


Recurrent oculomotor nerve palsy: A rare presentation of neurocysticercosis

Sir,

A non-diabetic, non-hypertensive, 34-year-old male presented with sudden onset of complete ptosis of left eye and partial ptosis of right eye of one day duration. He denied diplopia, headache, orbital pain, visual impairment or any weakness of body. Three months ago, he had similar symptoms, which recovered spontaneously by the fourth day. On examination, there was complete ptosis on the left side and partial ptosis on the right side. There was no nystagmus. The left pupil was larger (5.5mm) than the right (3.5mm) and both pupils were non-reacting to light and accommodation. No afferent pupillary defect was present. Fundoscopy revealed no abnormality. Left eye movement was limited to abduction and intortion on attempted down gaze. The right eye was moving fully except in the direction of the superior rectus muscle. The rest of the neurological examination was also normal. Magnetic resonance imaging (MRI) of the brain revealed single ring enhancing lesion (11.6x9.7 x 11.11mm) with perifocal edema and the central part of the lesion containing fluid (hypointense on T1W1 and hyperintense on T2W2) at the tegmentum of the left midbrain (Figure 1). The rest of the brain parenchyma, ventricular system and subarachnoid space was normal. The biochemical and cytological examination of CSF revealed protein of 50mg%, sugar of 40mg%, and 9 cells, all lymphocytes. Polymerase chain reaction (PCR) analysis of mycobacterium DNA was negative both in CSF and serum. Enzyme-linked immunosorbent assay (ELISA) for cysticercus was positive both in CSF and serum. X-Ray chest, thigh and arm were normal. The patient was treated only with edema-owing agents and he recovered in his symptoms on the sixth day. Follow-up CT scan at four months revealed complete resolution of the granuloma. At one-year follow-up, the patient was completely asymptomatic.

The case demonstrates that midbrain cysticercosis may present with recurrent episodes of unilateral or bilateral third cranial nerve affection.

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Thoracic neuroenteric cyst in a 60 year old male

Sir,

Neurenteric cysts are congenital intraspinal cysts. They are rare, particularly in the sixth decade of life. The cyst may remain undiagnosed for a long time or may be misdiagnosed.1 A case of isolated high thoracic neurenteric cyst in a 60-year-old male is discussed. The patient presented with a thoracic back pain, which worsened in the last two years. The pain was located in mid-scapular region and it radiated anteriorly and...
Letter to Editor

As a result of endodermal - ectodermal adhesions or as a result of abnormal separation of the germ cell layer in early embryological life. Neurenteric cysts may also be associated with anterior or posterior spina bifida, widened vertebral bodies, fused vertebrae, hemivertebrae and diastomatomyelia.

These cysts have been described by various names, including enteric cysts, enterogenous and archenteric cysts. The review by Agnoli et al of 33 histologically verified enterogenous intraspinal cysts, showed that 18 were located in the cervicodorsal spine, 80% were intradural extramedullary and 12% were intramedullary cysts.

The cysts can mimic arachnoid, epidermoid and teratomatous cysts. The content of these neurenteric cysts are known to be irritative to neural tissue which results in adhesions and subsequent attempts at excision become more difficult. The risk of recurrence in intracranial enterogenous cysts has been reported to be 37%. However there have been only isolated reports regarding recurrence in intra spinal cysts after partial excision.

In light microscopic analysis, the epithelium varies from a ciliated columnar lining to a typical gastric or small intestinal lining i.e. single pseudostratified columnar epithelium with or without mucusgranular mucus and a smooth muscle layer. There may be goblet cells. The enterogenous cysts lack the serosal layer. The cyst fluid can be mucoid, black, brown, chocolate, yellowish or occasionally colorless.

Neurenteric cysts, which are present ventral to cord, are not associated with vertebral anomaly. This is said to be due to notochord splitting or allowing endoderm to herniate into spinal canal. Subsequently the split notochord reunites giving rise to normal vertebrae.

References


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Neurenteric cysts are rare developmental cysts, which arise as a result of endodermal - ectodermal adhesions or as a result of abnormal separation of the germ cell layer in early embryological life. Neurenteric cysts may also be associated with anterior or posterior spina bifida, widened vertebral bodies, fused vertebrae, hemivertebrae and diastomatomyelia.

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Figure 1 and 2: MRI Thoracic spine T, and T2 weighted images showing oval, thin walled, well defined intradural cystic lesion located at T1- T2 vertebrae.

Figure 3: Cyst shows fibrous connective tissue lined by cuboidal columnar epithelium with pseudostratified epithelium.

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Thecoperitoneal shunt in case of symptomatic anterior sacral meningocele