LETTERS TO THE EDITOR

Neurocytosciricotic versus idiopathic epilepsy: a comparative study of 175 patients

Epilepsy seems to be the most common clinical manifestation of neurocysticercosis (NC),1-3 while NC has been regarded as the most commonly identifiable cause of epilepsy in some developing countries.4-6

Two groups of chronic epileptics, one with NC (61 patients) and the other with idiopathic epilepsy (in whom no cause of epilepsy could be identified) and normal CT scan (114 patients), were compared for sex, age, age of onset of epilepsy, type of epilepsy (International Classification 1981), and EEG findings. These patients were prospectively and randomly selected from a group of 580 epileptic outpatients who were evaluated and studied during the past four years. Single convulsions and patients less than 10 years old were excluded. A normal neurological examination was a criterion of inclusion in both groups. CT was performed in each case, and CSF examination when indicated. Only patients with a normal CT scan were included in the idiopathic epilepsy group. A standard 8-channel EEG was obtained in all patients. An EEG was considered abnormal if generalised or focal spike discharges or sharp waves were present or if paroxysmal slow activity (delta or theta; generalised or focal) was observed in the absence of spike discharges or sharp waves. The diagnosis of NC was made with the following criteria: 1) CT scan findings compatible with NC;2) Positive CSF immunological test (indiced and nonfluorescent or indirect haemagglutination) for NC; and 3) Surgical diagnosis of NC. For the control of seizures, a patient was considered free of seizures when epileptic fits did not occur after one year of drug therapy and follow up. All the patients were taking anticonvulsant drugs regularly at the time of this study.

The most common topographic finding in the NC group was multiple parenchymal calcifications (n = 55, 90-1%), followed by parenchymal cysts (n = 10, 16-4%), and hydrocephalus (n = 3, 4-9%).

CSF examination was performed in 18 (29-5%) patients of the NC group. Ten patients (16-4%) with neurocysticercosis showed abnormalities in the CSF, as follows: elevated protein levels (more than 50 mg/dl) 6, pleocytosis (more than five cells/cu mm) 7 (all with mononuclear preponderance), positive immunological test for NC in nine cases. Low CSF glucose levels were not observed in any case. Engonolops (more than 5%) were observed in two cases. Twelve patients (19-7%) had the active form of NC, according to the classification of Sotelo et al.5 A spinal tap was performed in 32 (28-0%) patients with idiopathic epilepsy, as part of another protocol of investigation not related to this work. All CSF examinations of the idiopathic group were normal.

There was a higher proportion of late onset epilepsy (onset over 25 years old) in the NC group (28 (46-6%), compared with the idiopathic group (33 (29-4%) [Chi square test = 5 (051)], p < 0.05). Normal EEGs were more prevalent in the NC group. Among the patients with the active form of NC, only one (8-3%) had an abnormal EEG, which consisted of continuous slowing of the right posterior temporal area.

A normal EEG without focal abnormalities was 61% in the NC group and 90% in the idiopathic group. There was no difference in sex related differences in the intensity of the host inflammatory response to cysterci in the central nervous system. In conclusion, any patient with late onset epilepsy, with a normal neurological examination, and living in an endemic area of taeniasis/cystercerosis, should be considered as having neurocysticercosis, regardless of the seizure type and the EEG findings.

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5 Goodwin DS, Aminoff MJ. Does the interictal EEG have a role in the diagnosis of epilepsy? Lancet 1984;1:937.

Angiostrongylus cantonensis abscesses in the brain

Angiostrongylus cantonensis is a rat lung worm with a geographical distribution from Madagascar to Hawaii. Humans are a para-""