014 – COMPRESSAO MEDULAR POR ABSCESSO PARAVERTEBRAL

Medullary compression by paravertebral abscess

Lima LAB, Camargo RC, Ferreira PM, Lana RP, Orsi VL, Gomez RS
Serviço Neurologia Clínica do Hospital Madre Teresa - Belo Horizonte,

Relato de Caso: A.A.F., 44 anos, internado com quadro de infecção urinária e escara infectada para tratamento. História prévia de mielite aos 20 anos de idade havendo como sequela paraplegia flácida em membros inferiores (mmii). Evoluiu com cervicalgia importante, rigidez de nuca, febre, taquicardia e perda da força motora do membro superior esquerdo de caráter progressivo, evolução proximal-distal, indolor e sem alterações de sensibilidade associadas. Ao exame clínico apresentava PA 160-70 mmHg, FC120bpm, FR24irpm, alerta, consciente, fácies toxemiada, importante rigidez nucal, dolorimento a palpação das vértebras cervicais, nervos cranianos sem alterações, sensibilidade geral preservada, inclusive em mmii, hiperreflexia em mmii com clônus e reflexo cutâneo-plantar em extensão bilateral, sem alterações esfincterianas, paraplegia em mmiii, membro superior direito normal e membro superior esquerdo com paresia proximal grave. A ressonância magnética (RM) de coluna cervical evidenciou abscesso paravertebral esquerdo com volume de 163 cm^3 com sinais de compressão medular em C4-C5 (imagem em T2-FLAIR). Visualizado também abscesso epidural de C2 a T8.Paciente foi tratado com oxacilina. A punção do abscesso paravertebral produziu alívio imediato da cervicalgia do paciente e o material foi enviado para cultura que evidenciou *Staphilococcus coagulase* negativo sensível a oxacilina. Paciente evoluiu com sepsis grave. Levado a UTI e à cirurgia para drenagem do abscesso em caráter de urgência. Antibioticoterapia foi modificada para Piperacilina-tazobactam.Evoluiu posteriormente com melhora clinica progressiva e melhora radiológica associada nos exames de RM de controle. Conclusão: O paciente portador de paraplegia ou paraparesia, com frequência tem em sua história natural, quadro de escaras de decúbito infectadas sendo fator de risco importante para infecção na coluna vertebral e seus anexos.

015 – ENCEPHALOMYELITIS DUE TO *SCHISTOSOMA MANSONI*'S INFECTION

Vale TC, Marques DP, Sousa-Pereira SR, Lambertucci JR.

Serviço de Infectologia/Neurologia – Hospital das Clínicas - Universidade Federal de Minas Gerais

Introduction: Schistosomiasis is a tropical disease caused by worms of the genus Schistosoma (*S*). Neuroschistosomiasis is an ectopic form of the disease and is mainly associated to S. japonicum infection. Involvement of the brain in the *S. mansoni* infection is rare, particularly when concomitant to myeloradiculopathy. Case report: We present a case of a 27-year-old woman who was admitted to the hospital with an unspecified myelopathy. She had a diagnosis of epilepsy secondary to neurocysticercosis established in her childhood in Montes Claros-MG. She was treated with dexamethasone for 20 days with improvement of symptoms. Shortly after, she recurred with evident flaccid paraparesis. Corticoid therapy was then prolonged to six months, after which she was readmitted due to a tonic-clonic seizure. An extensive laboratory work-up was normal. Cranial computed tomography scan showed diffuse residual nodulated calcifications in cerebral parenquima suggestive of neurocysticercosis. Thoracic and lumbar spinal magnetic resonance imaging (MRI) were normal. Two months later, she reported various episodes of tonic-clonic seizures. A brain MRI revealed an intensely enhancing post-gadolinium lesion in the right parieto-occipital region with nodular 'arborized' aspect. It also showed another mass in the left cerebellar hemisphere extending to the vermis. A biopsy of the parieto-occipital lesion showed multiple granulomas within which were found S. mansoni ova. Praziquantel and prednisone were administered. Three months later, she was seen without further episodes of seizures. Conclusion: *S. mansoni* encephalitis should be considered in the differential diagnosis in patients presenting with seizures and focal motor deficits from areas where schistosomiasis is endemic.

016 – INVASIVE ASPERGILLOSIS OF THE ORBIT

Vale TC, Fonseca PG, Pereira ACG, Gomez RS, Teixeira AL.

serviço de Neurologia – Hospital das Clínicas - Universidade Federal de Minas Gerais

Introduction: *Aspergillus* is a fungal mold that is virtually ubiquitous. Locally aggressive, invasive fungal masses may develop, particularly if the host is severely immunocompromised. Invasive aspergillosis may spread contiguously through bone and soft tissue to involve the orbit and brain, sometimes leading to fungal abscess formation. Case report: We present a case of a 38-year-old man who presented with left-sided symptoms, including visual field deficit, oculodynia and ptosis. Fundoscopy examination revealed a pale left optic disc. Computed tomography scans showed a mass in the left orbital apex. The mass had eroded the adjacent bone, involved the ethmoid and sphenoid sinuses, and extended into the cavernous sinus. Magnetic resonance imaging (MRI) following gadolinium administration showed enhancement of the mass. A biopsy of the sphenoid sinus was followed by left orbital exenteration. Pathologic examination revealed granulomatous inflammation and fibrosis. Branched, septated, fungal hyphae were identified on methenamine silver and periodic acid-Schiff stains, and *Aspergillus fumigatus* was identified from culture. Voriconazole was the treatment of choice. Patient had been diagnosed with AIDS sixteen years before, having had multiple therapy schemes, the last of which was lamivudine, tenofovir and fuzeon. Reportedly homosexual, he had previously been infected with syphilis, neurotoxoplasmosis and cytomegalovirus retinitis. Conclusion: Emphasis should be made to the need of optimal strategies for early diagnosis and appropriate treatment in order to decrease mortality rates in patients with invasive orbital aspergillosis.

017 – HYPERTROPHIC SPINAL PACHYMENINGITIS

Vale TC, Fernandes BFS, Barbora LSM, Moraes TEC, Sacramento DRC, Gomez RS, Teixeira AL.

Serviço de Neurologia – Hospital das Clínicas - Universidade Federal de Minas Gerais

Introduction: Hypertrophic pachymeningitis is a rare disease causing a chronic inflammatory hypertrophy of dura mater. The etiology is usually obscure, but it can be associated with trauma, infection and autoimmune diseases. Case report: A nineteen-year-old female was admitted to the hospital with a two-week history of headache and neck pain followed by nausea and vomiting. Neurological examination revealed neck stiffness and distal right lower-limb paresia and paresthesia. Kernig and Brudzinski's signs were positive. A peripheral paresia of right seventh nerve was also present. No fever, photophobia and skin rashes were observed. Lumbar cerebrospinal fluid (CSF) analysis yielded pleocytosis (351 leukocytes/mm3 with 21% neutrophils and 75% lymphocytes), elevated protein (732 mg/dL) and low glucose levels (21 mg/dL). Cranial computed tomography was normal. Tuberculous meningitis was suspected based on CSF and clinical findings and she received triple antituberculous treatment and dexamethasone. Two weeks later, she presented with worsening of neck pain and stiffness as well as of lower-limbs motor impairment. Examination showed a sensory level at T8 and urinary retention. Another lumbar CSF analysis showed pleocytosis and extremely high protein levels (4660 mg/dl). Froin's syndrome was confirmed after suboccipital spinal fluid analysis revealed only 231 mg/dl of protein. Magnetic resonance imaging showed an extramedullary T8 mass encompassing and compressing the spinal cord, hypointense on T2-weighted and isointense on T1-weighted images with attenuated, predominantly peripheral enhancement. She was treated with methylprednisone and recovery of pain was observed. Conclusion: This case highlights the challenges faced by clinicians on the diagnosis of tuberculous meningitis.