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The author declares that no conflict of interest exists.

CLINICAL SNAPSHOT

Intracranial Hypotension Due to a Large Thoracic Meningocele

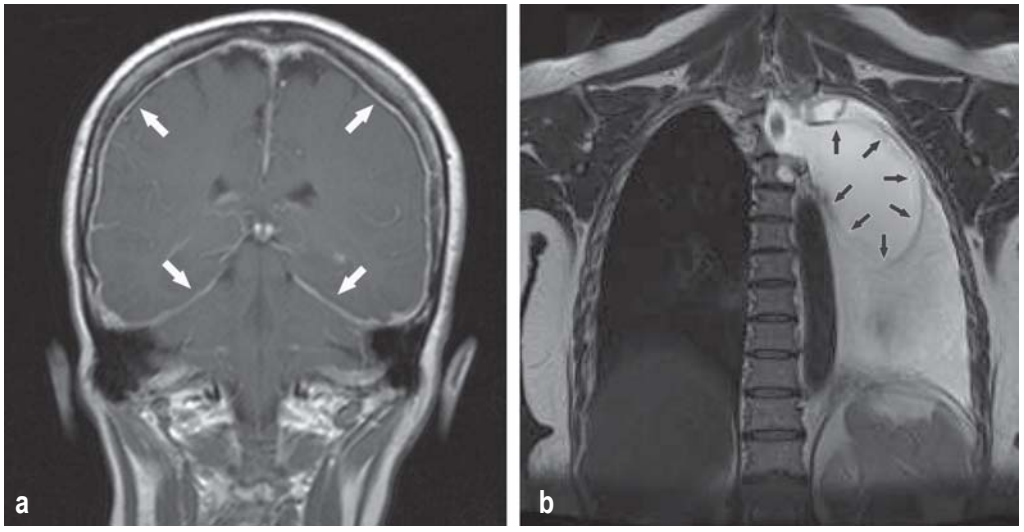

Figure:
a) Following contrast medium administration, cranial MRI shows meningeal enhancement (arrows) on the coronal T1 image.
b) Evidence of a T2 hyperintense protrusion of the spinal canal (arrows) towards the left thoracic side with a maximum craniocaudal extension of 8.7 cm (a pleural effusion can be seen below this; note also the bony defect at the level of T3).

A 51-year-old female was admitted as an inpatient due to diplopia that lasted several minutes and did not vary depending on the direction of gaze. The patient did not complain of other symptoms such as headache. Physical examination revealed no focal neurological deficits and, in particular, no ocular motility disorder. Following administration of contrast medium, cranial magnetic resonance imaging (MRI) revealed meningeal enhancement *(Figure a)*. Lumbar puncture revealed a CSF opening pressure of 0 mmH_2O in the presence of normal CSF findings (no evidence of meningitis or meningeosis neoplastica). Intracranial hypotension resulting from CSF loss syndrome is usually characterized by orthostatic headache, often accompanied by impaired hearing. In addition to meningeal enhancement, cranial MRI frequently : shows subdural hygromas. Finally, a chest MRI provided the causal explanation for the patient's intracranial hypotension, that is, an 8.7-cm left-sided thoracic meningocele originating from T2–4 and extending into the pleural space *(Figure b)*. We respected the wish of the patient—who was still symptom-free after 3 months (in particular, no dyspnea on exertion)—to undergo regular clinical follow-ups rather than surgical treatment.

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