


Calcified occipital glioblastoma

Sir,

A rare case of a glioblastoma having areas of calcification is reported. The relevant literature is briefly reviewed.

An 18-year-old boy was admitted with a one-month history of bifrontal headache, intermittent vomiting and diplopia. He had history of seizures since the age of four years. The seizures were not preceded by any aura and the ictus consisted of a blank expression lasting for a few seconds. His scholastic performance had been average. Clinical examination revealed bilateral abducens paresis and mild papilledema. There was right-sided homonymous hemianopia. There was no cognitive deficit, disconnection syndrome or motor weakness. Skull radiograph and CT (Figure 1) done three years earlier had revealed calcification at the left occipital pole, without any mass effect. CT done at the time of present admission showed a large, mixed, attenuating and partly enhancing lesion at the left occipital pole having areas of calcification.

Left occipital craniotomy and a radical resection of the tumor-bearing occipital pole was carried out. The tumor was firm, solid and gritty and was not very vascular. The postoperative period was uneventful. Histopathology revealed a highly cellular tumor made up of anaplastic and pleomorphic cells with several mitotic figures and bizarre giant cells. Astrocytic proliferation was seen in the peripheral areas. There were areas of necrosis with palisading of nuclei and angioendothelial proliferation. Many areas of calcification were seen. The tumor was positive for glial fibrillary acid protein (GFAP). A diagnosis of glioblastoma multiforme with calcification was made. The lesion was then subjected to radiotherapy and chemotherapy. The patient was free from recurrence for three years after surgery, after which he was lost to follow-up.

Calcification may be seen in gliomas, especially in oligodendrogliomas and in mixed gliomas that have a benign histological appearance. It is unusual in high grade astrocytomas and glioblastomas; it is likely that some part of the previously low grade tumor may dedifferentiate into glioblastoma. Histological markers suggesting a better prognosis in glioblastomas include presence of giant cells and differentiation. The presence of calcium deposits has rarely been recorded.

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References


Acute inflammatory demyelinating polyneuropathy following plasmodium vivax malaria

Sir,

Acute Inflammatory Demyelinating Polyneuropathy (AIDP), seen following viral, bacterial infections or immunization, is uncommon following parasitic infection. We could locate 11 cases of Guillain Barre Syndrome (GBS) following malarial illness from the literature. Eight of these cases were following P. Falciparum infection and three were following P. Vivax infection. We report a case of AIDP / GBS following P. Vivax malaria that needed ventilatory support.

A 39-year-old male developed fever with chill and rigor. His hematological examination showed ring forms of P. vivax. He was treated with chloroquine (total 1500mg base) and pri-