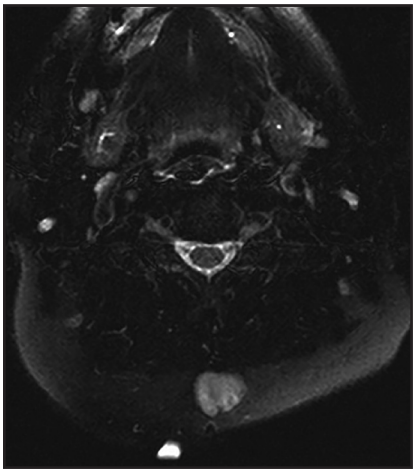

FIGURE 1. *T2 STIR axial sequence at the level of the palpable subcutaneous nuchal nodule demonstrates a 2.2 cm by 1.7 cm well-demarcated rounded lesion superficial to the paraspinal muscular fascia primarily exhibiting T2 prolongation. Superficial to this, susceptibility signal is present at the old surgical incision site.*

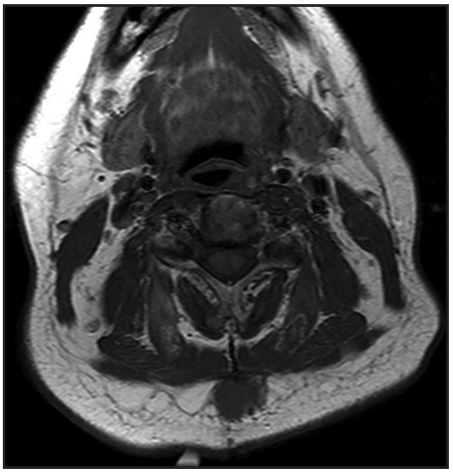

FIGURE 2. *T1 axial sequence through the palpable nuchal nodule shows near-homogeneous T1 prolongation. The margins of the mass are well seen and there is no infiltrative effacement of the adjacent fat.*

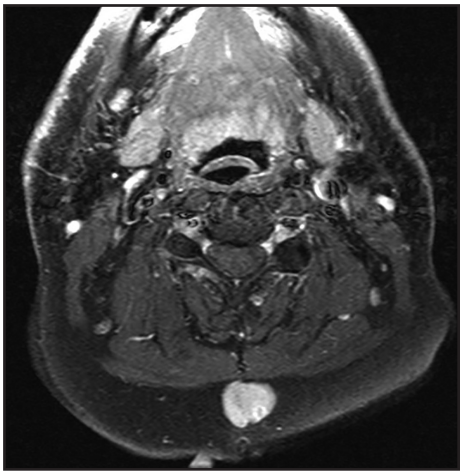

FIGURE 3. *T1 fat-saturated, contrast-enhanced axial sequence shows that the nuchal nodule has diffuse contrast enhancement. There is no enhancing tract within the scar about the nodule.*

with systemic metastases, Eberhart et al[3] reported a 91% rate of bone involvement, 13% soft tissue/lymph node involvement, and a 4% (one case) rate of lung metastasis. Their reported median time to metastasis was 18.5 months, ranging up to 11 years after initial treatment.

With respect to surgical seeding of disease resulting in metastases, several studies implicate ventriculoperitoneal (VP) shunt placement as a risk factor for developing extraneural disease.[2] Only one case report was found describing a case of subcutaneous seeding of medulloblastoma. Galarza[2] et al reports a 6-year-old male patient who was diagnosed with cerebellar medulloblastoma and treated with VP shunting, tumor resection, and craniospinal radiation. Four months later, he presented with new masses in the nuchal area and abdominal wall, both of which were resected and proven to be medulloblastoma metastases. The authors suggested a mechanism of direct implantation during surgery, as the location of disease would be atypical for hematogenous or lymphatic spread.

CONCLUSION

Our patient had an uncommon presentation of medulloblastoma recurrence within a nuchal incisional scar several years after his surgery. To our knowledge this has only been described once in the literature. MRI was useful in characterizing the palpable nuchal mass; however, pathological analysis was necessary to definitively determine the malignant nature of this lesion. This rare case adds to the data that delayed surgical tract metastases can occur even lacking other areas of recurrence, and should be included in the differential diagnosis of a growing palpable scar mass despite a delay between surgery and presentation.

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