LETTERS

Anticoagulant medication was initiated, followed by prednisone. Visual complaints improved, and the serum inflammatory markers normalized.

DISCUSSION

The diagnostic criteria for TA are mainly clinical; nevertheless, laboratory analysis frequently reveals increased ESR and CRP. Although they are not gold standard, CTA and MRI are useful keys to diagnosis. During the acute phase, inflammatory infiltration affects all layers of the arterial wall, whereas at the chronic phase fibrous tissue replaces the damaged layers and arterial stenosis may develop. Differential diagnoses include other type of large vessel inflammatory vasculitis.

CVT is a disease that also affects younger individuals; however, associated arterial thrombosis is identified in only 10% of the patients. Whilst blood coagulation disorders are important causes of CVT, multiple factors may contribute as a precipitant of venous thrombosis. Despite all the efforts to find its etiology, it remains unidentified in 20% of the patients. Our patient fulfilled four of the six criteria for TA, had radiological imaging suggestive of CVT and was extensively investigated to exclude other conditions.

CVT and TA have clinical similarities which are important to be remembered during the diagnostic work up. Simultaneous presence of CVT and TA is unexpected and raises the possibility of either causal or casual association between these two conditions.

References


Cervical and axial dystonia in a patient with syringomyelia

Distonia cervical e axial em uma paciente com siringomielia

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Abnormal electromyographic activity is commonly found in patients with syringomyelia, but involuntary movements have only rarely been reported.

We have reported the case of a patient with large syringomyelia, who developed cervical and axial dystonia.

CASE REPORT

A 40-year-old woman presented with progressive sensory loss and weakness of the lower limbs, followed by urinary retention. Concomitantly, she developed repetitive
painful involuntary movements of the head, neck, and thoracolumbar region.

Her history was remarkable for pulmonary and meningeal tuberculosis at the age of 35 years. In that occasion, she discovered to be HIV positive.

Neurologic examination revealed reduced pinprick, touch and temperature sensation to the level of C4 on the right, and T2 on the left side of the body. Vibration and joint position senses were absent in the lower limbs, which were plegic and atrophic. Deep tendon reflexes were normal in the upper and absent in the lower extremities. Involuntary jerky movements, primarily consisting of retrocollis and thoracolumbar extension were noticed. Mental status and cranial nerves were normal.

Laboratory evaluation was unremarkable. Brain magnetic resonance imaging (MRI) was normal. Cervical and thoracic MRI disclosed a large septated syringomyelia extending from the cervicothoracic junction to the conus medullaris, with evidence of arachnoid adhesions (Figure). The electromyography showed cervical and axial dystonia.

The patient underwent a T4-6 laminectomy with syringo-subarachnoid shunt. Her neurologic condition remained unchanged two years after the surgery. She received botulinum toxin A in the splenius capitis, deep cervical paraspinal, and thoracolumbar paravertebral muscles bilaterally. She experienced marked improvement of the involuntary movements and pain.

**DISCUSSION**

The patient presented cervical and axial dystonia concomitantly with the onset of progressive neurological signs, which led to syringomyelia diagnosis.

Syringomyelic dystonia has been rarely reported and included cases with torcicollis1,2, dystonia of the legs3, dystonia of the hands and arms4, cervical dystonia5, and blefarospasm1.

The mechanisms of involuntary movements secondary to spinal cord lesions have yet to be fully understood.

Electrophysiological findings suggest a role for damage of α-motor neuron, lesion of spinal interneurons, and damage to descending motor pathways1.

Few cases of syringomyelia as a complication of tuberculous meningitis have been described. There is usually a latent period between the evidence of inflammation and the development of syringomyelic symptoms, which varies between 7 to 28 years. In these cases, arachnoid adhesions and multifocal loculations were often present, which resulted in treatment failures and poor prognosis5.

We described a rare case of dystonia associated with syringomyelia, highlighting the involvement of spinal cord lesions in the genesis of involuntary movements and reinforcing the importance of obtaining a spinal cord MRI when investigating a case of dystonia with atypical presentation.

**References**