IVth ventricular neurocysticercal cyst
A rare cause of acute hydrocephalus

An 11-year-old boy presented with acute-onset projectile vomiting, bifrontal headache, and altered sensorium. Contrast-enhanced MRI brain was suggestive of intraparenchymal and intraventricular neurocysticcosis, with an intraparenchymal ring-enhancing lesion with central scolex in the left cingulate gyrus and a large cyst enlarging the IVth ventricle, with obstructive hydrocephalus (figure). In contrast to intraparenchymal cysts, intraventricular cysts are large and typically lack an identifiable scolex. Confirmation of cysticerci is based upon identification of scolex in the intraparenchymal lesion or use of high-resolution T2 MRI sequences, which are superior in identifying scolex in intraventricular cysts.

Figure

MRI brain with IVth ventricular and left parietal neurocysticerci

Axial T1 (A) and axial T2 (B) MRI show a small cystic lesion with eccentric scolex (arrow) without perilesional edema in the left cingulate gyrus. Supratentorial ventricle is dilated without any periventricular ooz. Axial fluid-attenuated inversion recovery (C), axial T2 (D), and postcontrast sagittal T1 (E) MRI show ballooned IVth ventricle with intraventricular cystic lesion (arrows), which is better appreciated on thin-cut high-resolution T2 image (D) (arrows), however, scolex was not identifiable in the intraventricular cyst. Axial T2 (F) MRI shows a normal outlet foramina of the IVth ventricle.

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