INTRODUCTION

- Cerebral mucormycosis is a rare but fatal infection, primarily seen in immunocompromised individuals.
- It is caused by the fungi of the class *Mucormycetes*.
- We describe a case of cerebral mucormycosis in a patient with uncontrolled diabetes mellitus.

CASE DESCRIPTION

- A 38 year old Pakistani man with a history of poorly controlled diabetes mellitus was admitted with a 4 week history of generalized lethargy, night sweats and weight loss.
- On initial examination, he was pyrexial and had enlarged supraclavicular lymph nodes.

HOSPITAL COURSE

**Week 1:**
- The patient was initiated on antibiotics for pneumonia, and insulin for his diabetes.
- He underwent bronchoscopy to rule out tuberculosis (TB).
- He developed sudden onset left leg weakness.
- CT head demonstrated right sided brain lesions with surrounding vasogenic edema.
- MRI brain confirmed ring–enhancing lesions, likely tuberculomas.
- He was initiated empirically on TB treatment and intravenous steroids.

**Week 2:**
- He developed signs of meningism and bulbar weakness.
- Repeat CT head now revealed bilateral ring enhancing lesions with worsening of vasogenic edema.
- Neurosurgeons performed mini-craniotomy, with aspiration of a right parietal brain abscess.
- Histology and culture confirmed the presence of hyphae of *Apophysomyces variabilis*, a mucoraceous mold.
- CT head showing worsening vasogenic edema.

**Week 3-4:**
- He developed signs of meningism and bulbar weakness.
- Repeat CT head now revealed bilateral ring enhancing lesions with worsening of vasogenic edema.
- Neurosurgeons performed mini-craniotomy, with aspiration of a right parietal brain abscess.
- Histology and culture confirmed the presence of hyphae of *Apophysomyces variabilis*, a mucoraceous mold.

**Week 5:**
- Patient progressively deteriorated with significant impairment of his level of consciousness.
- Multidisciplinary team and family made a unanimous decision for palliation.

DISCUSSION

- Currently, there is no standardized non-culture-based test of serum or CSF.
- There is no NICE UK guideline for the management of mucormycosis.
- Diagnosis is on the basis of clinical suspicion, imaging and sampling.
- Etiological agent identification is via direct microscopy, culture and immunohistochemical staining.
- Management involves prompt institution of antifungal treatment and surgical intervention, such as debridement.

TAKE-HOME POINTS

- Cerebral mucormycosis can present clinically and radiologically as cerebral tuberculosis.
- It is imperative to maintain an elevated level of clinical suspicion for atypical infections, especially fungal infections, in immunocompromised patients presenting as TB.
- Cerebral mucormycosis is difficult to diagnose, difficult to treat and difficult to survive.

REFERENCES