This 36-year-old Negro, with neurofibromatosis since childhood, was well until two years ago when he developed a painful mass on his right index finger. This was treated by excisional biopsy and the tissue diagnosis was reported as pleomorphic sarcoma. The mass recurred in 1964 and extended to involve the entire palm. Biopsy was now interpreted as neurofibrosarcoma. There were many neurofibromas and "cafe au lait" spots on the trunk and extremities.

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Diagnosis:
LATERAL INTRATHORACIC MENINGOCELE

Figure 1 reveals a large nodule in the right lung which is considered to be metastatic from the lesion in the right hand. Figure 2A is a spot film of the left dorsal region showing a left paravertebral mass with erosion of the bodies of the seventh, eighth and ninth dorsal vertebrae (Fig. 2B). Because lateral meningocele was suspected myelogram was performed (Fig. 3A and B). This revealed an intrathoracic pouch communicating with the subarachnoid space.

Bunner1 defines lateral intrathoracic meningocele as "a sacciform protrusion of the dura through an enlarged intervertebral foramen which then projects anteriorly between the ribs into the thoracic cavity and displaces the posterior part of the parietal pleura forwards."

A recent review of the subject of intrathoracic meningocele2 lists a total of 37 cases in the literature. All but nine occurred in patients who had Von Recklinghausen's neurofibromatosis. The sex distribution of intrathoracic meningocele is approximately equal. The protrusion occurs more frequently on the right, occasionally being bilateral.3 The meningoceles vary in size from a few centimeters to huge lesions occupying most of a hemithorax. There is usually associated kyphoscoliosis. Erosion of the vertebral bodies, pedicles and ribs is common.

Many meningoceles are asymptomatic and discovered during routine chest roentgenography. In patients with obvious neurofibromatosis, they are often understandably diagnosed as "dumbbell" neurofibromas and the lateral meningocele is discovered at operation. However, paravertebral intrathoracic lesion in a patient with neurofibromatosis is more likely to be lateral meningocele than neurofibroma.1 The diagnosis of lateral meningocele is readily established by myelography, as in the present case.

The nature of the relationship to neurofibromatosis is unclear, and there is ordinarily no neurofibroma in the vicinity of the meningocele. In these respects, the lesion is similar to congenital absence of the orbital roof, pseudarthrosis of the tibia and angular kyphoscoliosis, all of which frequently occur in association with neurofibromatosis.4

REFERENCES