debridement and intensive care due to hemodynamic instability. Mycological analysis revealed hyphae compatible with Mucorales, confirming cutaneous mucormycosis. Antifungal therapy with liposomal amphotericin B was initiated, with progressive improvement of the lesion after additional debridement. However, the patient ultimately died in the ICU due to ventilator-associated pneumonia. Cutaneous mucormycosis often results from direct inoculation of fungi into traumatized areas, such as bites, wounds, or surgical sites. Diabetic patients, particularly with poor glycemic control, are at increased risk for invasive forms. Treatment requires early and aggressive management, including extensive surgical debridement and appropriate antifungal therapy, with liposomal amphotericin B as the treatment of choice. Despite these measures, morbidity and mortality remain high, especially in patients with comorbidities or significant immunosuppression. This case highlights cutaneous mucormycosis as a severe infection associated with skin trauma and risk factors such as uncontrolled