PSYCHIATRIC MANIFESTATIONS AND NEURO-COGNITIVE PROBLEMS ASSOCIATED WITH HIV

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ABSTRACT
HIV associated neuro-cognitive disorder is a blanket term that covers a spectrum of neuro-cognitive disturbances in HIV infected individuals ranging from asymptomatic neuro-cognitive impairment (ANI) to HIV associated dementia (HAD). With the institution of combination of retroviral drugs for the treatment, the incidences of severest forms have decreased over the years and the milder forms are more often encountered in clinical setting.

Key words:
HIV associated neuro-cognitive disorder, AIDS dementia complex; HIV-associated dementia (HAD); HIV encephalopathy

Case:
43 years old male, with positive HIV status for the past 12 years on HAART was referred to Psychiatry OPD for complaints of irrelevant excessive talk, using different names for others, sleep disturbance for past two months. The patient has been on regular follow up and continuous treatment for the past 12 years. There was no family history suggestive of any psychiatric illness. On examination, there was no focal neurological deficits or signs suggestive of acute CNS infection. Initial verbal responses were in tandem with the conversation and later on it was found to be tangential with increased fluency. Psychomotor activity as well as quantum, tone and speed of talk were increased. Mood was apathetic. There were no delusions or hallucinations. Lobar function test revealed perseveration. All the basic investigations were normal. Viral markers for HBV and HCV infections were negative and CSF analysis was normal. CD4 count was 124. Neuroimaging (MRI) revealed prominent sulci and gyri, dilated ventricles and periventricular hyperintensity. Though neuroimaging findings such as prominent sulci and gyri, dilated ventricles and periventricular hyperintensity point towards HIV related neurocognitive disorder, clinically in addition to psychiatric manifestations patient presents with perseveration only. So this may be construed as atypical HIV neurocognitive disorder which should be confirmed with the follow up.

Discussion:
Major neuro-cognitive disorder due to HIV is diagnosed when there is an evidence of cognitive decline from a previous level of functioning in one or more domains (Memory, attention, language, learning, perceptual-motor etc). The decline in these domains must cause significant interference in day to day activities. The decline should not occur due to delirium or due to any other mental disorder. Another diagnostic entity described in Diagnostic and Statistical Manual of Mental disorders (DSM 5) is minor neuro-cognitive disorder due to HIV which is diagnosed when there evidence of cognitive decline but it does not cause any interference in daily activities.

Conclusion:
Whenever a case of HIV infection is diagnosed, it is important to evaluate the neuro-cognitive profile as early as possible. This is important because HIV infection has a long window period and the neurocognitive
deterioration might have started even before the diagnosis is made. There have been instances of HIV infection presenting with neurocognitive deficits alone. However it is important to rule out other CNS infections and HIV encephalopathy before making a diagnosis of HIV associated neuro-cognitive disorder.

**REFERENCES:**


