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MR in Cisternal Hydatid Cysts

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Summary: We describe a case of multiple hydatid cysts in the cerebral subarachnoid space. The diagnosis was based on clinical findings, latex test results, cerebrospinal fluid examination, and MR imaging findings.

Index terms: Subarachnoid space, cysts; Brain, magnetic resonance

Cerebral hydatid disease is rare, and it usually occurs in children. We report a case of multiple hydatid cysts in the cerebral cisterns.

Case Report

A 58-year-old man reported having headaches for several years that had worsened in the 3 months preceding examination. He had no history of recent trauma, vomiting, or seizures.

Magnetic resonance (MR) imaging revealed multiple small multiloculated lesions in the interhemispheric fissure, sylvian fissures, and suprasellar, ambiens, and quadrigeminal cisterns. The lesions had high signal intensity on T2-weighted images (Fig 1A) and low signal intensity on T1-weighted images, and were slightly hyperintense with respect to cerebrospinal fluid (CSF) on balanced images (Fig 1B). After contrast administration, the walls of the lesions enhanced mildly (Fig 1C).

CSF examination revealed hooks of scolices. Casoni and latex tests were positive for *Echinococcus granulosus*. At imaging, no cysts were found in the liver or lungs, and the patient had no communicating hydrocephalus.

Discussion

Intracranial granulosus echinococcosis is uncommon. Only about 2% of cases of hydatid disease involve the brain, even in endemic areas (1). The most common sites of involvement are the cerebral parenchyma (especially the parietal lobes) and the subarachnoid spaces after secondary involvement (2, 3).

Cysts are usually single and unilocular and may be large. Rarely, the cysts may be multilocular or multiple. Cysts in the subarachnoid space are commonly found in the spinal canal as a complication of ruptured cysts involving the spinal column; they are less likely to be the result of rupture and dissemination of intracranial cysts (4–6). In the cerebral cisterns, the most likely pathway of dissemination is hematogenous spread to the meninges and rupture into the subarachnoid space.

MR imaging findings of intracranial hydatid cysts have been described (7). The fluid of the hydatid cyst and the pericyst, which is a peripheral capsule of the cyst, are the two components that may be visible by imaging. A secondary process involving the cyst, such as calcification, infection, rupture of entodermic membrane, or perifocal edema, may also be identified.

MR imaging is believed to be more sensitive and reliable than computed tomography (CT) in depicting the pericyst layer, which appears as a halo, or in showing perilesional edema (2). CT is, however, more sensitive and accurate than MR imaging in detecting hydatid cyst calcifications (2, 8).

Our patient had multiple small cysts close together in the cerebral subarachnoid space. On contrast-enhanced T1-weighted MR images, we clearly identified the pericyst capsules. CT scans showed neither calcification in the cysts nor hydatid disease elsewhere in the body.

In formulating a differential diagnosis, the most difficult lesions to distinguish from hydatid cyst are arachnoid cyst and epidermoid tumor (9, 10). Epidermoids usually have slightly hyperintense signal intensity on proton density–weighted MR images and they usually engulf nerves and vessels, whereas arachnoid and hydatid cysts displace adjacent structures. Racemose cysticercosis in the subarachnoid space also should be considered in the differential diagnosis (11). These cysts may then become

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multiloculated, simulating a cluster of grapes (12, 13). The presence of hooks in the CSF examination and the positive latex and Casoni tests confirmed the diagnosis of hydatid disease in our patient.

References