A 15-year-old boy presented with progressive weakness of the right lower limb for 2 months associated with bowel and bladder incontinence. Physical examination revealed weakness of the right lower limb (muscle power 3/5) with spasticity. The knee and ankle jerks were exaggerated bilaterally and the cremasteric reflexes were absent; the plantar response was extensor on the right side. All modalities of sensation were absent in the right lower limb below the inguinal ligament. The anal sphincter tone was also lost. There was no spinal tenderness or deformity.

We did a magnetic resonance imaging of the spine, which revealed a solitary well-defined intramedullary cystic lesion at the L1 level (Figure 1). A scolex was visible inside the cystic lesion suggestive of neurocysticercosis—colloidal stage. There was no other lesion in the spinal cord, brain or eye. A western blot of the serum was positive for cysticercus antibodies. While in the hospital, the weakness progressed to involve the left lower limb. We treated him with dexamethasone 12 mg/day followed by albendazole 400 mg b.i.d. for 28 days. At the end of 1 month, the patient had regained 4+5 power in both lower limbs and control of bladder and bowel functions.

Infections like tuberculosis, cysticercosis, schistosomiasis and toxoplasmosis are among the rare causes of intramedullary cord compression. Isolated intramedullary spinal neurocysticercosis is very rare with less than 50 cases reported so far in the literature. Usually a surgical excision is performed. However, recent anecdotal reports suggest that medical management alone may be effective in selected cases.

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Figure 1. Magnetic resonance images of the spine showing a cystic lesion appearing hypo-intense on T1-weighted (A) and hyperintense on T2-weighted images with surrounding oedema (B) and enhancing with gadolinium (C).
References
