phaeohyphomycosis and duration of antifungal treatment must be individualized using radiological evidence of resolution. Infection due to phaeohyphomycosis must be considered in fungal granulomatous inflammations.

G. Samson Sujit Kumar, Manish Dugar*, Geeta Chacko
Departments of Neurological Sciences and *Medicine I, Christian Medical College and Hospital, Vellore, Tamilnadu, India. E-mail: geetachacko@cmcvellore.ac.in

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Air guns, although considered to be toys, can cause injuries ranging from trivial to grievous. The potential of airguns for causing injury is underestimated. Recent concerns have been raised about the safety of them as toys.

A rare case involving a young boy, who was accidentally hit by an air gun pellet during play, is described. Although there are many previous reports of intracranial air-gun pellet injuries, transorbital cerebellar injury due to air-gun pellets has not been reported previously in Medline.

We present a 15-year-old boy was hit accidentally by an air gun pellet during play. There was a small entrance wound in the lower right orbital fold and he and his family were primarily concerned about his eyes on admission. Neurological examination including visual acuity and eye movements were intact. The X-ray and CT scan showed the presence of an air-gun pellet to the posterior fossa [Figure 1a, b, c]. Other CT scan images showed that the air gun pellet travelled through the orbit without penetrating the globe. It passed into the middle cranial fossa and lodged in the posterior fossa.

Considering the trajectory of the pellet, the patient underwent cerebral angiography which was normal.

A suboccipital craniectomy in the prone position was performed and the air-gun pellet was removed as confirmed by a CT scan (Figure 1d). During the operation, we used only anteroposterior and lateral X-rays for localization of the pellet. Cefazolin and then oral cephalexin were administered to the patient for two weeks. No antiepileptics were administered to the patient. The patient had an uneventful postoperative course.

Air gun pellets are low velocity missiles that cannot pass easily through the adult skull bone. The possible points of entrance into the skull are through the eye, temporal and frontal bones and

Figure 3: T2 weighted image in sagittal plane (a) and axial plane (b) showing occipital encephalocele with bony defect and scalp mass isointense with the cortical grey matter and multiple flow voids.

syndrome. The cerebellum within those cephaloceles is usually dysplastic and gliotic.[5]

Plexiform NF, hallmark of NF-I are found in 30-40% of all patients with NF-I. They usually arise along the axis of a major nerve, are unencapsulated and infiltrate producing fusiform appearance. They commonly occur along orbital division of V nerve, but other areas are not exempt often associated with sphenoidal dysplasias, they are hypervascular and enhance intensely on post contrast MR.

Our patient had an occipital encephalocele with dysplastic cerebellum. However, the presence of additional parietal bony defects a finding well described in NF-I and the associated plexiform neurofibroma of the adjacent scalp suggests that the bony defect in our case could be due to the mesodermal dysplasia of NF-I.

The peculiarity of this case of NF-I lies not in the presence of plexiform NF, bony dysplasia or cephalocele, findings well documented in literature, but in their unusual occipital location a site hitherto reported till now only in one case so far to the best of our knowledge.

N. K. Bodhey, A. K. Gupta
Departments of Imaging Sciences and Interventional Radiology, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, Kerala, India.
E-mail: narendrakb2001@yahoo.co.in

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