

lower dose IV tPA (0.6 mg per kg), one patient also received intra-arterial tPA and another an emergent extracranial to intracranial bypass [3–5].

Our case report points out a broad controversy concerning incorporation of vascular imaging studies into the decision to give IV tPA. Recent updated guidelines for early management of ischemia recommend vascular imaging at the time of initial brain imaging without guidance for clinicians on how to incorporate this information into the decision to administer IV tPA [6]. The impact of vascular imaging on the efficacy of IV tPA is not clear, as it was not required in the major studies of IV tPA. Various levels of controversy exist concerning administration of IV tPA when imaging demonstrates lack of intracranial thrombus, cervical carotid artery occlusion or dissection, intracranial aneurysm/vascular malformations, chronic aortic arch dissections or moyamoya.

Low quality evidence exists for incorporating these imaging findings into the decision to give IV tPA but for many findings, the results of vascular imaging studies have unclear significance. Our case report adds to the literature in patients with moyamoya and should encourage others to report such controversies.

5. Conclusion

The presence of moyamoya disease may not be an absolute contraindication to intravenous or endovascular revascularization in

<http://dx.doi.org/10.1016/j.jocn.2016.01.016>

hyperacute ischemic stroke and underscores that many perceived contraindications to thrombolytic and mechanical revascularization therapies are relative.

Conflicts of Interest/Disclosures

The authors declare that they have no financial or other conflicts of interest in relation to this research and its publication.

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Post-transplant lymphoproliferative disorder of the cervical spine mimicking an epidural abscess



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ARTICLE INFO

Article history:

Received 13 January 2016

Accepted 17 January 2016

Keywords:

Cervical spine

Epidural abscess

Post-transplant lymphoproliferative disorder

Spinal cord compression

ABSTRACT

Post-transplant lymphoproliferative disease (PTLD) is a recognized complication following solid organ and stem cell transplants with subsequent immunosuppression and is the most common malignancy complicating solid organ transplantation. Improved survival and use of aggressive immunosuppression following solid organ transplants have led to increased diagnosis of PTLD. Nevertheless, spinal involvement in PTLD is extremely rare. To our knowledge, this is the first report of PTLD causing epidural spinal cord compression of the cervical spine, mimicking the imaging and pathology of an epidural abscess. The patient underwent posterior and subsequent anterior decompression and stabilization. Rarity of occurrence of PTLD in the spine with absence of diagnostic imaging features may preclude differentiating it from the more commonly occurring lesions such as epidural abscess which occurs in a similar clinical setting. As the management strategy and overall prognosis are dramatically different, the importance of considering PTLD in the differential diagnosis for epidural spinal cord compression in a transplant recipient patient cannot be overemphasized.

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1. Introduction

Post-transplant lymphoproliferative disease (PTLD) is a heterogeneous group of lymphoid and/or plasmacytic proliferations

occurring in the setting of solid organ transplant (SOT) and hematopoietic stem cell transplant (HSCT) patients following immunosuppression. The incidence of PTLD ranges from 1–16% and depends on the presence or absence of various risk factors [1].

PTLD manifests closer to or in proximity to the allograft in cases of early diagnosis but can present in a variety of organ systems at any time [2,3]. Spinal involvement with PTLD is very rare with only

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one case report of thoracic epidural spinal cord compression secondary to PTLD reported in the literature to our knowledge [4]. We encountered a patient with cervical spinal cord compression from an epidural PTLD lesion, mimicking an epidural abscess.

2. Case report

A 64-year-old man presented to the emergency department with progressive quadriparesis over 1 week. The past medical history was significant for alcoholic cirrhosis requiring an orthotopic liver transplant 11 years prior on continued chronic immunosuppression.

Physical examination was remarkable for presence of a T4 sensory level with a motor strength of 4/5 (Medical Research Council grade) strength in the proximal upper extremities diminishing to 2/5 strength in the hands and complete paraplegia involving the lower extremities. MRI revealed a ventral C5–T1 soft tissue lesion suggestive of an epidural phlegmon with the possibility of an underlying infection (Fig. 1).

The patient underwent emergent posterior C4–C7 laminectomy and decompression followed by C3–T1 posterolateral fusion. Purulent phlegmon was observed and evacuated. Secondary to minimal improvement and subsequent early post-operative neurologic decline, the patient underwent anterior decompression and fusion



Fig. 1. Pre-operative sagittal T1-weighted (A) and T2-weighted (B) MRI illustrating a C5–T1 stenosis and ventral epidural lesion, hypointense on T1-weighted and T2-weighted imaging with enhancement on the sagittal post-contrast MRI sequence (C). An axial T2-weighted MRI (D) at the level of C6–C7 showed severe spinal canal stenosis.

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