

Development of Acute Psychosis after the Remission of Tuberculosis Meningitis :A Case Report

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1. INTRODUCTION

We report a case of 31- year- old male tuberculosis patient who developed psychotic symptoms. One- third of the World population is infected by tuberculosis representing the second common cause of death in adults in 2000 (1). There are reports about acute psychotic episodes following administration of isoniazid (2) and ciprofloxacin (3). Psychotic symptoms developed 6 years after the onset of tuberculosis in the patient. He had severe complications including Pott's abces and tuberculosis meningitis. In the past the use of isoniazid, ciprofloxacin and other antituberculosis medication did not lead to toxic psychosis.

2. THE CASE

He was admitted to our psychiatry department with the complaints of insomnia, verbal aggression, cursing, talking to himself. He did not eat anything due to thoughts of being poisoned by his family for nearly 4 weeks. He had jealous delusions about his wife. He was diagnosed as tuberculosis due to hemoptysis at the age of 24. When he was 28, pleuritis developed. He suffered from back pain and operated for Pott's abces on his medulla spinalis at the age of 29. When he was 30 he suffered from severe nausea. and vomiting and disorientation. He was treated for tuberculosis meningitis and parenchymatous infection (Figure 1,2). He was treated at the intensive care unit. Neurological examination, lumbar puncture, cytological examination, BT and MR revealed no pathology including acute hydrocephalus. His general examination revealed no significant abnormality except mild anemia, mild increases in liver enzymes due to antituberculosis medication. After remission of tuberculosis meningitis, psychiatric consultation was needed for depressive state and insomnia. He was prescribed olanzapine 5 mg/day PO, mirtazapine 15 mg/day PO in addition to antituberculosis medication. He was hospitalized due to developing psychotic symptoms. Psychiatric examination revealed that he was oriented, self care was poor, aggressive to the interviewer. He was in decreased psychomotor activation. He avoided eye contact, he had depressive affect, irritable mood, emotional instability, incoherent speech, jealous and persecutory delusions . He had no hallucinations and no insight. He had auditory deficiency due to autotoxicity, of long term streptomisin use. Cooperation was with writing. He was not in the acute phase of tuberculosis. We planned the control cerebral BT of the patient and tuberculosis meningitis and parenchymatous infiltration were shown after one year. Granulomas were disappeared with medication and hypodense areas which remained as sequels (Figure 3). He was prescribed haloperidol 20 mg/day PO, biperidene 2 mg/day PO and quetiapine 600mg/day PO. In a short time confusion developed and psychiatric medication stopped. Hydration and antituberculosis medication were continued and he was oriented again. EEG was within normal limits. Then quetiapine 200mg/day PO was prescribed and he was in remission in a short time.

3. CONCLUSION

We suggest that the psychosis might be related to the tuberculosis meningitis and parenchymatous infection which were well cured at the intensive care unit. This case report is interesting because of late onset of acute psychosis in a tuberculosis patient.

4. REFERENCES

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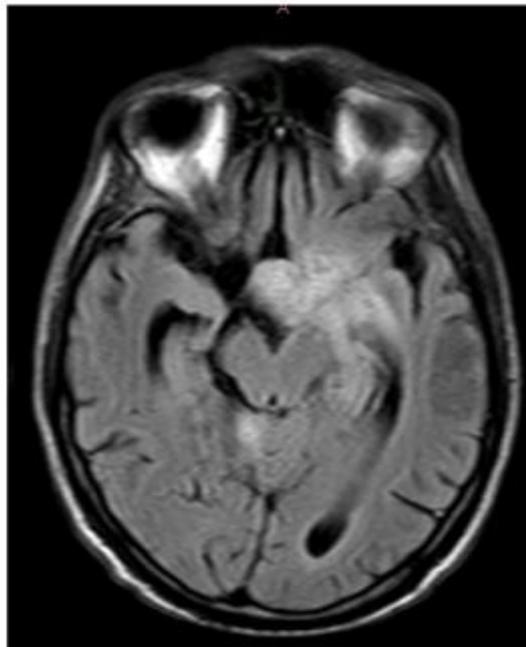


Figure 1: Infiltration on limbic system and the infiltrations of left amigdale, hippocampus and inferior frontale lobe at the axial flair sections

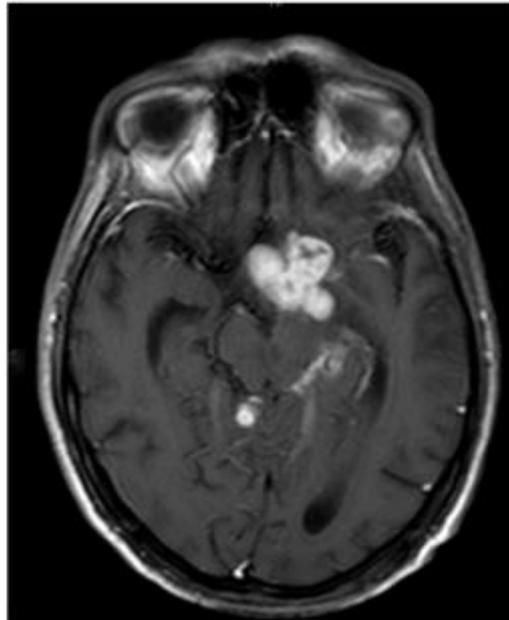


Figure 2. Nodular contrast intaked granulomas of sisterna at the plane level of mesencephalon at contrasted axial section



Figure 3. Control BT of the patient with tuberculosis menengitis and parenchymatous infiltration after one year.