against the need to treat a potentially disabling or life-threatening disease such as MG.

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NeuroImages

Figure. (A) T_2 -weighted sagittal image showing a rim of hypointensity around the vermis and the brain stem. (B) T_2 -weighted axial image revealing hemosiderin coating the cerebellum and the left 8th cranial nerve (arrow). (C) T_1 -weighted sagittal image with gadolinium showing an intramedullary tumor. (D) Gradient echo scan showing hemosiderin coating of the spinal cord at lower thoracic level.

Superficial CNS siderosis and spinal pilocytic astrocytoma

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A 61-year-old woman presented with a 10-year history of unsteady gait and recurrent falls. She also complained of progressive hearing loss, which had started at the age of 42 years. Neurologic examination showed mild scanning dysarthria, bilateral dysmetria, gait ataxia, hyperactive tendon reflexes with a Babinski sign on the right side, and an equivocal response on the left.

Routine hematologic and biochemical blood tests, as well as specific investigations for the exclusion of infectious, endocrine, or metabolic disorders, were within normal limits. Audiometry revealed a bilateral sensorineural

type of deafness. MRI T_2 -weighted images revealed a rim of hypointensity around the brain stem, cerebellum, the eighth cranial nerve bilaterally, and in the sylvian fissures. This finding was consistent with superficial siderosis. An MRI of the spine showed a space occupying intramedullary lesion extending from T_{12} to L_4 spinal segment, which histopathologically proved to be a pilocytic astrocytoma.

Superficial siderosis of the CNS is a rare condition. In most reported cases it was the consequence of chronic subarachnoid hemorrhage due to vascular malformations or different types of tumors.¹

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