Case Report

Abstract

Congenital Cytomegalovirus co-incidentally diagnosed at the second month of life. The case was transferred to our facility due to severe respiratory failure and bilateral pneumonia, post cardiac arrest. At the age of one and a half months, the patient suffered from respiratory distress and inability to suckle. Afterwards sought medical advice in four facilities who reassured the parents that nothing abnormal. After few days of reduced oral intake, the patient suffered from cyanosis and transferred to the nearest facility where he had bradycardia and impending cardiac arrest. The patient was intubated and hooked to conventional mechanical ventilation, then transferred to our facility due to unavailability of Pediatric Intensive Care Unit at the primary facility. On admission,the initial investigations showed extensive bilateral pneumonia and Methicillin resistant staphylococcus aureus pleural effusion. Computerised Tomography Brain showed bilateral scattered cerebral and basal ganglia calcifications. EmpIrical antibiotics; Ampicillin/Gentamicin were started which were changed to Meropenem/Linezolid even before the result of pleural fluid culture and sensitivity. Inotropic support and sedation were started for the patient. After stabilising the patient, we started to tackle the cause. Owing to Microcepaly together with cerebral and Basal ganglia calcifications, I can we thought of Cytomegalovirus as the cause of the condition. Cytomegalovirus Immunoglobulin M was positive, so Cytomegalovirus PCR in urine yeilded ten million copies. Mechanical ventilation was gradually weaned off after 21 days but the prolonged sedation period led to Withdrawal syndrome which was managed by Intravenous Lorazepam. Fortunately the Withdrawal syndrome was successfully managed. The patient was discharged and started on Ganciclovir. Fortunately we were able to diagnose the case and discharge. Now the patient is under follow up. Congenital Cytomegalovirus infection needs a high index of suspicion to diagnose.