

Table 2: CT/MRI findings/ location in 23 patients with Toxoplasmic Encephalitis

CT/MRI findings / location	No.	(%) of Patients (N=23)
Frontal	10	43.47
Parietal	9	39.13
Occipital	5	21.73
Temporal	6	26.08
Basal ganglia	9	39.13
Cerebellum	4	17.39
Cortical-medular junction	5	21.73
Thalamus	2	8.69
Corpus callosum	3	13.04
Peritrigonal region	2	8.69
Parahypocampus girus	1	4.34
Precentral girus	1	4.34
Parasagittal girus	1	4.34

Mortality resulted in 13 patients (56.52%), with time duration 6 days (range 3-10 days). Twenty two (95.65%) patients were treatment with Trimethoprim (10 mg/kg/day) plus Sulfamethoxazole (50 mg/kg/day) and only one case treated with Pyrimethamine (50 mg/day) plus Sulfadiazine (4 g/day) and folinic acid (25 mg/day) that proved successful. Anticonvulsant agents were administered in the occurrence of convulsions. Glucocorticoids were added as adjuvant therapy in complications with a mass effect. Highly active antiretroviral therapy (HAART) began after at least 2 weeks of antiparasitic therapy. Side effect in patients treated with Cotrimoxazole: hypersensitivity reactions occurred in 2 patients (8.69%); gastrointestinal adverse events occurred in 7 patients (30.43%); mild rhabdomyolysis occurred in 1 patient (4.34%); hemolytic anemia occurred in one patient; however, no patient stopped taking therapy. In 10 cases that survive 4 of them had clinical improvement by the 9th day of treatment and 6 cases had clinical improvement by the 21th day. Imaging studies showed complete resolution of the lesions by 28-45 days.

5. Discussion

The above article highlights valuable epidemiological and clinical data about latent and reactivated *Toxoplasma gondii* infection in HIV-infected patients in Albania, because no data has been reported in our population on the TE incidence. In our study the seroprevalence of toxoplasmosis in HIV patients resulted 58.59%. Some study presented it from 20-73.7% (10). This high prevalence maybe can explain with regional area of our country. Most Toxo-IgG antibody seropositive cases were males. The sex predilection could be attributed to the higher risk of professional, consumption of meat etc (9). Studies made about the spread of toxoplasmic infection in different age groups have shown an incidence of this infection that increases with age (presence of specific antibodies from 8% for ages 2-6 years old in 53.4 % for those over 40 years old (9,22-24). We found higher positivity for IgG antibodies, 39.13% in the emigrated patients, related to their life style (most of them work as farmers).

The cerebral form was found mostly at the ages 35-55 years old, as a consequence of the reactivation of latent infection

(11,25) Also this group age has the high prevalence of adult retrovirois in Albania (26). CNS toxoplasmosis presented 15 different semiotic signs mostly reported headaches, vomits, clinical symptoms described by other authors (10,11,25,27). We had variety of topographic cerebral lesions in our patients, mostly resulted ganglionar lesions, frontal and parietal. We evidence the fact that mostly the cases had multiple lesions, based on the literature data (20). The mortality was relatively high, related with the lately coming of these patients to us. Noticed that TE was the first AIDS manifestation in 78.26%. We know that TE is the one of the most common opportunist infections in AIDS; showed in 10-50% of them with a high mortality (28) Mostly our cases were treated with Trimethoprim/sulfamethoxazole, as a first choice for treating TE because it is unexpensive, effective and well-tolerated. This medicament is also well prescribed in literature (29). We think that our above data can contribute to the deeper recognition of TE, which as was evidenced represents a protozoosis often problematic and potentially deadly.

6. Conclusions

Toxoplasmosis is one of the most lethal opportunistic infections in AIDS patients. Therefore, new strategies to prevent Toxoplasmosis are necessary. In order to do this, we need exact data on seroprevalence of this infection in the normal population, which in our case means the positive HIV population. Considering its high rate of reactivation, all the HIV patients must be tested for the presence of *Toxoplasma gondii* antibodies, and all cases with positive toxoplasma antibodies should receive prophylaxis.

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