Transient Splenial Lesion of the Corpus Callosum in Clinically Mild Influenza-Associated Encephalitis/Encephalopathy

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BACKGROUND: Reversible lesions in the splenium of the corpus callosum (SCC), caused by various agents such as influenza, rotavirus, Escherichia coli, mumps, and adenovirus, were previously defined in a handful of cases. We present 5 cases with transient diffusion restriction of the SCC associated with influenza A virus infection.

MATERIALS AND METHODS: Five patients with influenza-associated encephalitis/encephalopathy and sudden-onset neurologic symptoms following a prodromal flulike episode were examined by MR and diffusion-weighted imaging (DWI).

RESULTS: Three patients, who had drowsiness and new-onset convulsions, recovered spontaneously without any medication. In the other 2 seizure-free patients, 1 had trigeminal neuralgia and headache and the other had facial numbness and left upper monoparesis. All patients had round well-defined ovoid hyperintense splenial lesions (14.94 ± 1.87 mm) on DWI with a significantly low apparent diffusion coefficient (ADC) of 0.41 ± 0.05 × 10⁻³ mm²/s compared with 0.84 ± 0.01 × 10⁻³ mm²/s of normal-appearing white matter. In the patient with a motor deficit, additional lesions were found in the cerebral deep white matter. The high signal intensity of the splenial and deep white matter lesions on DWI completely disappeared on follow-up studies, and ADC values also improved, returning to those of normal-appearing white matter on days 8–11. Clinically, all patients completely recovered on days 4–9.

CONCLUSION: A transient lesion of the SCC is a significant but nonspecific finding. It is probably due to edematous and/or inflammatory changes of the SCC. It may be the only detectable change in patients with good prognosis, indicating a clinically mild form of encephalitis/encephalopathy.

Influenza A is the most common upper respiratory tract infectious agent causing flulike symptoms. It is especially widespread in winter seasons and can cause epidemics. Besides Reye syndrome and hemorrhagic shock and encephalopathy syndromes, it can occasionally cause rapid progressive encephalopathy with high fever, alteration of cognition, and convulsion, which is called influenza-associated encephalitis/encephalopathy (IAEE), including acute necrotizing encephalopathy. IAEE is more common and has a poorer prognosis in children than in adults. In clinically mild IAEEs, neurologic symptoms can recover quickly, usually without any specific medication.

The previously described brain lesions in patients with IAEE include restricted diffusion involving the cerebral cortex and subcortical white matter in various localizations; symmetric lesions in the brain stem, basal ganglia, thalamus, and cerebellar white matter with or without brain edema; and mild brain atrophy. Transient restricted diffusion of the splenium of the corpus callosum (SCC) in patients with IAEE was also well defined in previous articles. However, it is not specific to IAEE and has been reported secondary to various infectious agents, including rotavirus, measles, herpesvirus 6, Salmonella organisms, mumps, varicella-zoster virus, adenovirus, O157 Escherichia coli-associated hemolytic-uremic syndrome, Legionnaires’ disease, and unknown pathogens. Neither the exact pathophysiology nor the specific site predilection of transient SCC lesions was clear.

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inversion recovery (FLAIR; TR/TE/TI, 8000/100/2000 ms; 1 excita-
tion) images were obtained by using 5-mm section thickness with
1-mm intersection gap and a 256 × 256 matrix size. After intravenous
administration of 0.2 mg/kg of gadodiamide (Omniscan), contrast-
enhanced T1-weighted SE sequences were also obtained in 3 orthog-
onal planes.

DWI was performed by using an axial multisection single-shot
echo-planar SE sequence (TE, 91 ms; shortest TR ranging from 4200
to 4300 ms; 1 excitation; 1833.3 Hz/pixel bandwidth; echo-planar
factor, 89; 22 sections with 5-mm section thickness without intersec-
tion gap; matrix size, 112 × 256; field of view, 220 × 220 mm in 29.5
seconds). The apparent diffusion coefficient (ADC) maps were calcu-
lated on a pixel-by-pixel basis. Standard mean ADC values of each
region of interest from lesions and normal-appearing white matter
were calculated automatically and expressed in 10⁻³ mm²/s.

Results
All patients were previously healthy and had no history of
seizure, usage of antiepileptic drugs, or any type of vaccination
during the last 2 years. Neurologic symptoms became promi-
ient on days 2–5 after the initiation of a prodromal flu episode
and high fever (40.3–41.8°C). The new-onset convulsions (on
days 2–4) occurred in 3 patients before being admitted to the
hospital and resolved spontaneously without any medication.
These 3 patients also had drowsiness and some abnormality on
electroencephalography. In the other 2 seizure-free patients, 1
had trigeminal neuralgia and headache (on day 2) and the other
had facial numbness and left upper monoparesis (on day
5). Rapid-onset neurologic symptoms following a prodromal
flu episode were typical for IAEE. In all patients, influenza A
virus was isolated from their throat swabs, allowing the diag-
nosis of IAEE. The influenza genome was not detected in any
of their CSF by polymerase chain reaction. Clinically, all pa-
tients were completely recovered on days 4–9. The results of
blood count, routine biochemistry, and CSF analysis of all
patients were in normal limits during illness.

Initial MR imaging examination of each patient was per-
formed on the day that his or her neurologic symptoms devel-
oped (on days 2–5). All patients had significant transient le-
isons in the SCC on their initial MR images (Figs 1A, -C, -E
and 2A–C). Lesions were well defined, ovoid, and centrally
located in the SCC. The mean diameter of splenial lesions was
14.94 ± 1.87 mm. They were slightly hyperintense on FLAIR
and T2-weighted images (Figs 1A, -B and 2A) but not detect-
able on T1-weighted images. No lesions were enhanced on
postcontrast images. All lesions were prominently more
hyperintense on isotropic DWI than on T2-weighted and FLAIR
images (Figs 1C, -D and 2B). They had significantly lower
signal intensity and ADC values (0.41 ± 0.05 × 10⁻³ mm²/s)
than those of normal-appearing white matter (0.84 ± 0.01 ×
10⁻³ mm²/s) (Figs 1E, -F and 2C) on ADC map images. In 1
patient who had mild motor deficits, there were additional
lesions in the cerebral deep white matter (Fig 1B, -D, -F). No
other signal intensity or diffusion change was detected in the
other patients.

Follow-up examinations were performed on days 8–11.
The high signal intensity of all lesions on DWI disappeared
(Figs 1G, -H and 2D), and their ADC values (0.81 ± 0.04 × 
10⁻³ mm²/s) were recovered to normal-appearing white mat-
ter (0.84 ± 0.01 × 10⁻³ mm²/s).

Discussion
IAEE is a complex clinical syndrome, including both enceph-
alis and encephalopathy.¹,⁶ When there is no evidence of
inflammatory change, the term “encephalopathy” is used in-
stead.¹⁴ There is probably a continuum and/or an overlap be-
The pathogenesis of IAEE is not clear because of a lack of pathologic correlation in mild forms of the disease. The autopsy findings are mainly from the results of necrotizing encephalopathy (ie, the clinically worst form of IAEE). Autopsy results show that the integrity of the blood-brain barrier (BBB) seems to be an important prognostic factor, and the disruption of the BBB promotes neuronal degeneration with severe clinical findings. A toxin-mediated aberrant immune activation causing endothelial injury, microvascular angioathy and perivascular edema, or inflammatory cytokine release from virus-stimulated glial cells causing rapid breakdown of the BBB can be responsible for the neurotoxic effect. However, direct viral invasion of neurons can also occur, because a positive influenza antigen has been reported in brain tissue. The clinical severity of IAEE can be moderated by the degree of immune competence of the host, virulence of the agent, route of entry, and coexistence of other predisposing factors such as age, previous vaccination, hypoglycemia, electrolyte imbalance, vitamin deficiency, or seizures.

In the mild form of IAEE, the reversal of restricted diffusion and lack of any significant enhancement without fulminating brain edema suggest a limited direct invasion of neurons, which is not sufficient to cause an immunologic response with resultant rapid breakdown of the BBB. The cytotoxic edema seen in acute cellular energy failure, such as acute arterial infarction, can possibly be the cause of decreased ADC values, because cytotoxic edema is hardly ever reversible. Intramyelinic edema due to separation of myelin layers seems to be the main contributor of these transient changes. Osber et al suggested that reversible restricted diffusion in the SCC is due to transient disruption of energy metabolism and ionic transport, causing reversible myelin vacuolization or intramyelinic edema. Furthermore, autopsy studies of patients with serious neurologic complications have shown that the acute reactive changes, such as congestion and hyperemia without inflammatory infiltration, are more frequent than demyelination and neuronal degeneration.

Fig 2. Patient 4 (6 years old) with IAEE and fever and sudden-onset convulsion on day 3. A, Single ovoid well-defined splenial lesion (arrowheads) is slightly hyperintense on the T2-weighted axial image. B, The lesion (arrowheads) has prominently high signal intensity on isotropic DWI. C, ADC value of 0.34 ± 10−3 mm²/s obtained from the region of interest located in the lesion reveals restricted diffusion on ADC map image. D, Follow-up study on day 9 shows complete resolution of diffusion restriction on isotropic DWI.

As stated by Tada et al, another possible mechanism of transient ADC reduction of SCC is the influx of inflammatory cells and macromolecules, combined with related cytotoxic edema, similar to the changes occurring in multiple sclerosis plaques. The transient nature of the lesions suggests that the effect of virus on brain, either inflammatory or edematous, is reversible and may be the only detectable change in patients with good prognosis, a sign of clinically mild encephalitis/encephalopathy.

Differential diagnosis of lesions involving the SCC includes ischemia, infections, posterior reversible encephalopathy syndrome, diffuse axonal injury, multiple sclerosis, hydrocephalus, Marchiafava-Bignami disease, adrenoleukodystrophy, AIDS dementia complex, lymphoma, epilepsy, and antiepileptic drug usage. The transient feature of the lesion and other clinical and laboratory findings allow one to differentiate the infectious causes from others, but it is not easy to presume the exact infective agent by clinical and radiologic findings. In latter situation, various infectious agents including influenza, rotavirus, measles, herpesvirus, Salmonella organisms, mumps, varicella-zoster virus, adenovirus, E coli, and Legionnaires’ disease should be considered in the differential diagnosis.

Another challenging issue is the increased vulnerability of the SCC. Anatomic studies dealing with the corpus callosum demonstrate neither different fiber attenuation nor principally fiber composition in the SCC, compared with other regions of the corpus callosum. Although the SCC has an arterial supply from the vertebrobasilar system, contrary to other parts of the corpus callosum supplied by the carotid system, the absence of any signal-intensity change in the
The special affinity of the receptors on splenial axons or surrounding myelin sheaths to viral antigens or receptors on the antibodies induced by the antigens, expressed by elevated cytokines, can be the cause of this vulnerability, but this theory of Tada et al.14 has lack of pathologic correlation. The exact reason for increased predilection of the SCC is still unclear and needs further animal and human research, but it probably remains in debate because of lack of pathologic confirmation of such transient lesions in humans.

The major drawbacks of this study are the lack of histopathologic correlation and low sampling numbers. Rapid resolution of clinical and radiologic findings prevents the biopsy requirement. The rare occurrence of IAE is the natural cause of the low sampling number.

Conclusion

Although transient ADC reduction of SCC is not pathognomonic for IAEE, it is usually seen in patients with good prognosis, indicating a clinically mild form of encephalitis/encephalopathy. It is more likely due to intramyelinic edema or an inflammatory infiltrate of the SCC rather than a breakdown of the BBB or demyelination. Lack of pathologic correlation in such transient lesions does not allow us to identify the exact nature and pathogenesis of these lesions. Increasing numbers of such cases in the literature allow us to achieve a more reliable conclusion.

References