logic change.[1, 5] Neurologic deterioration in our case 1 five hours after the occlusion of the aneurysm was most probably caused by the compression of the donor artery by a massive hematoma beneath the skin flap, as anisocoria promptly regressed following hematoma evacuation. Decompressive craniectomy, performed after normalization of coagulation parameters, as well as intensive antiedematous therapy with prompt intubation and artificial ventilation most likely also contributed to the overall positive result. The problem remains how to avoid and correct coagulation abnormalities in surgically treated patients, who subsequently undergo endovascular intervention with the use of heparin. In our case, a gradual coagulation correction was used due to concerns that the bypass may thrombose in the case of too rapid correction.

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Subependymoma of septum pellucidum presenting with cough and exertional headache: a case report of spontaneous regression after incomplete surgical removal

Dear Editor,

Subependymoma is a rare intraventricular tumor usually located in the fourth (50-60%) and lateral ventricles (30–40%), less frequently in the septum pellucidum and spinal cord.[1, 2] Symptoms are related to CSF obstruction with headache as main symptom. Valsalva-related headache and transient altered mental status were rarely described.[3] Headache induced by Valsalva manoeuvre is usually considered an alarm symptom of intracranial lesions.[4] Here, we report a case of Valsalva-related headache due to subependymoma of *septum pellucidum*.

A 41-year-old man was admitted after CT scan occasionally discovered an intraventricular lesion. No neurological abnormalities were detected apart from a very mild mental slowness. He had a five-year history of short lasting headache triggered by cough, straining during defecation and physical exercise, with an increasing frequency in the last year. MRI revealed a lesion on the left side of septum pellucidum closely related to foramen of Monro. The mass appeared hyperintense in the T2- and hypo-isointense in T1-wheighted sequences without contrast enhancement (Figure 1A, B). With a preoperative diagnosis of subependymoma, the patient underwent a partial resection. The white, jelly-like, poorly vascularized lesion was removed incompletely due to its close relation to the deep veins and choroid plexus was coagulated. Postoperative CT scan showed a residual lesion (Figure 2). Histology showed a subependymoma. At the three-month follow-up neuro-

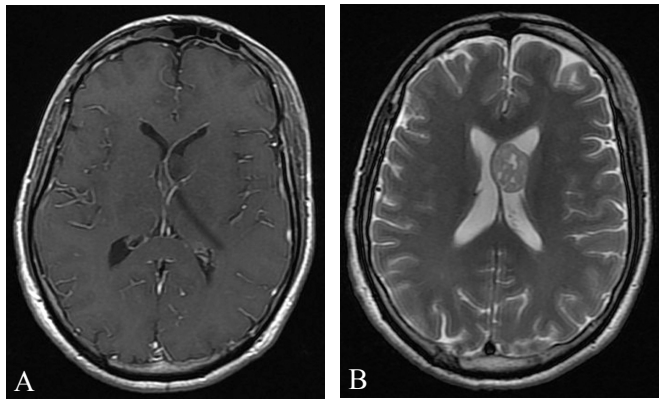
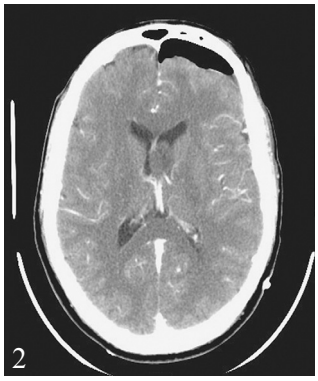


Figure 1.—T1 Post contrast (A) and T2-weighted (B) axial scans show an intraventricular tumor not enhancing with contrast. Note the close proximity to the deep veins.



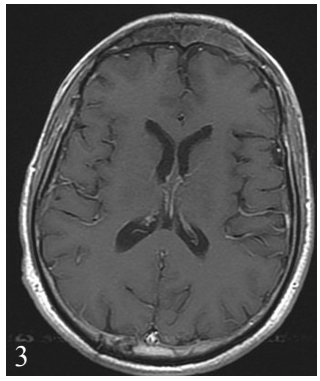


Figure 2.—Early postoperative post-contrast CT scan gives evidence of a residual lesion. Figure 3.—Two-year postoperative MRI. T1 post-contrast axial scan shows no residual lesion.

logical examination was normal and the patient was headache-free. No Valsalva or exertion triggered attacks were reported. Surprisingly, contrast-enhanced MRI showed a nearly complete regression of the lesion. At two-year follow-up, clinical situation was unchanged and neuroimaging was normal (Figure 3).

Cough-triggered headache consists of bilateral pain arising suddenly after Valsava-type maneuvres.[4] Our patient had a history of short-lasting attacks related to squatting or straining and exercise-triggered longer episodes of headache, and fulfilled the diagnostic criteria for respectively cough and exertional headache. In the reported cases of symptomatic subependymomas of the lateral ventricles headache is commonly reported as presenting symptom. Altered mental status has also been described in cases associated with hydrocephalus.[3] In the present case hydrocephalus was not documented, however a possible transient increase in intracranial pressure induced by Valsalva-related increase of intrathoracic pressure together with the close proximity of the mass to Monro's foramen might have induced a potential valve-like mechanism, causing intermittent hydrocephalus. This hypothesis is supported by postoperative disappearance of headache.

The spontaneous regression of the residual lesion after incomplete surgical removal is also remarkable. In fact short-term MRI control showed a significant regression of the residual lesion which completely disappeared later on. In published cases resection is the treatment of choice. Some patients underwent partial removal with very low recurrence rate regardless of postoperative radiotherapy,[5] but spontaneous regression of subependymoma following incomplete surgical removal has never been described. Since coagulation of choroid plexus also was performed, we wonder if this might have played a role in the spontaneous regression of the lesion.

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Paget's disease and thoracic spinal cord compression: when should we operate?

Dear Editor,

Paget disease of bone (PDB) is a well-known skeletal disorder characterized by an abnormal bone turnover leading to hypervascular, weakened and structurally disorganized bone at one or multiple sites (monostotic or polyostotic disease).[1] The abnormal bone remodeling can lead to spinal stenosis with cord compression. Incidence of spinal stenosis with cord compression in pagetic patients is 6% and several underlying mechanisms have been described[2]. Pharmacologic treatment has been demonstrated being effective in pagetic spinal stenosis but surgery is advocated in certain cases. We report the case of a 63 year-old man presenting with a 1-month history of progressive signs of myelopathy and thoracic back pain. A CT scan revealed the standard radiologic findings for PBD, including a sclerotic lesion with osteolytic spots into the enlarged body and neural arch, circumferential expansion with severe spinal stenosis (Figure 1). T3 vertebral body was collapsed with more than 50% of vertebral height loss, causing a segmental kyphotic deformity.