The cerebellum within those cephaloceles is usually dysplastic and gliotic. PLEXIFORM NF, hallmark of NF-I are found in 30-40% of all patients with NF-I. They usually arise along the axis of a major nerve, are unencapsulated and infiltrate producing fusiform appearance. They commonly occur along orbital division of V nerve, but other areas are not exempt often associated with sphenoidal dysplasias, they are hypervascular and enhance intensely on post contrast MR. Our patient had an occipital encephalocele with dysplastic cerebellum. However, the presence of additional parietal bony defects a finding well described in NF-I and the associated plexiform neurofibroma of the adjacent scalp suggests that the bony defect in our case could be due to the mesodermal dysplasia of NF-I. The peculiarity of this case of NF-I lies not in the presence of plexiform NF, bony dysplasia or cephalocele, findings well documented in literature, but in their unusual occipital location a site hitherto reported till now only in one case so far to the best of our knowledge.

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References
Lumbar spinal dural arteriovenous fistula with a supply from a lumbar multiameric arterial system

Sir,

Spinal dural arteriovenous fistulas (AVFs) are abnormal arteriovenous communications on the surface of the dura. They are supplied by the branches of the vertebral, intercostals, lumbar, middle sacral or subclavian arteries and rarely by the branches of the internal iliac artery. SDAVFs represent at least 35% of all spinal vascular malformations in large series. [1]

A 50-year-old male presented to the neurosurgical department with burning sensation of foot bilaterally with episodes of urinary retention and progressive weakness in right lower limb for the last one month. There was mild spasticity of both lower limbs, right more than left, with grade 5/5 power. However, the day before surgery his power in the lower limbs worsened suddenly to grade 4/5 in proximal and grade 3/5 in the distal muscle group. Deep tendon reflexes in the lower limbs were exaggerated, right more than left. The anal and cremasteric reflexes were absent. MRI of the dorso-lumbar spine [Figure 1] was highly suggestive of a dural AVF with abnormal tortuous intradural flow voids in T2 WI seen in the thoracolumbar region. There were hyperintensities within the spinal cord at this level. Spinal angiogram [Figures 2-]

Figure 2: Selective right L3 lumbar angiogram oblique views.

'Unsubtracted and DSA images'. Right lumbar metameric origin of L3 and L4 at L3 level from abdominal aorta. Dural fistula from L4 radicular branch

Figure 1: MRI lumbar region T2 W sagittal showing dilated tortuous epidural vein, cord changes

Letter to Editor

nose.[1] It is usually assumed that low velocity missiles in contrary to high velocity missiles[2] do not penetrate the brain very far and lodge near the entry points.[3] In the present case the right eye has been the point of entrance. As in the majority of previous reports, the entrance wound was small. In one reported case the pellet entering through the orbit lodged in the occipital lobe.[3] In other previous reports the pellet could not penetrate farther than the cavernous sinus when entering through the orbit, probably due to resistance in the trajectory of the pellet.[1, 4]

Although the air-gun pellet could be removed rather easily in this case, use of ultrasound and other intraoperative imaging modalities could be of great help in localization of the pellet in similar cases.

There is no evidence-based recommendation concerning antibiotics in such cases, but its administration seems rational. Since the air-gun pellet was lodged in the cerebellum, no antiepileptics were administered.

This case again shows the potential of air-guns for causing serious injuries. This and previous reports show that air-gun pellets can penetrate the brain far enough to injure any intracranial elements in their trajectory.[1, 3, 4]

Actions are needed to make airguns safer and reduce their availability to children and teenagers.

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