hypothesis that the development of intermittent hypotension in children with AIDS, as described by Lipson et al, may be caused by a direct effect on the auditory nerve, either by infection or compression. Rex et al also reported a HIV-negative patient with bilateral deafness, a slow-onset loss of vision, and bilateral palsies of the 8th, 9th and 11th cranial nerves, but a CT scan revealed hydrocephalus. The possible mechanisms of the raised intracranial pressure are discussed. Despite the normal intracranial hypertension, the children in these cases were relieved of the symptom by treatment with oral fluconazole. As in the cases of children with AIDS described previously by Lipson et al, the children suffered from AIDS and were treated with fluconazole for opportunistic infections. In contrast to the children described previously by Lipson et al, the children described by us did not have a history of diabetes or other risk factors for ear infection. We therefore conclude that the association between intermittent hypotension and AIDS is real and may be caused by the direct effect of the virus on the auditory nerve.

AIDS patients with cryptococcal meningitis can be treated with oral fluconazole. The most common side effects of this drug are mild gastrointestinal symptoms, headache, and rash. In addition, fluconazole can cause an elevation in hepatic enzymes, which is usually mild and reversible. In rare cases, fluconazole can cause severe liver injury, which may be fatal. Therefore, HIV-infected adults who are treated with fluconazole should be monitored closely for signs of hepatic injury.

We conclude that fluconazole is a safe and effective treatment for opportunistic infections in HIV-infected children. However, more studies are needed to determine the optimal treatment regimen and duration of therapy, as well as the long-term effects of fluconazole in this population.
Deafness and blindness in a HIV-positive patient with cryptococcal meningitis.

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