Neurocysticercosis in a young Indian male: not an uncommon scenario

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To the Editor—I read with interest the case report by Ng et al[1] of a young Indian male who was diagnosed with neurocysticercosis (NCC). The patient presented with headache and monoparesis with no history of fever or seizures. Magnetic resonance imaging delineated a well-circumscribed hypointense cystic lesion with a contrast-enhancing wall and an eccentric intracystic signal with perilesional oedema. Such a characteristic ring-enhancing lesion with eccentric intracystic signal suggestive of scolex is definitive radiological evidence of NCC as per the absolute diagnostic criteria described by Del Brutto.[2]

Brain abscess, another differential considered by the authors, seems unlikely in the absence of fever. Malignant glioma was another consideration but the lesion was so well demarcated it was dismissed by the authors. In such a case of a young male who was resident in a cysticercosis-endemic area and who had characteristic neuroimaging findings, therapy for NCC in the form of steroids and cysticidal therapy was warranted. There seems to have been no indication for proceeding with craniotomy to excise the lesion. In addition, the patient had no seizures, precluding refractory epilepsy as a justification for surgical intervention. If the entire lesion with firm capsule was excised as stated, and in the absence of any other documented NCC lesion or cysticercosis at any other site such as soft tissue or muscle, there would have been no reason to prescribe cysticidal therapy.

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