Figure. All panels are with gadolinium enhancement. (A) Parasagittal T1-weighted MRI of the brain showing a bacterial abscess in the dorsal pons. (B) Axial T1-weighted images of the same abscess. (C, D) As per (A) and (B) but after stereotactic needle aspiration.

Solitary brainstem abscess

Gary Sclar, MD; Peter Boardman, MD; and Charles J. Prestigiacomo, MD, Brooklyn, NY (G.S.), and Newark, NJ (P.B., C.J.P.)

A 39-year-old man presented with a 2-day history of progressive right body numbness, left lateral rectus palsy, and ataxia. Brain MRI revealed a possible abscess (1 cm $\times$ 1.1 cm) in the left pons. Broad-spectrum antibiotics were started but after 4 days the patient became lethargic, with ptosis and hydrocephalus. The lesion had grown to 2.4 $\times$ 3.4 cm (figure, A and B). A stereotactic needle biopsy was performed and 3 mL of pus aspirated. Cultures

revealed *Streptococcus intermedius*, a Gram-positive anaerobic bacteria. The patient received a 6-week course of ceftriaxone and metronidazole. Residual symptoms and signs included severe right facial and moderate right body numbness; rapid end point horizontal nystagmus, most prominent on leftward gaze; a component of rotary nystagmus on upgaze; and jerky, dysmetric visual pursuits in the horizontal (but not vertical) plane. The patient's gait had a strong stepage quality but only on the right side; he was unable to attempt tandem walking.

Solitary brainstem abscesses account for only 0.5% of intracranial abscesses overall, the pons being the most common site. Few are successfully treated and a minority of these by stereotactic aspiration.¹ Because of the small spaces involved, neurologic damage may progress rapidly. Aspiration seems to have been the turning point in this case.

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