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Cysticercotic Cyst of the Septum Pellucidum

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Cysts of the septum pellucidum, especially those producing symptomatic hydrocephalus, are rare. To our knowledge, this is the first report of a cysticercotic cyst of the septum pellucidum. The computed tomographic (CT) and other related radiologic findings of this entity are discussed.

Case Report

A 26-year-old Mexican-American woman was admitted for evaluation of occipital and frontal throbbing headaches. Her symptoms had increased in severity for 5 months and were exacerbated by bending over, and improved by assuming a supine position. CT scanning demonstrated a nonenhancing, rounded, homogeneous mass of cerebral spinal fluid density in the region of the septum pellucidum and anterior third ventricle (fig. 1A). Cerebral arteriography confirmed a lesion in the septum pellucidum.

Because of her deteriorating neurologic status, a decompressive drain was placed in the right lateral ventricle. Conray ventriculography with and without CT, was performed (fig. 1B). A mass, not communicating with the lateral ventricles, was demonstrated in front of the foramina of Monro in the region of the septum pellucidum.

A transcallosal frontal approach into the anterior horn of the left lateral ventricle revealed a bulging septum pellucidum which produced posterior displacement and compression of the interventricular foramina. Fine needle aspiration of the septum produced clear fluid without evidence of abnormal cells or organisms. A thin cystic cavity within the leaves of the septum pellucidum was partly removed and demonstrated several cysticercotic parasites. Marsupialization of the septum and remaining parts of the cyst into both anterior lateral ventricles resulted in clinical improvement.

Discussion

Clefts may occur within the septum pellucidum, commonly resulting in a normal cavum. This cavum usually appears radiographically as a small noncommunicating slit, and is an incidental and asymptomatic finding [1]. Occasionally, the slit may normally be prominent as demonstrated by CT. The main differential point between normal cavi and true cysts is obstructive hydrocephalus in the latter [2, 3].

Cysts producing symptoms due to increased pressure within the cavum itself are rare [2, 3]. Although Gubbay et al. [4] described symptoms due to dilatation of the cavum septi pellucidi, many authors including Shaw and Alvord [1]

suggest that normal cavi do not produce symptomatic obstruction. Headache, as demonstrated in our case, is the predominant clinical feature of cysts. Seizures and symptoms of increased intracranial pressure also occur frequently. Less common are gait disturbances, mental deterioration, and unilateral motor or sensory deficits [2].

The first two cases of pathologic cysts were reported by Dandy [5] in 1931. Since then, other cystic lesions have been described and have been well summarized [2, 3, 6–8]. To our knowledge, this case is the first report of a cysticercotic cyst of the septum pellucidum.

Oncospheres released from the eggs of the pork tapeworm *Taenia solium* may penetrate the gastric mucosa of man to disseminate to various tissues with a predilection for muscle, subcutaneous tissues, brain, and spinal cord. The clinical, pathologic, and CT findings of disseminated cerebral cysticercosis have been well described [9–15]. CT may show small areas of decreased attenuation that often enhance in the acute stage of parenchymal cysticercosis. Cerebral infarction, secondary to vascular occlusions produced by arachnoiditis and vasculitis, has been demonstrated [14]. The chronic stage of cysticercosis demonstrates multiple areas of nonenhancing calcification, some measuring 1–5 mm [16]. Homogeneous or ringlike contrast enhancement may be identified [14].

The differential diagnosis of a cyst of the septum pellucidum includes: ependymal and arachnoid cysts [3], subependymal astrocytomas [17, 18], other cystic gliomas [19], massive pituitary adenomas [20], cystic craniopharyngiomas [21], epidermoid and dermoid tumors [22], lipomas associated with agenesis of the corpus callosum [23], and rarely neuroepithelial (colloid or parafyseal) cysts [6].

The lack of material of fat density on CT tends to exclude lipomas and dermoids [22, 23]. A cystic glioma may show a CT pattern of enhancement identical to cysticercosis. This consists of a ring of enhancement with or without peripherally enhancing nodules [14, 19]. Ependymal and arachnoid cysts, unless complicated by infection, usually do not show enhancement. The lack of enhancement in our case and its location suggested exclusion of craniopharyngioma, epidermoid, and colloid cyst [21, 22, 24], but did not imply parasitic inactivity, especially because calcification was not

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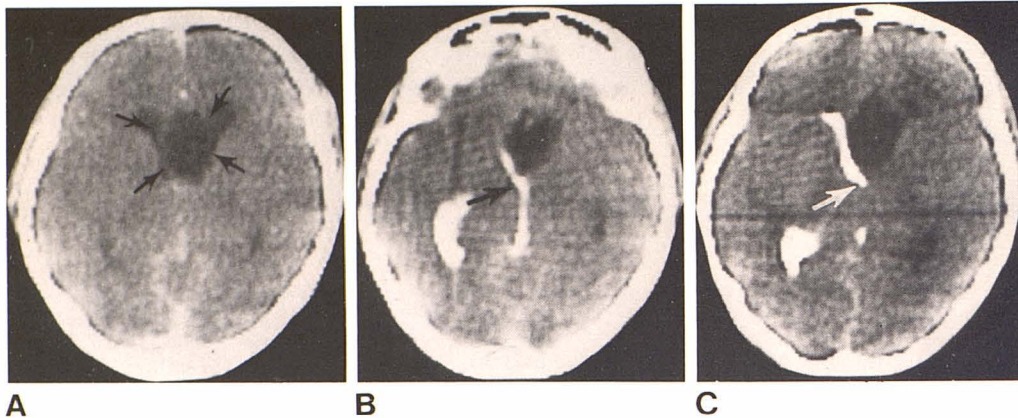


Fig. 1.—**A**, Contrast-enhanced CT scan. Oval cerebral spinal fluid density lesion (arrows) in region of septum pellucidum. Dilated anterior horns of lateral ventricles. **B** and **C**, Post-Conray ventriculogram CT scans. Filling of right lateral ventricle and third ventricle. Nonfilling left lateral ventricle is identified. Cyst of septum pellucidum anterior to right foramen of Monro (arrows).

observed. Pituitary adenomas usually show some evidence of sella turcica enlargement and more homogeneous enhancement than extraaxial cysticercotic cysts [14, 20]. Hydatid disease, not reported in this region, produces either a single, low density, intraaxial structure much larger than a cysticercotic cyst or small, clustered grapelike lesions (P. E. S. Palmer, personal communication) [25, 26]. However, the diagnosis of parasitic disease should be considered in an individual from an area in which cysticercosis is endemic whenever a homogeneous low density lesion is detected, particularly in or about ventricular or cisternal structures.

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