Case	(406) Racemose neurocysticercosis: a case report
Authors	L. Ortega Molina, G. Rodríguez Henao, N. Alonso Ordás, A. De Blas Mendive, S. Mauleón Rubio, A. Ovelar Ferrero.
Centre	Complejo Hospitalario De Navarra.

CASE PRESENTATION

A 39 years old woman from Ecuador, was admitted for second time at the emergency room complaining of headache and dysesthesias since one month before. At the time of exploration she had psychomotor agitation (started the last night), as well as signs of meningeal irritation.

The brain CT showed: multiple calcified parenchymal and subarachnoid nodules, and cystic lesions in the Silvian fissure and basal cisterns without edema, suggestive of calcified nodular and vesicular stages of neurocysticercosis, the last one in racemose type. MRI performed later confirmed the clinical suspicion without any other relevant finding.

The patient stayed at IUC for ten days. Mechanical ventilation was needed due to difficult control of her agitation. Treatment with corticoids and antiparasitic was performed with satisfactory evolution. CT performed 4 months later showed slight improvement.

DISCUSSION

Neurocysticercosis is the leading cause of parasitosis in the central nervous system and acquired epilepsy in developing countries (2). It is caused by the encysted larvae of the tapeworm taenia solium, acquired through fecal-oral contamination. It can affect any organ, but the most common sites of involvement are the central nervous system, eyes and muscle.

According to the location has been classified in to: subarachnoid-cisternal, parenchymal, intraventricular and spinal types. According to radiological findings, is divided into five stages: noncystic, vesicular, coloidal-vesicular, granular-nodular and calcified-nodular.

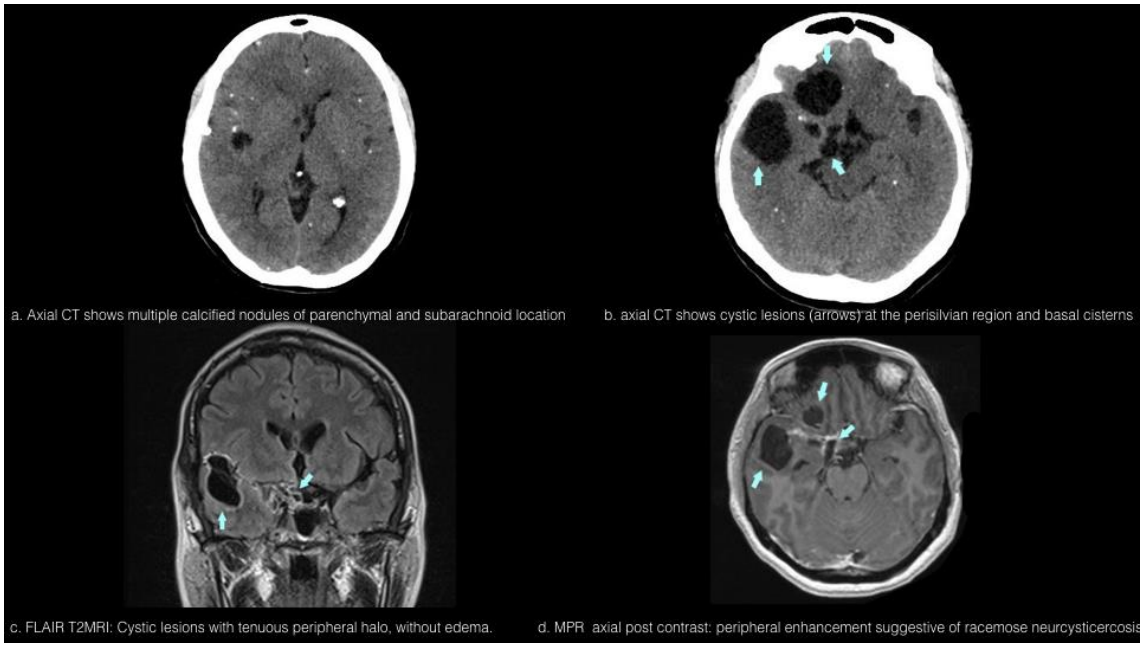
The clinical manifestations and radiological findings depend on load, type, size, location, stage of development of cysticerci, and the host's inmune response against the parasite.

The racemose variety is formed by a cluster of cysts and is typically seen around the rostral brainstem and in the Sylvian fissure, and usually lacks a scolex (1). It can occlude the circulation of cerebrospinal fluid and cause hydrocephalus. In addition, the death of the parasite triggers a strong inflammatory reaction, which gives rise to ependymitis and arachnoiditis, which in turn, can trigger other complications such as arteritis and cerebral infarcts, meningitis and ventricular obstruction.

Usually racemose neurocysticercosis is of poor prognosis and when complications are associated, mortality increase above 50% after two years (2).

CONCLUSION

Nowadays, neurocysticercosis is being diagnosed more frequently in developed countries due to inmigration and travels. Therefore, radiologist should knowradiological findings of the disease because clinical manifestations are usually nonspecific, so that's why imaging plays an important diagnostic role, especially in racemose neurocysticercosis.



BIBLIOGRAPHY

- Kimura ET, Higuera JA, Corona R, Chavez L, Perochena A, Quirós LY et al. Neurocysticercosis: Radiologic-Pathologic Correlation. Radiographics 2010; 30:17051719.

- Zapata CH, Vargas SA, Uribe CS. Neurocisticercosis racemosa, diagnóstico orientado por neuroimágenes. Biomédica 2017; 37(supl1):26-32.