Recognising immunotherapy-induced meningoencephalitis: a case during treatment for primary metastatic melanoma of the bladder neck

Joel Grunhut,1 Shimron Brown,1 Jose Lutzky,2 Leor Skoczylas1

SUMMARY
Although novel immunotherapy has shown promise for patients with melanoma, a more activated state of the immune system may lead to adverse systemic effects. Immunotherapy-induced meningoencephalitis is a rare and seldom reported adverse effect of immunotherapy but with the expanding role of immunotherapy in cancer treatments it must be recognised. Patients receiving immunotherapy should receive a proper warning about the potential for this life-threatening condition. Herein, we report a patient in his 70s with neurological changes after his second treatment with dual immunotherapy for a primary metastatic melanoma of the bladder neck.

BACKGROUND
In 2021, there will be an estimated 106,110 new melanomas diagnosed in the USA.1 Ipilimumab and nivolumab are human immunoglobulin programmed death 1 (PD-1) immune checkpoint inhibitor (CPI) antibodies that selectively block interactions between PD-1 expressed on activated T cells with ligands programmed death-ligand 1 (PD-L1) and PD-L2 expressed on antigen-presenting cells and cancer cells that result in significant enhancement of T-cell function.2 These drugs are used to treat melanomas that cannot be treated surgically or that have already metastasised.3

Immune-related adverse events caused by novel immunotherapy such as CPIs, are a rare but complex and clinically important subject.4 5 These may manifest in various compromised neurological states such as aseptic meningitis and encephalitis.4 Often, patients’ presentations encompass a wide range of diseases and differential diagnoses. Diagnosing immune therapy-related adverse events is important due to the potential life threatening sequelae and the complexity of management. Physicians may delay proper treatment or may not know whom to refer for assistance in the management of this complex disorder.

Here, we report an exceedingly rare case of a patient undergoing immunotherapy treatment for primary metastatic melanoma of the bladder neck who exhibited significant cognitive decline following treatment with ipilimumab and nivolumab. These effects were observed in this patient only and research is required to prove causation. The distinctive presentation, differential diagnosis, management and treatment of immunotherapy-induced meningoencephalitis (IIM) is discussed.

CASE PRESENTATION
A white male above the age of 70 (height: 6’ 0” (1.83 m); weight: 216.1 lbs (98.0 kg); body mass index: 29.3 kg/m²) was found to have a rare primary malignant melanoma of the bladder neck without evidence of metastatic disease after several episodes of haematuria and urinary obstruction. The patient was referred to a national comprehensive cancer institute and was started on immunotherapy. He received a dual ipilimumab and nivolumab (anti-PD1, PDL1, anti-CTLA4) infusion within 2 months of his initial hospitalisation for urinary obstruction. Adverse events included increased fatigue and he slept for most of the week at home after his second round of immunotherapy. Indeed, his wife reported that the patient experienced an episode of sleep for 20 hours without interruption. On awakening from this, he stood up and fell to the ground shortly after, prompting a visit to the hospital emergency department. The patient was noted to be confused on admission to the hospital.

DIFFERENTIAL DIAGNOSIS AND INVESTIGATIONS
The patient had diabetes but was not hypoglycaemic on arrival, ruling out a hypoglycaemic event. Patient was noted to have an elevated temperature of 37.8°C and so an infectious cause for confusion was suspected. Urinary tract infection was suspected secondary to melanoma of the neck of the bladder prompting a urine culture and intravenous antibiotics were started. A multidisciplinary team consisting of infectious disease, urology and endocrinology led by the patient’s primary care physician convened to treat the patient. The patient’s oncologist was remotely based but informed and included in the decision-making process.

The following day there was no improvement in patient’s mental state. CT scan of the head without contrast was performed for suspected stroke, metastatic malignancy or other acute intracranial pathology. CT scan showed no evidence of acute intracranial pathology. Hypopituitarism, likely immune-related was noted and endocrinology advised on proper replacement therapy.

Continued cognitive decline pressed for a neurology consult in which the patient was found to have no spontaneous speech, inappropriate responses and apathy. Encephalopathy of a toxic metabolic or infectious cause was suspected. Cerebrospinal fluid (CSF) was obtained via fluorescent guided lumbar puncture. At this point, urine
cultures came back positive for *Staphylococcus aureus*, possibly from an indwelling Foley catheter. Intravenous antibiotics were continued according to sensitivities but mental state continued to decline. CSF cultures, viral panel and separate herpes simplex virus (HSV)-1 and HSV-2 CSF PCR tests were negative but CSF lymphocytosis was noted. MRI with and without contrast was performed but was difficult to interpret due to patient’s movements and inability to remain still during the examination (figures 1 and 2). Toxic metabolic causes were ruled out with blood workup that included chemistry comprehensive studies, basic haematology and thyroid studies. The team consulted the patient’s oncologist once more and agreed on a diagnosis of immune mediated lymphocytic meningoencephalitis and hypophysitis. This was a diagnosis of exclusion due to the negative workup and consistent cognitive decline.

**TREATMENT**

Consult with the patient’s remote oncology team led to a decision to treat as an adverse reaction to the immunotherapy and to begin a course of steroids. Methylprednisolone 40 mg=1 mL, intravenous push, every 8 hours and prednisone 5 mg=1 tab, oral, every morning, were administered. The patient immediately began to improve and was discharged 3 days later with continuous improvement in his mental and physical state (figure 3). Follow-up in the outpatient setting at the patient’s primary care physician revealed continued and maintained improvement without any deterioration or adverse events. These effects were observed in this patient only and research is required to prove causation.

**OUTCOME AND FOLLOW-UP**

Fortunately, 1-year follow-up with the patient found him to be back to his mental baseline, with no lasting effects from the hospitalisation. He continued to remain stable and did not receive additional immunotherapy treatments. His oncology

---

**Figure 1** Initial MRI: axial T2-weighted image with hyperintensities in the bilateral basal ganglia.

**Figure 2** Initial MRI: sagittal FLAIR-weighted image with mild but inconclusive hyperintensities seen in the meninges.

**Figure 3** Timeline of clinical events. Figure author: Joel Grunhut.
team is considering an additional round of immunotherapy with a single drug.

DISCUSSION
The clinical manifestations of IIMs are broad, atypical and encompass overlapping syndromes.6 This results in patients with IIM receiving treatment delays and possible consequential effects. There is a need to disseminate information regarding IIM in order to best inform physicians about recognition and management of such patients.

Before initiation of treatment with immune CPIs, patients should have a neurological evaluation to establish a baseline cognitive level.7 This will allow any future adverse neurological events such as IIM to be recognised earlier. This patient’s care may have been expedited if a proper cognitive baseline was established before treatment.

Patients with suspected IIM must have a full workup to rule out other metabolic or infectious causes. A thorough investigation is warranted in a patient on immune CPIs with developing neurological involvement. Manifestations of neurological impairment vary widely although some presentations to consider are confusion or delirium, headaches, altered behaviour, short-term memory loss, speech abnormalities, fatigue, focal weakness, decreased level of consciousness, hallucinations, spas tic tremors, fever and vomiting.8 Teams must take a thorough medical history, including evaluating current medications, and perform a thorough clinical neurological examination. Blood tests should assess metabolic abnormalities or signs of infection, followed by CSF analysis. Brain MRI can rule out metastasis and may pick up enhancement from encephalitis. Differentiation of IIM and aseptic meningitis requires a fine diagnostic workup as both conditions may present with lymphocyte pleocytosis, elevated protein, negative bacterial and viral cultures/serology in the CSF analysis, abnormal leptomeningeal enhancement on brain MRI, and improvement with high-dose corticosteroids although altered mental status is less usual with aseptic meningitis.9

In patients with presumed IIM, corticosteroids should be introduced rapidly, while continuing to treat with antiviral medications until negative CSF viral panels are returned.6 In this patient, treatment with corticosteroids helped improve his neurological status back to baseline.

This case exemplifies the importance of an experienced multidisciplinary team in recognising and treating IIM. In these rare and potentially harmful situations, accurate diagnosis and management must rely on an experienced multidisciplinary team. Future cases should continue to be disseminated through literature to enable future studies in understanding the pathophysiology and aetiology of IIM. Future research should identify if demographics, cancer type and other patient specific factors play a role in the onset of IIM.

Contributors JG, SB, JL and LS have equally participated in the planning, conduct, reporting, conception and design of this case report. JG, SB, JL and LS participated equally in acquisition of data or analysis and interpretation of data gathering of data, analyses and manuscript preparation. JG, SB, JL and LS all acknowledged final submission of this manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Consent obtained directly from patient(s).

Provenance and peer review Not commissioned; externally peer reviewed.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

Case reports provide a valuable learning resource for the scientific community and can indicate areas of interest for future research. They should not be used in isolation to guide treatment choices or public health policy.

ORCID iD
Joel Grunhut http://orcid.org/0000-0002-8104-9679

REFERENCES
1. Key statistics for melanoma. American Cancer Society, 2021. Available: https://www.cancer.org/cancer/melanoma-skin-cancer/about/key-statistics.html [Accessed 22 Nov 2021].
2. Hammers HJ, Plimack ER, Infante JR, et al. Safety and efficacy of nivolumab in combination with ipilimumab in metastatic renal cell carcinoma: the CheckMate 016 study. J Clin Oncol 2017;35:3851–8.
3. Moser JC, Wei G, Coloma SV, et al. Comparative-effectiveness of pembrolizumab vs. nivolumab for patients with metastatic melanoma. Acta Oncol 2020;59:434–7.
4. Thouvenin L, Olivier T, Banna G, et al. Immune checkpoint inhibitor-induced aseptic meningitis and encephalitis: a case-series and narrative review. Ther Adv Drug Saf 2021;12:2042096211004744
5. Postow MA, Sidlow R, Heilman MD. Immune-related adverse events associated with immune checkpoint blockade. N Engl J Med 2018;378:155–68.
6. Haugh AM, Probasco JC, Johnson DB. Neurologic complications of immune checkpoint inhibitors. Expert Opin Drug Saf 2020;19:479–88.
7. Shields LBE, Alsorogi MS, Mar N, et al. Immune-Related meningoencephalitis following nivolumab in metastatic renal cell carcinoma. Case Rep Oncol 2021;14:1051–8.
8. Larkin J, Chmielowski B, Lao CD, et al. Neurologic serious adverse events associated with nivolumab plus ipilimumab or nivolumab alone in advanced melanoma, including a case series of encephalitis. Oncologist 2017;22:709–18.
9. Schneider BJ, Naidoo J, Santomasso BD, et al. Management of immune-related adverse events in patients treated with immune checkpoint inhibitor therapy: ASCO guideline update. J Clin Oncol 2021;39:4073–126.
