

Australian And New Zealand Citator To UK Reports 1993

THE NEW ZEALAND
MEDICAL JOURNAL

Vol 116 No 1187 ISSN 1175 8716



A case of primary amoebic meningoencephalitis: North Island, New Zealand

Ray Cursons, Jamie Sleigh, Dell Hood and David Pullon

During the 10 years 1968–78, eight fatal cases of primary amoebic meningoencephalitis occurred in the Waikato area. All had been swimming at places along the primeval course of the Waikato River between Taupo and Matamata.

This paper reports a ninth fatal case of primary amoebic meningoencephalitis, involving a 10-year-old girl who swam at Okauia Springs in one or more of the 'Opal Springs' pools on the west bank of the Waikato River (just opposite the 'Crystal Springs' pool area) over Easter (21–24 April 2000), as well as in natural warm pools in the Rotorua area during the same period.

Case report

In late April 2000, a 10-year-old from Waipa District was notified to the Medical Officer of Health of Waikato District Health Board, with primary amoebic meningoencephalitis. In the week prior to the onset of her symptoms, the child had swum in two geothermal pools, one a natural, undeveloped spring near Lake Rotoma, and one part of a commercial pool complex in Matamata. She was known to have put her head underwater in both locations, as did many others present at the same times. Both exposures occurred during Easter. There had been no other exposures to thermal or other waters during the incubation time or during the two weeks of school holidays, which had immediately preceded Easter. The presenting symptom was headache, which began three and four days after the two swimming exposures. The headache was severe and persistent, with fever and vomiting developing over 48 hours. There was no rash. Clinically the child presented as a case of bacterial meningitis with pleocytosis and an elevated protein. Clinically she was thought to have pneumococcal meningitis and was treated with ceftriaxone and vancomycin. Her continued clinical deterioration and reduction in level of consciousness prompted a review of the diagnosis and consideration of less common causes of meningitis. Motile amoebae were seen in cerebrospinal fluid (CSF), and have since been confirmed by culture and polymerase chain reaction (PCR) as *Naegleria fowleri*. The child died three days after admission despite intensive therapy with intravenous and intrathecal amphotericin B, and intravenous rifampicin and co-trimoxazole.

At the commercial complex she had spent several hours in a chlorinated Olympic pool and used a playground-style slide into the pool repeatedly. She was thought by her family to have spent some time in a second pool at the complex, which has a warning posted alongside it advising swimmers not to put their heads underwater. The water in this pool received no treatment other than sand filtration. The family spent about an hour in the natural soda springs pool the following day. It was raining, and about 20–30 others were using the pools at the same time. Other members of the family reported putting their heads underwater, as did other pool users. After confirmation of the diagnosis, the public health response involved immediate public notification of the

NZMJ 12 December 2003, Vol 116 No 1187
URL: <http://www.nzma.org.nz/journal/116-1187/712/>

Page 1 of 5
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