

Solitary Neurocysticercosis Cyst (SNCC)

Anil Sharma MCh

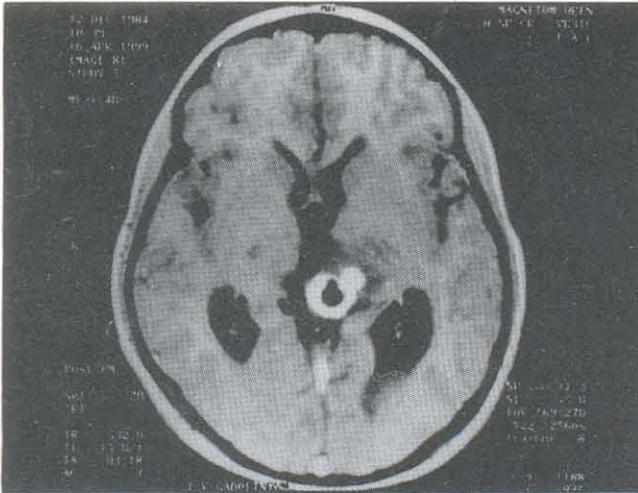


Exhibit A (Coronal)

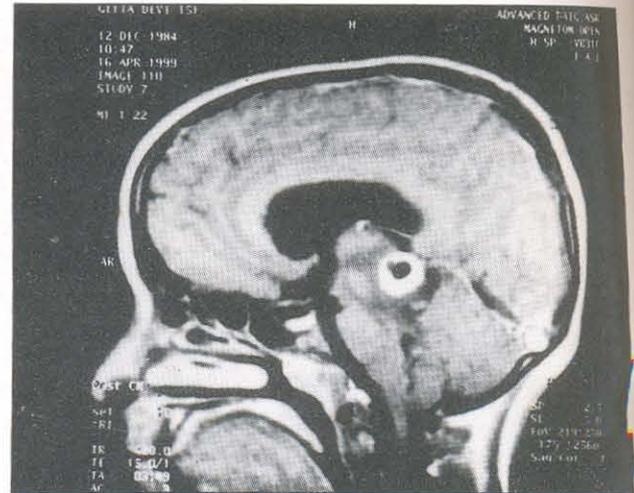


Exhibit B (Axial)

MRI films showing SNCC in T₁ weighted images as a lesion in the dorsal midbrain and causing aqueductal obstruction leading to hydrocephalus. Presented above is MRI of a young girl who presented with features of raised ICP in the form of headache, vomiting, double vision and diplopia of one month duration. Examination did not reveal any neurocutaneous markers or any swelling in any part of body. She underwent C.S.F. diversion (V. P. Shunt) and during followup was put on albendazole therapy.

MRI is more sensitive than CT scan in the detection of active neurocysticercosis cysts. Viable parenchymal cysts appear as vesicular structures with a fluid content having signal properties similar to CSF on both T₁ and T₂ weighted images. The scolex produces a high intensity signal inside the cyst on T₁ weighted images, a sign pathognomic of NCC. In later stages, as inflammation, odema, gliosis develop around the cyst, a perilesional high intensity signal appears on proton density/T₂ weighted image. As the cyst begins to degenerate, the fluid produces high signal intensity on T₁ weighted images, cyst becomes irregular in shape, the scolex is not visualised and the perilesional high intensity signal diminishes. The intraventricular cyst is also better detected by MRI than CT scan. The cyst appears as a 10-20 mm. spherical lesion isointense with C.S.F. on T₁ and T₂ weighted sequences.