Figure. (A) Axial T1-weighted MRI of the brain showing a low attenuation lesion involving the left uncus, with patchy enhancement after IV gadolinium administration. (B) Axial fluid-attenuated inversion recovery MRI showing extensive hyperintensity with mild mass effect involving the left temporal lobe, basal ganglia, internal capsule, and thalamus.

Tumefactive neuro-Behçet disease

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A man aged 23 years, with a previous clinical diagnosis of Behçet disease (recurrent genital and oral ulceration and papulopustular rash), sought treatment for a 3-week history of headache, fever, and progressive right-sided weakness. Clinical examination revealed a right homonymous hemianopia and mild right spastic hemiparesis. MRI of the brain showed a mass lesion involving the left temporal lobe with signal change extending into the left cere-

bral peduncle, thalamus, internal capsule, basal ganglia, and corona radiata posteriorly (figure, A and B). Stereotactic-guided biopsy of the left temporal lesion was performed, and histologic examination revealed a perivascular inflammatory infiltrate but no neoplasia. There was a clinical and radiologic response to treatment with prednisolone and azathioprine.

The most common lesions in CNS neuro-Behçet disease are multiple small T2 hyperintensities, predominantly at the mesencephalodiencephalic junction, but such lesions were not seen in this case.¹ Large masslike lesions on CT or MRI are extremely rare, and stereotactic biopsy should be considered in this situation.²

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