



# **Pediatric Neurology: Chapter 117. Tuberculous meningitis (Handbook of Clinical Neurology)**

*J.F. Schoeman, P.R. Donald*

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Tuberculous (TB) meningitis is common in resource-poor communities but also occurs in developed countries where the diagnosis is frequently delayed because of unfamiliarity with the disease. TB meningitis develops whenever a small intracranial tuberculoma (Rich focus) ruptures causing predominantly basal meningitis. This results in hydrocephalus, cranial nerve palsies, and ischemic brain injury secondary to tuberculous vasculitis. The primary source of TB is usually the lung. Early diagnosis is difficult because patients tend to present subacutely with nonspecific symptoms such as fever, cough, vomiting, listlessness, and failure to thrive. Lumbar puncture typically shows clear and colorless CSF with a low, predominantly lymphocytic, leukocytosis and raised protein and low glucose levels. Decision to treat is mostly clinical because of difficulty in demonstrating TB bacilli on routine smear and time needed for culture. A positive TB contact, Mantoux skin test, chest radiograph, CT/MRI brain scan, PCR for tuberculosis on CSF, and demonstration of TB bacilli from extraneural sources are invaluable in supporting a diagnosis of TB meningitis. Current World Health Organization guidelines recommend treatment with a four-drug regimen for 2 months, followed by a two-drug regimen for 10 months, the total duration of treatment being 12 months. Corticosteroids reduce mortality without changing neurological morbidity. Outcome relates closely to age and stage of disease.

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