Parkinsonism after Shunting for Hydrocephalus Secondary to Aqueductal Stenosis with Chiari Malformation

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Citation

Abstract
Parkinsonism has been well-documented in patients with communicating hydrocephalus, but it is an uncommon complication of shunting for obstructive hydrocephalus secondary to aqueductal stenosis. Although a number of hypotheses regarding anatomical and pathophysiological clues to this are proposed, its exact mechanism remains unclear. The author presents a unique case of parkinsonism after shunting for hydrocephalus due to aqueductal stenosis with Chiari malformation. Suboccipital craniectomy and duraplasty followed by ventriculoperitoneal shunting was performed, parkinsonian symptoms developed after the shunt revision, and short-term levodopa therapy resulted in complete recovery.

CASE REPORT
This 25-year-old man had a history of progressive headache during eight years before admission. He was admitted with increment in his headaches, drowsiness and vomiting with visual troubles; in the emergency room he was entubated because of development of loss of consciousness and bradycardia. Computerized tomography (CT) demonstrated obstructive hydrocephalus with a marked enlargement of lateral and 3rd ventricles (Figure 1). An external ventricular drainage (EVD) catheter was inserted to decrease the intracranial pressure. Magnetic resonance imaging (MRI) showed hydrocephalus associated with aqueductal stenosis, in addition to a hydromyelia extending from C2 to C5 level and tonsillar herniation confirming diagnosis of Chiari malformation type 1 (CM-1) (Figure 2). Following the removal of the EVD catheter, a suboccipital craniectomy and C1 laminectomy was performed. Intraoperative ultrasonography (US) revealed “pistoning” movement of the tonsils during systole-diastole pulsations. The dura mater was incised, the herniated tonsils were separated, and coagulated with achieving a free cerebrospinal fluid. Following duraplasty, valsalva maneuver was performed to ensure that foramen magnum obstruction by further tonsillar descent did not occur.

Figure 1
Figure 1: (A, B) Preoperative CT scan showing triventricular hydrocephalus secondary to aqueductal stenosis
Following the shunt revision, he rapidly developed severe parkinsonian symptoms with cogwheel rigidity on the left lower extremity, speech difficulty, incontinence, dysphagia, reduced facial expression, bradykinesia, postural instability, and upward gaze palsy. Pyramidal signs such as hyperreflexia, Babinski and clonus were also observed on the left side, but a repeat imaging did not reveal hydrocephalus (Figure 3). The diagnosis of secondary parkinsonism was made and levodopa-carbidopa-entacapone was commenced combined with tizanidine. His symptoms showed a dramatic response to the treatment. Serial radiological examinations during the next 10 months demonstrated normal ventricular size and regression of hydromyelia and the drug discontinued after last control, with no parkinsonism (Figure 4).

Figure 4
Figure 4: Follow-up CT (A) and axial T1- (B) and T2- (C) weighted as well as sagittal T1- (D) and T2- (E) weighted MRIs after shunt revision demonstrating regression of hydromyelia and alteration of the signal at the periventricular area

DISCUSSION

Characteristic clinical features of parkinsonian syndrome are mask-like expression, shuffling gait, rigidity and tremor of the limbs and involuntary pill-rolling movements of the fingers (1-5). It may develop in cases with shunt failure during multiple revisions, in addition to those with communicating hydrocephalus (1). So far, only several cases of parkinsonism after shunting for obstructive hydrocephalus have been reported (Table 1) (1-15). The presented unique patient differs from other reported patients in that he also had a hydromyelia extending from C2 to C5 level and tonsillar herniation, consistent with the diagnosis of CM-1. To the best of my knowledge, this is the first case of parkinsonism after shunting for obstructive hydrocephalus, associated with
Pathophysiologically, enlargement of the ventricles due to shunt malfunction or rapid subsequent change of ventricle size during revision may cause disruption and ischemia of the periventricular nigrostriatal dopaminergic pathways, resulting with parkinsonism (1-4,6,9,10,14). As seen in Table 1, there is a history with multiple shunting revisions for obstructive hydrocephalus in the most cases with parkinsonism (1,4,6-8,10,11,15). Pyramidal symptoms probably result from the involvement of corticospinal tract due to ventriculomegaly or overdrainage of the ventricles, but the possibility of surgical injury of the basal ganglia because of the placement of the catheter should also be considered since the findings of parkinsonism are contralateral to the site of catheter.

The availability of MRI has resulted in an increasing number of patients being diagnosed with CM-1 and hydrocephalus secondary to aqueductal stenosis. As did in the case, there are areas of high signal intensity at the levels of the corpus callosum and periventricular white matter on MRI, reflecting the compressive damage inflicted by the hydrocephalus and ischemia; and thus providing an evidence for degeneration of projection fibers in the basal ganglia and thalamus (2,13). In cases with CM-1, surgical technique to restore normal cerebrospinal fluid dynamics is a craniovertebral decompression and duraplasty. Intraoperative US may be used to evaluate the need for duraplasty and the adequacy of decompression, as did in the presented case.

Patients with parkinsonism complicating shunt placement for obstructive hydrocephalus frequently demonstrate a marked response to short-term levodopa treatment (6,8), but the remaining ones remain levodopa dependent, suggesting transient dopamine deficiency in the nigrostriatal tract due to improvement in blood flow of basal ganglia and midbrain (1-4,6,10,11,14). Owing to the rarity of the disease, however, the experience on surgical treatment and adjunctive drugs seems to be very limited.

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**References**


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