Clinical History
This 9-year-old boy presented with a three-week history of headaches, nausea, vomiting and subsequent neck and back pain. The headaches were described as diffuse, worse when standing and unimproved with over-the-counter medications. He had no major medical problems during his early childhood and had been performing well in school until this episode. He had been followed in Dermatology clinic since infancy for multiple hairy nevi on his extremities, neck and back.

Cerebrospinal fluid laboratory findings at presentation showed 8 white blood cells (with a differential of 93% lymphocytes), 1 red blood cell, a protein of 23 mg per dL and a glucose of 19 mg per dL. The opening pressure of the lumbar puncture was 44 cm of H$_2$O. CSF cultures were negative. Computed tomography of the brain showed no acute intracranial abnormality. Two months later, he developed complex partial seizures and a series of magnetic resonance images showed progressive leptomeningeal enhancement with superficial parenchymal involvement. He underwent a left frontal brain biopsy and insertion of a ventriculoperitoneal shunt for elevated intracranial pressure.

Material submitted: 1 H&E-stained section of the left gyrus rectus.

Points for discussion: What is the diagnosis?