

## Proliferating acephalic cestode larva of central nervous system

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*We reported two cases of racemose cysticerci (proliferating acephalic cestode larvae) affecting the central nervous system of two men aging 33 and 36 years respectively. In case 1, the lesion was in the basal subarachnoid space of brain (cerebellopontine angles) and in the thoracic spinal subarachnoid space. In case 2, the lesion lay in the basal subarachnoid space of the brain. Within a cavity as in the cerebral ventricle or subarachnoid space, a cysticercus cellulosae may be expanded and wrinkled to resemble a bunch of grapes, the so-called cysticercus racemosus. Basal cysticercosis of the brain may create clinical manifestations imitating tuberculous meningitis because of involvement of multiple cranial nerves.*

**Key words** : *Cysticercosis, Brain, Spinal cord, Central nervous system, Subarachnoid space.*

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**ประชา ชยาภิรม, กอบกุล ตั้งสินมั่นคง, สำราญ ช่วงโชติ, โปริลเฟอเรติง อเชฟาลิก เซสโทด ลาร์วา  
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เทอมโปริลเฟอเรติง อเชฟาลิก เซสโทด ลาร์วา มีความหมายเช่นเดียวกับเรซีโมส ซิสติเซอร์คัส เป็นซิสติเซอร์คัสที่ไม่มีสโคเลกซ์ จึงผิดไปจากรูปร่างของซิสติเซอร์คัสเซลลูโลเซ ที่มีสโคเลกซ์ เรซีโมส ซิสติเซอร์คัส พบน้อยกว่าซิสติเซอร์คัส เซลลูโลเซ ได้รายงานผู้ป่วยชายไทย 2 ราย อายุ 33 และ 36 ปี ตามลำดับ รายที่ 1 มีซิสติเซอร์คัส เรซีโมซัส ที่ช่องใต้ชั้นนอแรคนอยด์ของไขสันหลังระดับอกและแอ่งระหว่างเซเรเบลลัมกับพอนส์ รายที่ 2 มีเรซีโมส ซิสติเซอร์คัส อยู่ในช่องใต้ชั้นนอแรคนอยด์ที่ฐานของพอนส์ ภายในช่องว่าง เช่น ในช่องใต้ชั้นนอแรคนอยด์หรือโพรงสมอง (เวนตริเคิล) ส่วนถุง (แบลตเตอร์) ของซิสติเซอร์คัส อาจพองโตและบิดเบี้ยวเป็นกลุ่มถุงคล้ายพวงองุ่น ส่วนสโคเลกซ์มักสลายตัวไป หรือยากที่จะหาพบ เป็นที่น่าสังเกตว่าผู้ป่วยรายที่ 2 ซึ่งมีถุงพยาธิอยู่ที่ฐานสมองนั้นให้อาการคล้ายกันมากกับวัณโรคของเยื่อหุ้มสมอง จนเกิดการวินิจฉัยคลาดเคลื่อนทางคลินิก จึงควรระมัดระวังที่จะต้องแยกจากกันให้ดี เพื่อการรักษาที่ถูกต้อง

The adult tapeworm infection in human beings is exclusively in the gastrointestinal tract.<sup>(1)</sup> There were only two reported extragastrointestinal locations of strobilate tapeworm in human. One was in the subcutaneous tissue of a woman in Japan.<sup>(2)</sup> The other was in the spinal cord of a man in Thailand.<sup>(3)</sup> The human cestode larval infections found in Thailand are sparganosis, cysticercosis, and hydatid cyst.<sup>(1)</sup> Cysticercosis is far outnumbers the other two but is seldom reported because of its commonness. The central nervous system (CNS) cestode larval infections in Thailand are cysticercosis, and three cases of sparganosis.<sup>(4-6)</sup>

Cysticercus is probably the most common cystic lesions in the CNS.<sup>(7)</sup> It is the larval infection of *Tenia solium*, the pork tapeworm. There are two forms : cysticercus cellulosae and cysticercus racemosus. The more common cellulosae form is a fluid-filled bladder that contains the invaginated head (scolex) of the larva. The racemosus form is a proliferating form of the larval tapeworm that consists of multiple interconnected bladders of different sizes that lack scolices. Racemose cysticerci are believed to be aberrant cysticerci of *Tenia solium* or other species of cestode larvae such as *Multiceps multiceps*, and *Multiceps serialis*.<sup>(7)</sup>

In the proliferating form of the cestode larval infection, the scolex usually cannot be identified; so the term proliferating acephalic cestode larva is used.<sup>(8)</sup> In a review of acephalic cestode larva in man, Beaver and Rolon<sup>(8)</sup> recognized three distinct types namely sparganum proliferum, cysticercus racemosus, and undifferentiated sparganum or tetrathyridium. In no case, however, can the parasite be identified as the larval stage of a recognized species that have been known, or yet to be discovered.<sup>(8)</sup>

In Thailand, there were two reported cases of cysticercus racemosus; the lesions in both instances were removed from the fourth ventricles.<sup>(9)</sup> A case was initially diagnosed as a sparganum-like parasite of the brain.<sup>(10,11)</sup> After personal consultation with P.C. Beaver, the diagnosis of racemose cysticercus was considered.<sup>(1)</sup> We are adding two more cases of cysticercus racemosus of the brain found in Thailand because of its uncommonness.

### Case 1.

This example was previously presented at the International Congress of Neurological Surgery being held by the World Federation of Neurosurgical Societies on October 17-22, 1993 at Acapulco in Mexico.

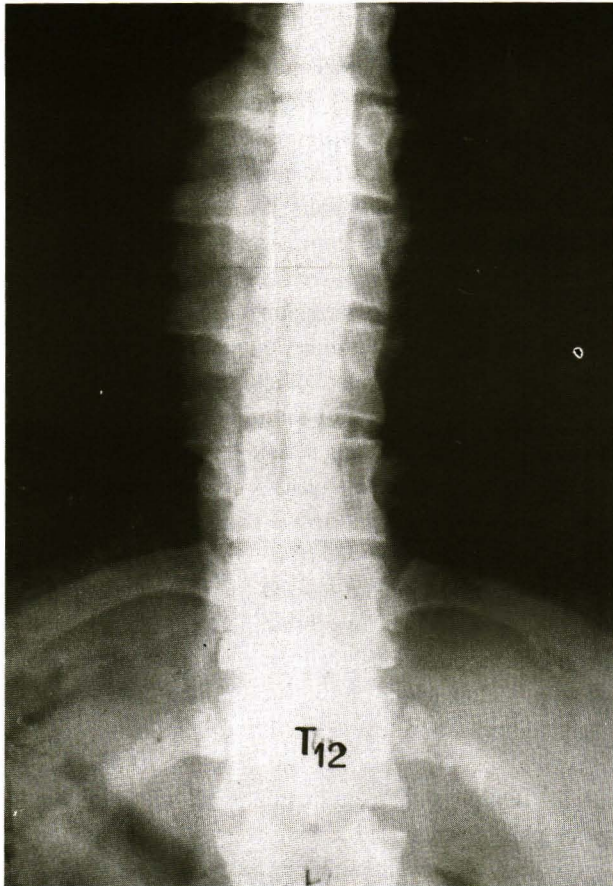
A 33-year-old male Thai school teacher, the native of Yala province, came from a family of fruit and rubber plantation. He exposed to dogs, cats, pigs and cows as well as to untreated water tapped from a waterfall. He often joined parties with rubber plantation workers where he enjoyed consuming alcohol and uncooked foods. He, nevertheless, was in good health until in 1990 when he first had back pain radiating to buttock and leg on the right side and was aggravated by lifting. Sometimes he felt numbness in the right leg. He was treated symptomatically for disorder of the lumbar disc. In May 1991, he had diplopia when he looked toward the right side, anxiety, insomnia, and weight loss. In September 1991, diplopia disappeared spontaneously. He, however, complained about weakness of the lower limbs. A month later, he was hospitalized because of severe low back pain.

On physical examination, there was mild lateral rectus palsy. Straight leg raising test was 90° bilaterally. Sensation was intact to both pinprick and fine touch. The motor power of legs was weak from iliopsoas downward with muscular atrophy. He could walk with the aid of a walker. Hyporeflexia was noted in his upper extremities. The lower limbs showed areflexia. There was no response in Babinski's test.

Laboratory studies showed 43% of hematocrit, 8,050 leucocytes/mm<sup>3</sup> with 51% neutrophils, 10% eosinophils, 1% basophils, and 38% lymphocytes.

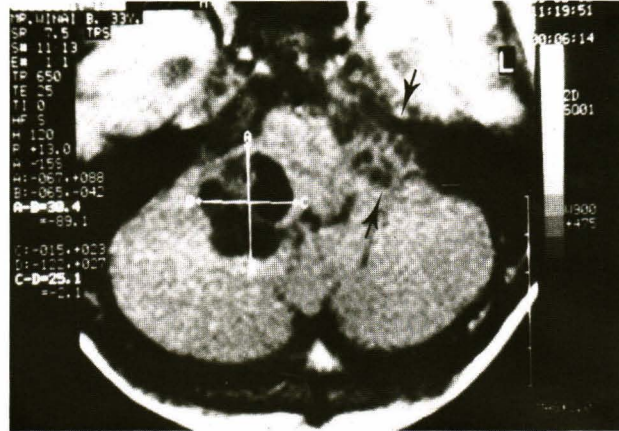
After 2 weeks of hospitalization his hearing was decreased in the left ear. An audiometry revealed moderate sensorineural hearing loss in this ear.

Myelography yielded a dry tap. So cisterna puncture through C<sub>1,2</sub> was performed. The clear and colorless CSF contained 35 mg/100 ml of protein, and 54 mg/100 ml of sugar, but no leukocytes. A repeated myelography showed a small extramedullary subdural defect at the right side of the dural sac at T<sub>6</sub> and complete block at T<sub>11</sub> (Fig.1).



**Figure 1. (case 1).** Myelography demonstrating a small extramedullary subdural defect of the radiopaque column at T<sub>6</sub> on the right side and complete blockage of the radiopaque column at T<sub>11</sub>. Note T<sub>12</sub>.

The magnetic resonance imaging (MRI) of the thoracic and lumbar levels of the spine exhibited a ring appearance at T<sub>11</sub>, and there was an evidence of abnormal flow of the CSF below the lesion. The findings corresponded well with the myelographic study. The MRI of the brain demonstrated two lesions (Fig.2). One was at the right cerebellopontine (CP) angle extending to the brainstem and measuring 3.4 x 2.5 cm; another smaller lesion was at the left CP angle. The fourth ventricle was partly obliterated. The third and lateral ventricles were dilated.

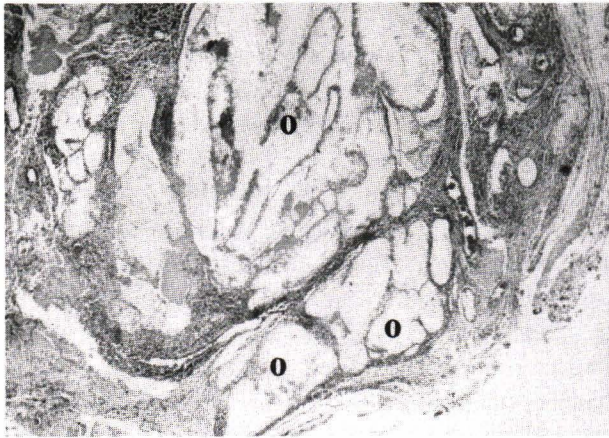


**Figure 2. (case 1).** MRI of brain showing lesion in each cerebellopontine angle. The large right one is marked by two cross lines (AB and CD). The small left one is between the the arrows. The partially obliterated fourth ventricle lies between two lesions.

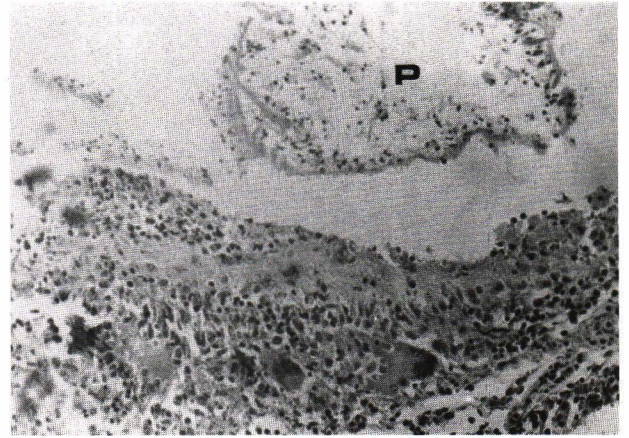
A total laminectomy from T<sub>10</sub> to T<sub>12</sub> disclosed the spinal cord to be wrapped around by chalky fat-like tissue and an encapsulated lesion, 1 cm across at T<sub>11</sub> which corresponded with the findings on myelographic blockage and MRI ring appearance. The lesion and chalky tissue were removed.

Histopathologically, the encapsulated lesion was a cystic organism provoking intense granulomatous reaction (Figs. 3-6). Eosinophils were present but not prominent. The worm possessed an eosinophilic homogeneous tegument (syncytium or cuticle), 5 to 10 microns in thickness. Beneath the tegument was nuclear layer of tegumental gland cells. Smooth muscle fibers were rare. The stroma was composed of loose meshes of mesenchymal cells, and connective tissue fibers, interspersed by calcareous bodies and vesicles (lacunae). After careful study, it was concluded that the worm represented a bladder of proliferating cestode larva without scolex (racemose cysticercus) of the spinal cord.

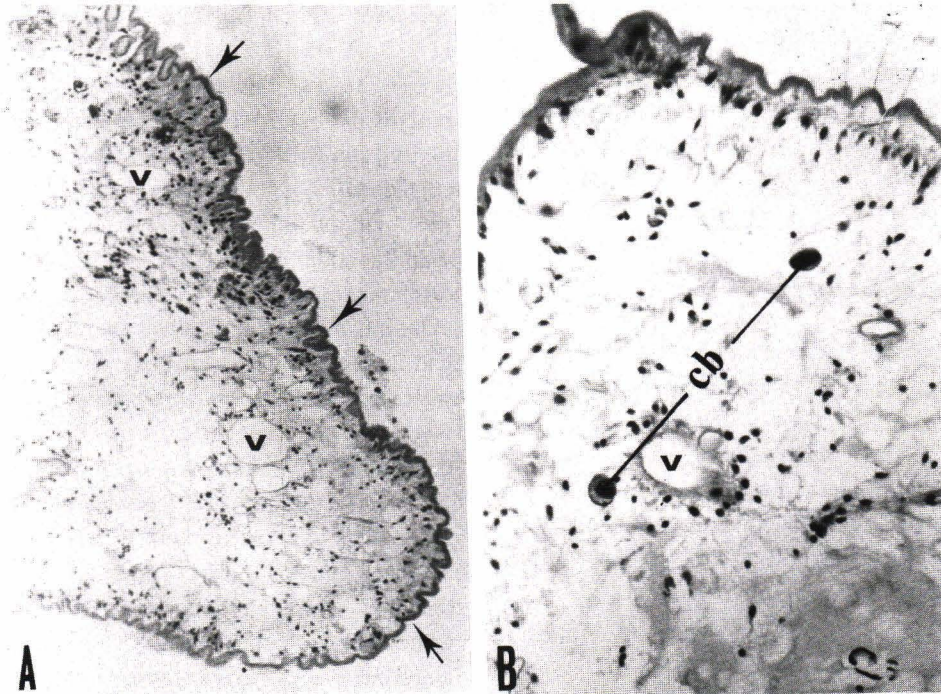




**Figure 3.** (case 1). Photomicrograph of low magnification showing folded cystic organism (O) being surrounded by dark zone of inflammatory reaction.

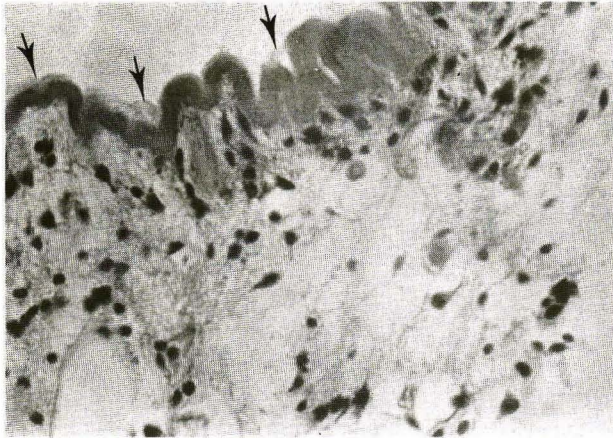


**Figure 4.** (case 1). Photomicrograph at medium magnification showing granulomatous reaction consisting mainly of histiocytes and foreign body giant cells. A piece of parasite (P) lies above the granuloma.



**Figure 5.** (case 1). Histopathology of cysticercus. A. Three layers of body of parasite are shown. The outer convoluted eosinophilic layer (arrow) is the tegument. The intermediate layer is composed of small, round, dense nuclei of tegument gland cells. The inner layer consists of mesenchymal cells and loose connective tissue fibers interspersed by vesicles (v) or lacunae. B. Distinctive tegument, subjacent tegument gland-cell nuclear layer, loose connective tissue layer, and calcareous bodies (cb) are demonstrated at higher magnification. Again noted vesicle (v).





**Figure 6.** (case 1). Cysticercus showing fine surface processes or microvilli (arrows) on the external aspect of the convoluted tegument at higher magnification.

Postoperatively, the patient was improved in motor power. One month later, however, his motor power and hearing deteriorated again.

In March 1992, a right suboccipital craniectomy was done and the lesion was excised subtotally to relieve the ventricular obstruction. It was also verified as cysticercus of racemose type.

Besides surgical treatment, antihelminthic drugs (yomesan, prasiquantel, and mebendazole) were also given.

The patient was eventually deaf bilaterally. There were additional right facial palsy of lower motor neuron type, hoarseness of voice, paraparesis, and neurogenic bladder. He received physiotherapy, occupational therapy, and other supportive regimens with little improvement. He was followed up monthly until March 1993 he aspirated food and died. The total course of his ailment was about 3 years.

## Case 2.

This instance was briefly mentioned previously by Pradatsundarasar.<sup>(1)</sup> A 36-year-old Thai man, the native of Kampangpej province, was hospitalized with blurred vision in the right and left eyes for 6 and 3 months respectively. Additionally, he complained of severe generalized headache without vomiting. Two weeks before hospitalization, he developed mental confusion.

Upon hospitalization, the patient walked with ataxic gait. Divergent squint was present at rest. He was unable to converge his eyes. The right palpebral fissure was smaller than usual. Hypalgnesia and weakness were noted on his right face. Fundoscopy revealed bilateral papilledema and atrophic optic discs. There was

stiffness of the neck.

Bilateral carotid angiographies disclosed enlargement of all cerebral ventricles. Pneumoencephalography revealed dilated third ventricle without evidence of obstruction.

Hemoglobin was 11 gm/100 ml. A leukocyte count showed 12,000 cells/mm<sup>3</sup> with 65% neutrophils, 10% eosinophils, and 25% lymphocytes. Blood sugar was 74 mg/100 ml. A ventricular puncture disclosed clear and colorless CSF with a pressure of 250 mm of water. It contained 8 cells (3 neutrophils and 5 lymphocytes) /mm<sup>3</sup>, 25 mg/100 ml of protein, and 22 mg/100 ml of sugar. A lumbar puncture exhibited very slow flowing of the clear and colorless CSF which contained 4 cells (1 neutrophil and 3 lymphocytes) /mm<sup>3</sup>, 25 mg/100 ml of protein, and 61 mg/100 ml of sugar. Only a few drops of the CSF were obtained in a repeated lumbar puncture a few days later. The pressure of the CSF could not be measured. The fluid contained 400 cells/mm<sup>3</sup> with 90% lymphocytes and 10% neutrophils.

With evidence of involvement of multiple cranial nerves, it was believed that the patient had a lesion at the base of the brain. The clinical diagnosis of tuberculous meningitis with communicating hydrocephalus was considered. The patient, then, received full antituberculous treatment including steroids. About 2 months in the hospital, he complained about hard hearing in the right ear. Streptomycin was then no longer given to him. Up to that time, the patient received 39 gm of streptomycin. He had also occasional fever. Penicillin and chloramphenicol were then added. His clinical course was progressively worsening. His mentality became dull. Finally he died in coma after 3.5 months of hospitalization.

At autopsy, the leptomeninges at the base of brain were covered by thick layers of gray and friable exudate. The optic nerves and tracts were also covered by the latter. Coronal sections of a 1,530-gm brain disclosed symmetrical hydrocephalus of all ventricles. The grey and white matters were congested. The spinal dura mater, leptomeninges, and spinal cord were congested. The spinal subarachnoid space was filled with grey and friable materials similar to exudated covering the base of brain.

Microscopically, the leptomeninges at the base of pons were the seat of granulomatous inflammation. Fibroblasts, lymphocytes, plasma cells, histiocytes, multinucleated giant cells, and small blood vessels were mingled in the granulomas. Fragments of cysticercus were embedded in the granulomatous exudate and in the substance of pons. The worm fragments folded upon itself and had microscopic features as described in case 1. Cuticle, nuclear layer, and calcareous bodies were identi-

fied. The scolex was not observed. The lesion was regarded as a racemose cysticercus (proliferating acephalic cestode larva) affecting the subarachnoid space at the base of brain.

## Discussion

Although cysticercosis is common in Thailand including those affecting the CNS the racemose form of cysticercus is rare. Generally, cysticercosis of the CNS occurs in four varieties according to locations eg parenchymatous, ventricular, meningeal, and a combination of these situations. The latter, for example, may be represented by combined parenchymatous and ventricular forms. When the parasite is floating in the CSF, such as in the subarachnoid space or in the ventricle, it may be expanded, folded, or wrinkle to become grape-like structure, the so-called racemose cysticercus. Examples of CNS cysticercosis reported by Patharangkura et al<sup>(9)</sup> are ventricular racemose cysticerci. An instance described by others<sup>(10,11)</sup> can be also regarded as cysticercus racemosus of the basal subarachnoid space of the brain as in our current two cases.

Slais<sup>(12)</sup> gave an interesting comparison between cysticercosis and intrauterine development of mammals. He compared the cysticercus cellulosae to normal mammalian embryo and cysticercus racemosus to hydatidiform mole. He regarded the racemose cysticercus to represent pathologic cysticercus cellulosae that become degenerated, expanded, and folded which is similar to degenerated placental villi in hydatidiform mole.<sup>(12)</sup>

It is interesting to note in our case 2 that the lesion was erroneously considered and treated as tuberculous meningitis. This is related to the location of the lesion at the base of brain to resemble typical location of exudate in tuberculous meningitis.<sup>(13)</sup> Moreover, the latter is common in Thailand. The erroneous clinical diagnosis and management for tuberculosis, then, may occur when cysticercosis affects the base of brain. It is, then, suggested in such situation that the diagnosis and management should be revised when there is no clinical response to antituberculous treatment.

The discovery of other human cestode larva, especially sparganosis, is increasing in Thailand and far-east.<sup>(14)</sup> The diagnosis as cysticercosis is simple in a non-proliferating form, especially in the presence of scolex. In case of a proliferating acephalic cestode larva, it is difficult to pin-point the species because we do not know for certain that these larvae will display their normal features while in a state of uncontrolled proliferation. We, however, do believe that a proliferating cysticercus will have a tegument that will vary in thickness from very thin in some places to thick in others, just below the outer

acellular layer of the tegument (syncytium) there is a row of tegumental gland cells (the cells responsible for forming the tegument) that are evident by their relatively large nucleus. When the tegument is thin, these nuclei are scanty, but when the tegument is thick they are more numerous and closer together. Lying between the syncytial layer and the gland-cell nuclei are very small circular and longitudinal muscle fibers. These are usually not noticeable in most histologic preparations. Other muscles are not observed in the bladder wall of normal or proliferating cysticerci, and this is one of the key diagnostic features. Excretory canals are usually present in proliferating cysticerci and may be quite enlarged. They have a lining membrane and this differentiates them from lacunae which lack a lining membrane. Proliferating cysticerci may appear to have a solid body in some sections through smaller portions while they may have a large lacuna and a thin wall in other sections.

In differential diagnosis, proliferating spargana differ from cysticerci in that nearly all sections show a solid body and there are bundles of muscle fibers that run in different directions through the parenchyma. Seldom are lacunae (vesicles) seen and the tegument is generally thick. In human cases, the skin is almost always involved, although other organs may also be invaded.

The tetrathyridium of *Mesocestoides* is similar to the sparganum in that it has a solid body, but the parenchymal muscle fibers are arranged in a circular band that separate the cortical and medullary regions.

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