SUMMARY

Neurotuberculosis continues to be a serious infection in many developing countries. Infection may be either primary or due to reactivation and may present as subacute meningoencephalitis or a focal tuberculoma.

Unfortionatly, the diagnosis is often delayed until the patient has reached the second stage when neck rigidity and other neurological signs appear.

Although the diagnosis is easy if all the associated signs, symptoms and laboratory results are typical, yet the major problem lies in the fact that it is a difficult infection to exclude.

Therfore, clinicians should have a high index of suspicion in patients who present with early signs and symptoms of meningitis as listlessness, irritability, anorexia, vomiting, loss of weight refusal to smile or play, vague ill health, photophobia, or headache, Persistance and combination of several of these symptoms should alert the clinician to the possibility of tuberculous meningitis before the appearance of neck stiffness, focal neurological signs, disturbance of consciousness or convulsion.

Abnormal chest roentgenograms, positive tuberculin skin tests, a history of contact and c.s.f. smear that is positive for acid-fast bacilli are all valuable

criteria when present.

Roberts, 1981 reported that 60% of patientswith tuberculous meningitis had completey normal chest roentgenograms, 64% had negative tuberculin skin test, only one patient had a history of contact with an active case and non of c.s.f. were positive for acid fast bacilli. Therefore; meticulous clinical examination might point to a clue for proper diagnosis.

The mortality rate is higher in children who are disoriented confused, stuporous or semiconscious and highest in children who are comatosed.

The sequalae rate is highest in children with motor neurological signs. The prognosis is bad in children when they develop changes in sensorium or positive neurological signs (Myint,1980) and some are left with neurological damage.

The cross sectional anatomy of the brain shown on computerized tomography facilitate accurate localization.

Intracerebral inflammation is associated with cellular infiltration and oedema and allow detection by computerized tomography at an early stage.

Inflammation causes alteration in vascularity of blood vessels of blood brain barrier which can be

recognised by contrast enhancement.

Although cerebral tuberculosis is essentially clinically diagnosed and confirmed by c.s.f. examination, all cases show meningeal enhancement after I.V. contrast media which can be of diagnostic significance.

However, computerized tomography is mainly of value in detecting complications especially hydrocephalus secondary to basal adhesion, subdural effusions, cerebral abscess or infarction and oedema due to vascular occulsion. All these complications necessitate prompt neurosurgical mangement to achieve better prognosis, and favourable recovery.

Empirical chemotherapy is often imperative and procrastination in mangement can be dangerous. In many cases steroid therapy have a vital role in ensuring an acceptable outcome.

Discovery of meningitis in children serves as an alarm signal to look for unsuspected active case in close relatives or friends or in the school.