Spinal cord and root disorders

**PP2256**

**A case of Sjögren’s disease presenting with transverse myelitis**

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**Objective:** Transverse Myelitis (TM) is a clinical syndrome in which an immune-mediated process causes neural injury to the spinal cord. We here reported a case of Sjögren’s disease presenting with transverse myelitis.

**Case report:** 63-years-old female patient had a history of back pain, difficulty in walking, joint pain and dryness of the eye and the mouth for more than 9 months. In her MR imaging, transverse myelitis was detected between the right paramedian T6-T7 level. High dose steroid (1,000mg/day) treatment was started and the patient was referred to our clinic. In her examination, she had paraparesia and hypesthesia at the legs dominantly at the right side. Schirmer test was 5mm, tear break-up time was 5 seconds. Sjogren’s disease was diagnosed by: RF and Anti La positivity, thoracic transverse myelitis, history of dry eye and mouth along with a positive Schirmer test, artralgias in small joints, morning tenderness and sicca symptoms. After three sessions of 1gr cyclophosphamide therapy, weakness and sensorial complaints had decreased in her follow up.

**Discussion:** TM may occur in patients with Sjögren’s syndrome. CNS Sjögren’s syndrome may present as acute transverse myelitis, regressive myelitis, Brown-Sequard syndrome, neurogenic bladder or lower motor neuron disease. TM appears to be the most frequent form of spinal cord involvement in CNS Sjögren’s syndrome occurring in about 1% of all patients with Sjogren’s syndrome. Retrospective analysis has to be made to determine the real incidence or prevalence of TM in Sjogren’s disease.

**Disclosure:** Nothing to disclose

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**PP2257**

**Lumbar spinal cord fMRI during electrical stimulation of the anterolateral leg**

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**Introduction:** To determine the feasibility and reproducibility of lumbar spinal cord fMRI by electrical stimulation of anterolateral leg and to detect the possible characteristics of lumbar spinal cord fMRI activated areas and signal intensity changes.

**Methods:** All studies were performed at GE1.5T Signa MR, using an eight-channel abdomen coil for RF pulse transmitting and receiving. The skin on the anterolateral leg (L5 sensory dermatome) of twelve volunteers, which have no neurological disease, were stimulated by a electrical stimulator (intermittent pulse, frequency 20HZ) in this study using a single-shot fast spin echo sequence to detect fMRI activation based on SEEP effect. Block design was used as activation patterns, such as R1-S1-R2-S2-R3-S3-R4. The imaging data were analyzed with SPM8.

**Results:** Spinal fMRI activation was found in the lumbar spinal cord in all volunteers (12/12). In the sagittal, activations were mainly located in L1 (10/12), T12 (12/12), T11 (10/12) vertebral level. In the axial, activations were mainly located in the simulative ipsilateral dorsal horn and slight activation were also been found in ventral horn and the contralateral dorsal area. The activation signal intensity changes varied widely ranging from 0.3% to 2.0%, among subjects.

**Conclusions:** It is feasible to study the lumbar spinal cord fMRI based on SEEP effect using the 1.5T MR and a repetitive activation distribution ranged from L1 to T11 was detected in this study. However, further research is needed to prove the accuracy of activation and eliminate the false activations surround the spinal cord causing by CSF pulsation.

**Disclosure:** Nothing to disclose
PP2258

Necrotizing granulomatous polyradiculitis – an unusual presentation of neurosarcoidosis?

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Introduction: The approach to non-structural polyradiculitis represents a diagnostic challenge. It demands an extensive workup for infectious, inflammatory and neoplastic disorders, occasionally requiring a nerve-biopsy. Necrotizing granulomatosis (NG) is a histopathological pattern found in micobacterial/fungal infections, some forms of vasculitis and rarely in sarcoidosis.

Case report: 50 year-old man presented a 5-month progressive bilateral (left-predominant) inferior limb weakness, Obstipation, erectile dysfunction and urinary retention. Neurologic examination: areflexic flaccid paraparesis, unable to walk without bilateral-assistance. Spinal-MRI: lumbosacral-root with contrast-enhancing areas of aglommeration and thickening. Laboratory screening: normal (including angiotensin-converting enzyme/serum calcium/immunological study/HIV). CSF: lymphocytic pleocytosis (27 cells), hyperproteinorrachia (298 mg/dL), negative bacterial/micobacterial/fungal cultures and negative Borrelia burgdorferi/herpes virus-1,2/cytoomegalovirus/Epstein-Barr/Micobacterium tuberculosis PCR. Repeated cytometry analysis: few small lymphocytes. EMG: asymmetric lumbar polyradiculopathy. Thorax/abdomen/pelvis CT-scan: normal (including high-resolution thorax CT-scan). He started corticosteroids with progressive recover. Spinal-MRI was repeated revealing normal features. After a 6-months tapering, treatment was suspended. However, symptoms/MRI abnormalities relapsed after 6-months and a lumbosacral-root biopsy was proposed, disclosing a NG. Corticosteroids were again effective and azathioprine was started as corticosteroid-sparing agent.

Discussion: We present a recurrent corticosteroid-responsive lumbar polyradiculitis. The diagnosis remains uncertain. An infectious etiology was excluded and vasculitis seems extremely unlikely (without systemic involvement/negative immunologic study). Neurologic involvement in sarcoidosis is well-known. Our patient hasn’t symptoms/signs of systemic sarcoidosis, nonetheless neurosarcoidosis may precede this diagnosis in up to 74% and persists an isolated manifestation in 10-17% patients. Literature review found few neurosarcoidosis cases with NG histopathology. So, according to Zajicek criteria, this case may represent a possible neurosarcoidosis.

Disclosure: Nothing to disclose

PP2259

Endovascular treatment of cervical intramedullary arteriovenous malformation – a case report

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PP2260

Subarachnoid hemorrhage secondary to spinal arteriovenous fistula. A case report

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PP2261

A Bickerstaff’s brainstem encephalitis case report: rapid responsive to IVIg and corticosteroid therapy

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PP2262

Abstract withdrawn

PP2263

Spinal cord compression revealing AL amyloidosis: a case report

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PP2264
Relationship between the Sit-to-Stand test and lower extremity muscle strength in ambulatory patients with incomplete spinal cord injury
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PP2265
Subacute combined degeneration in a patient with anti-gastric parietal cell antibodies
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PP2266
Chronic pain and blood serum glycosaminoglycan levels in patients with syringomyelia treated with combination of ceruloplasmin, oxymethyluracil and “Alflutop”
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PP2267
Electrophysiological and histological changes of paraspinal muscles in idiopathic scoliosis
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PP2268
Idiopathic acute longitudinally extensive transverse myelitis and peripheral axonal motor neuropathy in a 37-year-old woman
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