A 57-year-old man developed over one week gastroenteritis. The patient rapidly worsened, had impaired consciousness and status epilepticus. Because of no response to standard treatment regimens for SE, he was sedated, intubated and admitted in ICU. Neurological examination was limited, due to sedation but showed a left pyramidal syndrome. Biological tests showed hemolytic anemia and thrombocytopenia. Brain MRI (Figures 1–3) findings were consistent with abnormal findings in thrombotic microangiopathy. Surprisingly, ADAMTS13 deficiency and Shiga toxin–secreting strain of *Escherichia coli* were identified. The patient was treated with plasmapheresis. He recovered favorably, radiologic lesions had disappeared at day 34, he was discharged from ICU at day 62.

Thrombotic microangiopathy is defined by arteriolar and capillary thrombosis with characteristic abnormalities in the endothelium and vessel wall. Clinical and paraclinical signs are microangiopathic hemolytic anemia, thrombocytopenia, and organ injury [1]. Posterior reversible encephalopathy syndrome is the most common brain imaging abnormality in severe manifestations of thrombotic thrombocytopenic purpura [2]. Large infarctions and hemorrhage are less frequent. Thalamus, dorsal pons, centrum semiovale and splenium are the most
Figure 1
Axial diffusion weighted imaging (DWI) MRI. DWI showed high signal intensity in the thalami, pallida, left putamen, right caudate nucleus head, insulas and mesencephalus. Axial ADC map (not shown) showed restricted diffusion in corresponding areas.

Figure 2
T2 FLAIR axial MRI. Bilateral white matter hypersignal...
frequently affected structures in haemolytic uraemic syndrome [3]. Treatment is based on plasma therapy and anticomplement therapy [1].

**Contribution of authors**

Pierre Bailly, Gwenaël Prat, Jean-Marie Tonnelier took care of the patient in ICU, wrote the paper. Douraied Ben Salem performed the MRI. He read and corrected the article.

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**References**

