Letters to the Editor

Medicine Revisited: Safeguard Yourself against "Oblivious to the Obvious"

Sir,
We are writing to you to describe the case of a young male who presented with innocuous clinical features while subsequent investigations directed us to an unexpected diagnosis. A young male was diagnosed locally as abdominal tuberculosis and empirically started on antitubercular therapy. He was referred to us with acute onset right-sided abducens nerve palsy and right-sided lower motor neuron LMN type of facial nerve palsy. Magnetic resonance imaging (MRI) of the brain with contrast showed pachymeningeal thickening and enhancement [Figure 1]. Cerebrospinal fluid (CSF) analysis revealed elevated CSF proteins (123 mg/dL). Investigations for infective etiology, granulomatous disorder, and autoimmune disease yielded no results. We postulated idiopathic hypertrophic pachymeningitis (HPM) as a causative which could explain the neurological presentation. Subsequently, the patient developed anisocoria with delirium. General and neurological deterioration due to multiorgan dysfunction continued despite optimal antibiotics and supportive treatment. Repeat neuroimaging showed no fresh changes. Subtle clues such as persistent anemia and thrombocytopenia despite blood product transfusion, no response to steroids or antitubercular therapy, and steady clinical worsening prompted a diagnostic bone marrow study. It suggested acute leukemic changes for which prompt treatment was instituted. Our patient was a case of acute leukemia with HPM notoriously disguised as abdominal tuberculosis with systemic dissemination.

Leukemic involvement of the central nervous system is well known. Dural involvement has been reported in solid tumors, lymphoma, and leukemia. Differentiation between the two forms of HPM-idiopathic and secondary is difficult. Contrast-enhanced MRI showing “Eiffel-by-night sign” is noted in up to 60% of idiopathic HPM patients and 12% with secondary HPM. Pathologically diffusely thickened fibrosed dura with inflammatory cell infiltration, more marked at the periphery, imparts a hyperintense signal on T1 sequences. This new sign if found points toward idiopathic HPM. Clear indications for meningeal biopsy, which is the gold standard investigation, are lacking. We deferred meningeal biopsy due to progressive thrombocytopenia despite platelet cover. While steroids remain the

Figure 1: Coronal section of contrast-enhanced magnetic resonance imaging of brain showing pachymeningeal enhancement. The enhancement uniform without a hypointense streak between adjacent folds of falx cerebri, indicative of secondary hypertrophic cranial pachymeningitis

mainstay of treatment for HPM, alternatives include azathioprine, cyclophosphamide, methotrexate, and cyclosporine, alone or in combination with steroids. Withdrawal of steroids may trigger the recurrence of neurodeficits, hence should be monitored closely. In cases similar to ours, specific treatment such as focal radiotherapy must be tried. Systemic chemotherapy is of limited value as it may not be able to reach the dural space.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Sachin A Adukia, Gopal Krishna Dash
Department of Neurology, Narayana Hrudayalaya, Bengaluru, Karnataka, India

Address for correspondence: Dr. Gopal Krishna Dash, Department of Neurosciences, Mazumdar Shaw Hospital, Narayana Hrudayalaya, Plot - 258/A Bommasandra Industrial Area, Hosur Road, Annakul Taluk, Bengaluru - 560 099, Karnataka, India. E-mail: dashdrgk@gmail.com

REFERENCES

Sir,

Oligodendrogliomas are tumors of glial cells, and they represent approximately 4%–5% of all primary brain tumors. The majority of oligodendrogliomas are supratentorial (>90%) and infrequently encountered in the posterior fossa. Infratentorial cystic oligodendrogliomas are very uncommon, and most of them belong to pediatric age group. We report a cerebellar cystic oligodendroglioma in a young adult.

A 36-year-old male presented with a history of headache and vertigo of 1-month duration. Neurological examination showed impaired tandem gait with no other neurological deficits. Noncontrast and contrast computed tomography of the head revealed a large, well-defined, hypodense vermian lesion, with areas of patchy contrast enhancement. No evidence of calcification noted. Magnetic resonance imaging (MRI) showed a large inhomogeneous solid cystic lesion. The large cystic component is hypointense on T1-weighted images and hyperintense on T2-weighted images whereas small solid component is isointense on T1-weighted images and hypointense on T2-weighted images. On contrast study, only solid component showed heterogeneous enhancement with evidence of blooming on susceptibility-weighted images.

A radiological impression of hemangioblastoma and the possibility of pilocytic astrocytoma was kept in mind, and the patient was prepared for surgery.

A midline suboccipital craniectomy with complete excision of the lesion was performed, and postoperative recovery was uneventful. Histopathological examination (HPE) of the specimen showed a...