Multiple giant cavernous angiomas of the brain

Sir,
Cavernous angioma (CA) of central nervous system (CNS) is an uncommon disease and presents with seizures, hemorrhagic episodes, and rarely with focal deficits.[1] Multiple CAs are often familial. Giant CAs (GCAs) are extremely rare and multiple GCAs are still rarer. Sometimes, these lesions can be fatal from massive hemorrhage. Most GCAs present as multicystic lesions with hemosiderin ring around on MRI giving a ‘bubbles of blood’ appearance.[2] Radiofrequency thermocoagulation-assisted surgery[3] and neuronavigation[4] have been advocated by some to treat such lesions with minimal blood loss and precision, respectively. We report a case with multiple CAs with two of the lesions assuming a giant size (more than 4 cm in diameter).

A 46-year-old male, was operated for a left cerebellar CA in 1984, a ventriculoperitoneal shunt followed by total excision of the lesion was done. Postoperatively he had improved completely. Follow-up brain computerized tomography (CT) in 1991 showed a left parietal CA. As he was asymptomatic, surgery was not advised. Subsequently, the patient was lost to follow up. In the present admission he was admitted for severe headache, vomiting and ataxia. Magnetic resonance imaging (MRI) of brain revealed a giant cavernoma measuring 5.3 cm in diameter in the left parietal lobe [Figure 1] and another slightly smaller recurrent lesion in the left cerebellar hemisphere measuring 4.2 cm in diameter [Figure 2]. There were in addition multiple small lesions in both the cerebral hemispheres with evidence of minor hemorrhages [Figure 3]. There was no history of similar illness in the family. Through a combined approach (posterior fossa and supratentorial parieto-occipital craniotomy), both these lesions were excised completely by standard microsurgical techniques. The patient had an uneventful postoperative recovery. A follow-up CT scan revealed complete excision of the two giant CAs. The diagnosis of CA was confirmed by histopathological examination. At the time of discharge, he had minimal ataxia.

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References


Figure 1: Axial T-2 weighted image showing a left cerebellar lesion

Figure 2: Axial T-1 weighted image showing a left parietal lobe cavernous angioma with ‘bubble of blood’ appearance

Figure 3: Gradient sequence image showing multiple lesions in both the cerebral hemispheres with evidence of hemorrhage inside
Sir,

An eight-year-old boy presented with post-traumatic right-sided periorbital ecchymosis and swelling of the eyelid with palpebral fissure closure. A few days later he was unable to fully open the eye and was complained of diplopia. On examination, he had normal visual acuity and fields. The right eye was mildly proptosed and depressed, with periorbital ecchymosis and swelling [Figure 1a]. There was no subconjunctival or scleral hemorrhage. Fundoscopic examination was normal. Extraocular movements were normal in the left eye. He was able to move the right eye in all directions except superiorly. Forced duction test of the right eye was negative.

A CT scan of the brain and orbits showed a hematoma in the superior rectus–levator complex [Figure 1b-d]. No fracture was seen. The patient was treated conservatively and eye movements gradually improved.

Isolated hemorrhage into an ocular muscle following trauma is very uncommon. Only one case of isolated post-traumatic superior rectus hematoma has been reported in the English literature to date.[1] More frequent are reports of inferior rectus hematoma. The commonest cause of a post-traumatic diplopia is mechanical entrapment of soft tissues due to a blow out of the orbital floor. Hemorrhage and edema in the orbital fat causing septae to become taut, can also restrict ocular movement. In both of these conditions, forced duction test is positive. However, in injury to the ocular muscles, the forced duction test is negative.[2] Isolated hemorrhage into ocular muscles does not have any other characteristic clinical feature to distinguish them from other causes of post-traumatic diplopia. Evidence of a bleed may be seen, if the hematoma extends along the muscle sheath to its insertion on the globe.[3]

The paucity of clinical findings to distinguish this rare phenomenon from the more

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References
