

TABLE I—*Diagnostic Utility of C-Reactive Protein (CRP) Test in Cerebrospinal Fluid.*

Meningitis	N	CRP +ve	CRP -ve	Sensitivity	Specificity	Positive Predictive value
Pyogenic	30	24	06	80	100	100
Tubercular	40	06	34	15	100	100
Control	30	-	30	-	-	-
Total	100	30	70	-	-	-

predictive value. Absence of C-reactive protein rather than its presence is more important for the diagnosis of tubercular meningitis(3-5). Maximum prediction of pyogenic meningitis can be made if the test is positive. Additionally this test virtually rules out the possibility of tubercular meningitis. However, recommending it for routine clinical application needs further evaluation utilizing accurate and precise quantitative assay for measuring C-reactive protein levels in the cerebrospinal fluid.

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Lateral Sinus Thrombosis with Neurocysticercosis

Cysticercosis is a frequent parasitic infection in developing countries and is related to poverty, ignorance and pig rearing practices in community(1). Variety of structural involvement of central nervous

system and orbit have been reported but cysticercus involving lateral sinus causing thrombosis is extremely rare.

A 13-year-male child presented with complaint of headache for 3 months. Headache was insidious in onset, localized to right temporal and frontal region and present throughout the day. There was no history of fever, vomiting, photophobia, blurring of

vision, ear discharge, seizures and altered sensorium. Birth, developmental and family history were non contributory. On physical examination, patient was conscious and afebrile. His vitals were normal. Examination of ear, nose and throat was normal. Systemic examination was also normal. Ophthalmoscopy did not show evidence of raised intracranial pressure.

Hemoglobin, total and differential leucocyte count were within normal range. Biochemical and cytological evaluation of the cerebrospinal fluid did not reveal any abnormality. CT scan of cranium showed small hypodense lesion in right lateral sinus with a hyperdense nodule within, suggestive of lateral sinus thrombosis. On MRI, right lateral sinus showed a small space occupying lesion with mixed intense signals on T1 and T2 with loss of flow void signals and reversal of blood flow and no significant enhancement with contrast. Examination of stool (three samples) did not reveal any ova or cyst. Patient was treated with albendazole (15 mg/kg/day) orally for 28 days. Patient was intensively monitored during first week and discharged. After 3 months, repeat CT and MRI of patient were normal.

Neurocysticercosis is common in developing countries, and is an important cause of epilepsy (9.1%) and hydrocephalus in children(1). Seizures (80-90%) are the most common neurological manifestations of symptomatic cysticercosis(2,3). The disease may also present with headache, chronic meningitis or symptoms of intracranial space occupying lesions(4). Isolated non-neurological manifestations such as ocular or dural cysts account for less than 5% of cases of symptomatic disease(5). Our case presented

with headache, hitherto undescribed in literature. The noninvolvement of lateral sinus in neurocysticercosis may be due to high velocity of blood flow that prevents lodging of embryo in lateral sinus. MR venography is the ideal investigation for diagnosing such conditions.

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