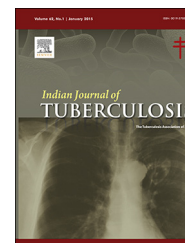


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Case Report

A lengthy primary intramedullary tuberculoma of the spinal cord extending from C4 to D8: A case report

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ABSTRACT

Spinal intramedullary tuberculoma is a rare cause of spinal cord compression. We report a case that had an intramedullary spinal cord tuberculomas where the diagnosis was made by MRI and biopsy. The clinical presentation was that of a cord compression in a 30-year-old male febrile patient. This case of intramedullary spinal tuberculoma with a longitudinally extending lesion of the cervicothoracic spine from C4 to D8 is presented for the rarity of its presentation.

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1. Background

This case of intramedullary spinal tuberculoma (IMST) with a longitudinally extending lesion of the cervicothoracic spine from C4 to D8 is presented for the rarity of its presentation. Generally, IMST occur usually in young people and most commonly involve the thoracic spinal cord.¹ The most common site of involvement was dorsal cord followed by cervical, cervicodorsal, and dorsolumbar regions.^{2,3} Spinal cord compression can be due to various causes, but IMST is a rare cause. In this case of IMST, the diagnosis was confirmed by radiological, cerebrospinal fluid analysis, and by biopsy.

2. Case report

A 30-year-old male, HIV-negative patient presented with acute onset of numbness from the level of mid thorax with history of tight band-like constricting sensation over mid thorax with shock-like radiating pain over the lower back since more than 45 days with history of stiffness of both the lower limbs. The patient developed progressive weakness of both lower limbs with tripping of toes and spasms of both lower limbs over a period of 45 days with bladder disturbances. The patient had low-grade fever for last 2 months with evening rise of temperature.

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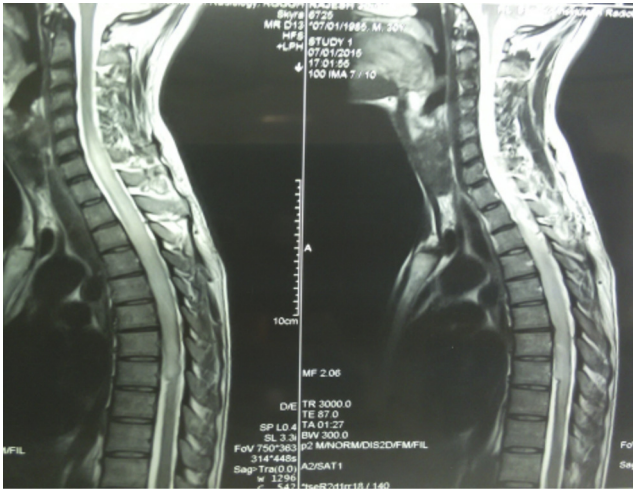


Image 1 – MRI showed cord expansion with T2 hyperintensity noted from level C4–D8.

On examination, the patient was afebrile, vitals were normal. Cardiovascular, respiratory, and abdominal examinations were normal. The patient's higher mental function examination was normal and had no meningeal signs. The cranial nerves and fundus were normal. The tone was increased in both lower limbs with a pyramidal pattern of weakness in both lower limbs with exaggerated deep tendon reflexes from the C5 level with bilateral plantar extensor and

absent superficial reflexes. All modalities of sensation were reduced below D4 level.

The blood investigations were done; the complete blood count, and renal and liver function test serum B12 levels were normal. The patient had a positive Mantoux (15 mm). CSF analysis showed elevated protein 750 mg, sugar 88, the cell count was nil, and gram stain-negative and oligoclonal band were negative. MRI was done and found to have a cord expansion with T2 hyperintensity noted from level C4 to D8 (Images 1–3). The T2WI signal was weak in most of the central part and had enhanced margins in a rim shape. A collarette-like weak signal could be observed in the exterior margin, with sharp margins and “target sign” change. In addition, the lesion showed intense homogeneous enhancement on contrast from lower D4 to D8 and on MRS showed a lipid peak.

In addition to anti-TB treatment, the patient underwent a C6–D8 decompressive laminectomy with midline myelotomy and excision biopsy of the lesion. On histopathology, the tissue biopsied showed extensive areas of caseation necrosis with scattered population of epithelioid histiocytes, lymphocytes, plasma cells, and few neutrophils suggestive of tuberculous pathology.

3. Discussion

The spinal tuberculosis constitutes a very common form of nonpulmonary tuberculosis and by far the most common granulomatous spinal infection. The first case of IMST was reported in 1828 by Albercombe.¹ Generally, most of the

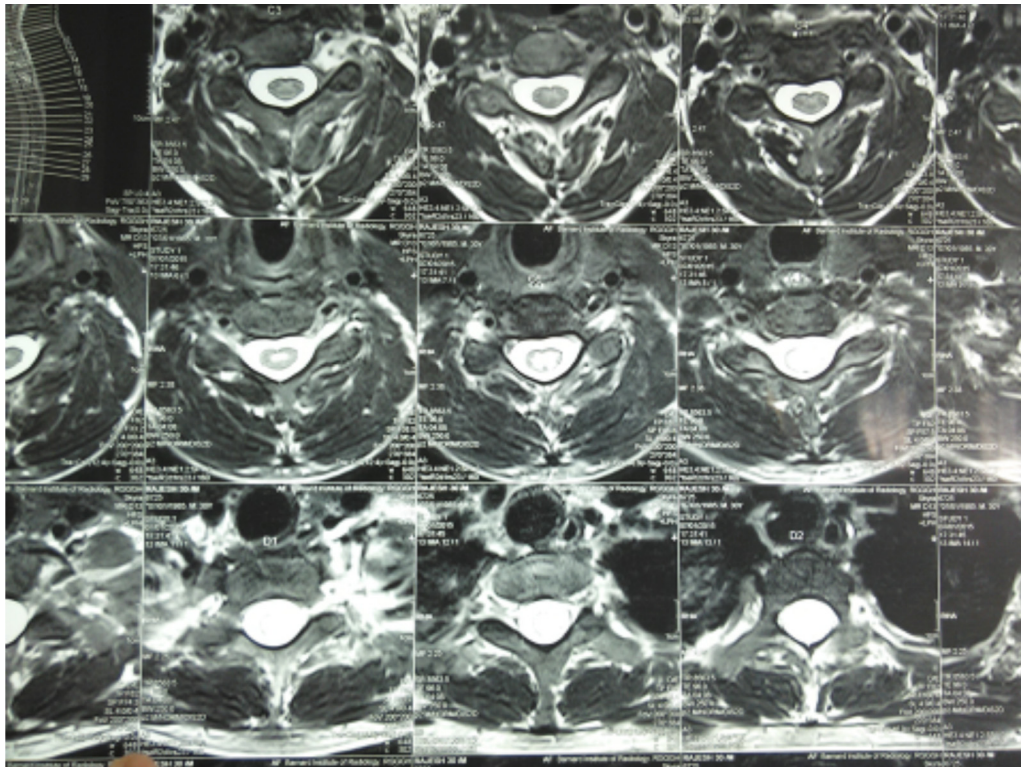


Image 2 – IMST had characteristic 'Target sign'.

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