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## Acute Psychosis due to severe malaria caused by *Plasmodium vivax* – a case report

Malaria is one of the most common infectious illnesses in India with more than 1.07 million reported cases every year (malaria in India), and large number of deaths. India contributes for 40% of all malaria cases outside Africa and more than 85% reported cases of malaria in South - East Asia annually.

We report the case of a 65 year old male who presented with altered mental status and urinary incontinence for 4-5 days. Patient was apparently alright around 4-5 days ago, when one day while getting back to his residence from market he could not figure out where to go. A fellow pedestrian recognized him and helped him to get home. He was found talking irrelevant and was disoriented to time and place. Patient also complained of urine incontinence and shivering without fever. In this condition he consulted a neurologist and underwent MRI scan of his brain which showed multiple subacute and chronic lacunar infarct with ischemic leukoariosis and generalized cerebral atrophy. He was diagnosed as multi infarct dementia. However, on the day of admission, he developed high grade fever with chills and rigors, associated with all above complaints. He denied any history of drug abuse, alcohol intake, or any psychotic disorder in the past and he was on no other medication. On clinical examination, patient was found to be disoriented to time and place and restless, even failing to recognise his family members. His temperature was normal, pulse 104/min, BP 170/80 mmHg and O<sub>2</sub> saturation was 96%. He had no pallor, cyanosis or jaundice. Chest, CVS and Abdominal examination were unremarkable. CNS examination revealed neck rigidity but no other focal neurodeficit. However, both Pupils were dilated but fully reactive to light.

Investigations revealed trophozoites of *P. vivax* in peripheral smear and antigen test was positive for *P. vivax* but negative for *P. falciparum*. Other routine haematological and biochemical parameters were within normal limits. The patient was treated with oral Chloroquine and intravenous artesunate in appropriate dosages along with supportive measures. The patient responded well and his symptoms (fever and psychosis) resolved within 12 hours of starting therapy. The patient was discharged in a clinically stable condition and was advised to take Primaquine for 14 days. Follow-up evaluation after three weeks showed no residual neurological deficit.