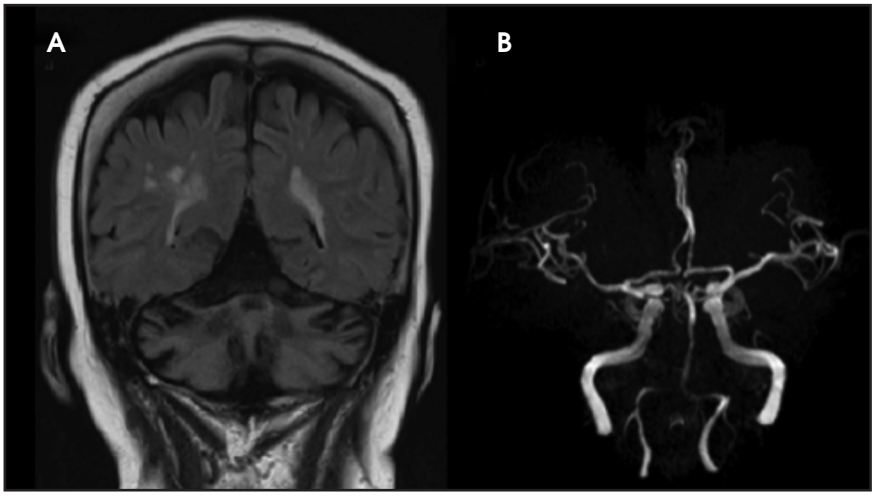

***FIGURE 4**. Coronal T2-weighted FLAIR (A) showed no abnormally high signal intensity within the cerebellum. Incidental finding of leukoariosis and periventricular hyperintensity in keeping with deep white matter ischemic (arrow). Magnetic resonance angiography (B) demonstrates no significant intracranial vasculopathy.*

directed to identify the source of recurrent subarachnoid hemorrhage. Contrast-enhanced MR studies and MRA through the circle of Willis should be obtained. In the absence of an intracranial abnormality, further evaluation should include MR imaging of the spine to look for spinal cord lesions. If no source is identified, further evaluation with conventional catheter angiography may be warranted to exclude a vascular lesion.

Primary differential diagnoses include meningoangiomatosis and neurocutaneous melanosis. Meningoangiomatosis is a rare, benign disease characterized by leptomeningeal calcifications and hamartomatous proliferation of meningeal cells along the leptomeninges and cortex. In neurocutaneous melanosis, on the other hand, multiple cutaneous nevi will be seen. Imaging reveals melanin deposits within the parenchyma and leptomeninges; these deposits appear similar to those in SS.

Assessing clinical outcomes is difficult in light of the disease's slow progression. There is currently no effective treatment; previous attempts to treat with iron chelation have been unsuccessful.[8]

CONCLUSION

Superficial siderosis of the central nervous system is a rare and insidious condition that must be considered in all patients with cerebellar syndrome of unknown cause in order to avoid delays in diagnosis and treatment. Determining the underlying cause is crucial, as eliminating the source of bleeding may halt further disease progression.

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