84 years). There was a slight male predominance in the reported patients (n = 10). All cases in which the subtype was reported (n = 6) were nodular sclerosis type [2]. Our patient is unusual in that he represents the first case of mixed cellularity HL presumably presenting as a primary CNS tumor to our knowledge. In regard to location, six out of 16 tumors presented in the cerebellum and six cases arose in various lobes [2]. Our patient's tumor presented in the left cerebellum. The current patient demonstrated Epstein-Barr virus (EBV) positivity via *in situ* hybridization. Seven other patients in the literature were assessed for EBV association; two patients showed immunoreactivity for EBV latency-associated protein and four out of five patients showed positivity by *in situ* hybridization for EBV [2].

The most common treatment approaches have included radiation therapy, either localized or whole brain, after resection (n = 12) [2]. Three patients underwent chemotherapy treatment in conjunction with radiation therapy. In 90% of patients, there was no evidence of disease at follow-up (range 1 month–10 years; median 12 months). Only one recurrence has been reported at 14 months after combined chemotherapy treatment [2]. Our patient received whole brain radiation following resection with no evidence of recurrent tumor at his 7 month follow-up.

Due to differing prognosis and treatment, it is important to distinguish HL from other CNS lymphomas such as diffuse large B cell lymphoma, which account for the majority of primary CNS lymphomas. It is also important to ensure that there is no evidence of lymphoma elsewhere in the body.

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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Clinical presentation and treatment considerations of a ruptured posterior spinal artery pseudoaneurysm

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ABSTRACT

Spinal artery pseudoaneurysms are rare vascular lesions with poorly defined natural history, diagnostic paradigms, and treatment strategies. We present a 68-year-old woman with severe back pain and left lower extremity weakness with spinal subarachnoid hemorrhage due to a ruptured T5 region posterior spinal artery pseudoaneurysm, and review issues related to radiologic diagnosis and endovascular and open neurosurgical interventions.

1. Introduction

Spinal artery pseudoaneurysms are rare vascular lesions of the craniospinal axis typically caused by inflammatory vasculopathies, spondyloarthropathies, and trauma. Natural history data, diagnostic paradigms, and treatment strategies are poorly defined for these lesions, as only 10 patients with ruptured posterior spinal artery (PSA) aneurysms have been published to our knowledge [1,2]. We present a 68-year-old woman with increasingly severe back pain with left lower extremity weakness and paresthesias who was found to have thoracolumbar spinal subarachnoid hemorrhage (SAH) due to a ruptured pseudoaneurysm of the PSA at the T5 level arising from a right T7 segmental artery.

2. Case report

2.1. History and examination

A 68-year-old woman presented to her local emergency department with 10 days of severe, sharp low back pain that developed suddenly during physical exertion. Initial MRI of the thoracolumbar spine demonstrated a thoracic intradural lesion (Fig. 1A–C) and lumbar SAH (Fig. 1D–F). The patient was transferred to our institution, where her neurologic examination was notable for 4+/5 strength throughout the left lower extremity and diminished sensation to light touch along the left medial calf and foot. There was no clonus and her Babinski reflex was negative.

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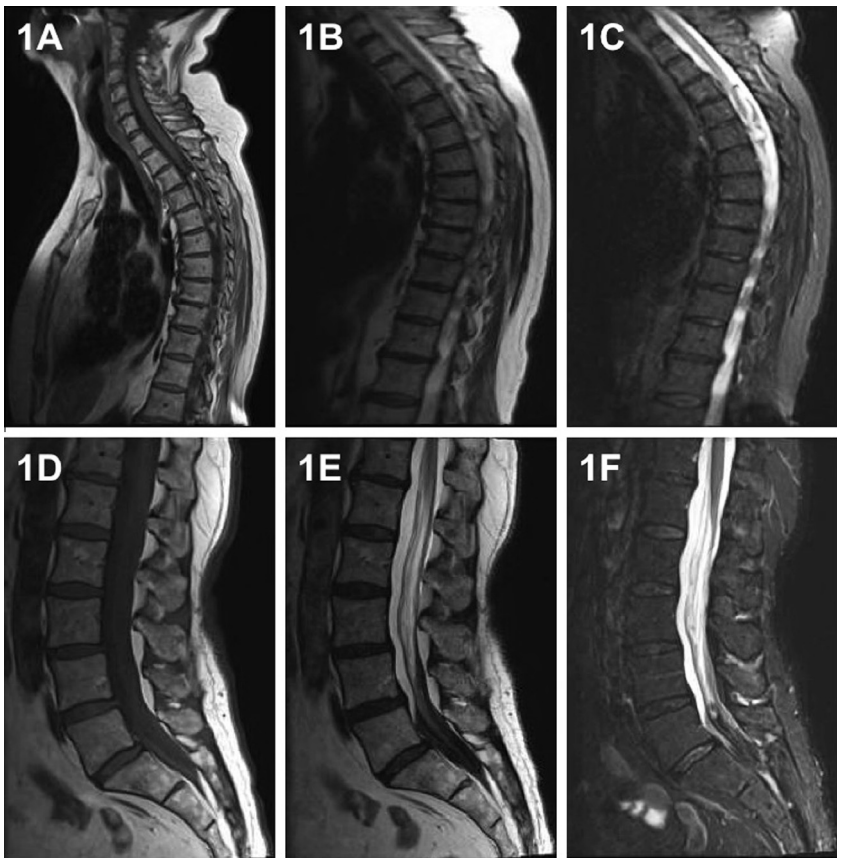

Fig. 1. Sagittal T1-weighted (A), T2-weighted (B), and short T1 inversion recovery (STIR) (C) MRI of the thoracic spine demonstrating T1-weighted hyperintense/T2-weighted hypointense early subacute spinal subarachnoid hemorrhage (SAH) at the T3–T6 levels. Sagittal T1-weighted (D), T2-weighted (E), and STIR (F) MRI of the lumbar spine demonstrating layering T1-weighted hyperintense/T2-weighted hypointense early subacute spinal SAH at the L5–S1 junction.

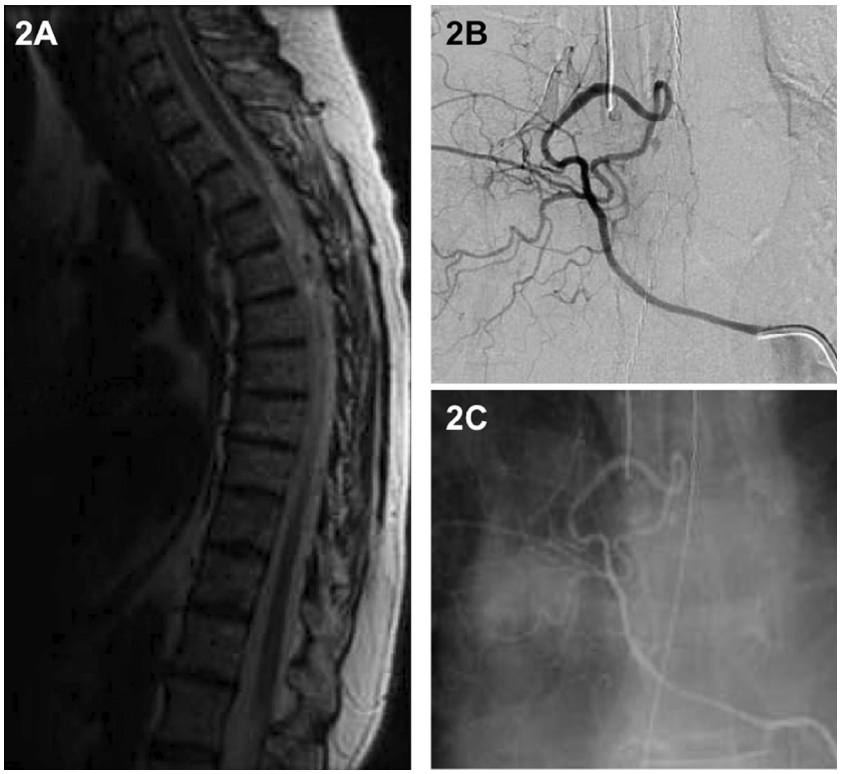

Fig. 2. (A) Sagittal dynamic magnetic resonance angiography contrast-enhanced image of the thoracic spine demonstrating a right paramedian 3 mm fusiform pseudoaneurysm at the T5 level. Catheter spinal digital subtraction angiography (B) and digital spinal angiography (C) images of a right T7 segmental artery catheter injection demonstrating a right paramedian 3 mm fusiform pseudoaneurysm located at the T5 level. No arteriovenous shunting was appreciated.