Massive Non-Encephalitic Neurocysticercosis

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Picture.

A 45-year-old garbage collector was referred to our department with a history of tonic-clonic seizures and risky sexual behavior (anilingus). A neurological examination was

normal. Contrast-enhanced cranial CT showed calcified lesions and viable parasites compatible with a diagnosis of massive non-encephalitic neurocysticercosis. Oral metallic implants impeded performing brain MRI. Hepatitis and HIV serologies were negative. The patient was discharged with steroids and an anticonvulsant. Delayed cysticidal therapy was planned; however, albendazole therapy was immediately initiated in another hospital, which led to brain edema, uncontrolled seizures, rostrocaudal deterioration and death.

Cestoda infections are rare in developed countries (1). In contrast, neurocysticercosis is a leading cause of adult-onset epilepsy in Latin America. Massive infections are classified as encephalitic or non-encephalitic (2). In patients with the encephalitic presentation, cysticidal drugs can cause extensive parasite lysis and aggravate brain inflammation (2). In patients with non-encephalitic massive neurocysticercosis, cysticidal therapy is usually considered; (2) however, rapid initiation of antiparasitic medications can launch an encephalitic process.

The authors state that they have no Conflict of Interest (COI).

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