が近年報告されているが，特異な点としては，HIV陽性の神経梅毒患者ではHIV陰性の神経梅毒患者に比べてより若年であり，高頻度に第2期梅毒の症状を呈する[21]．また，AIDS未発症のHIV感染者で梅毒性髄膜炎の頻度が高いことも示されている[6]．他に，HIV感染を合併した梅毒患者で非典型的な症状を呈することが報告されている[6]．本症例は，神経梅毒には稀な小脳失調で発症しており，HIV感染が免疫系の異常を介して梅毒の経過に影響を与えた可能性が考えられた．

ま と め

急性小脳失調で発症したHIV感染を伴う神経梅毒の48歳男性例を報告した．髄膜血管型と考えられるが，病態の背景に血管炎に伴う小脳の血流低下の存在が推定された．

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<Abstract>

Neurosyphilis with HIV infection developing acute cerebellar ataxia. A case report.

by
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The patient was a 48-year-old male who developed acute cerebellar ataxia following a fever and a sore throat. The serum Venereal Disease Research Laboratory (VDRL) test, *Treponema pallidum* particle agglutination (TPPA) test and HIV-1 antibody test were positive. The CD4 cell count was 828/μl and the HIV-RNA level was 7.6×10^4 copies/mL in serum. Cerebrospinal fluid (CSF) examination showed pleocytosis, an elevated protein concentration, and positive TPPA. We diagnosed neurosyphilis with HIV infection. Brain magnetic resonance imaging (MRI) showed no abnormality. ^{123}I-IMP-SPECT demonstrated decreased blood flow predominantly in bilateral cerebellum and parietooccipital lobe. He was treated with penicillin intravenously at 24 million units per day for 21 days. The cerebellar ataxia gradually improved, accompanied by improvements in the serum VDRL test results and cell count of CSF. This is a rare case of neurosyphilis with HIV infection that developed acute cerebellar ataxia.

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