Hematomyelia in Systemic Lupus Erythematosus and Secondary Antiphospholipid Syndrome: Case Report

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Introduction

Central nervous system hemorrhage is a rare and potentially lethal complication. It occurs with a greater frequency in the intracranial zone and is mainly intracerebral or subdural. Intraspinal hemorrhage is much less common, can be epidural, subdural, subarachnoid, or intramedullar, and can have devastating consequences. Intramedullar hemorrhage, also known as hematomyelia, is the rarest form of intraspinal hemorrhage.

From the first report of “spontaneous hematomyelia,” published by Richardson in 1938, some cases have been reported but its incidence has not been established. The term “spontaneous” makes reference to hemorrhage that is not related to trauma, vascular malformations (VMF), or tumors, and in most cases was associated with a hemorrhagic diathesis or anticoagulant treatment.

We present the case of a patient with systemic lupus erythematosus (SLE) and secondary antiphospholipid syndrome (SAPS) who developed hematomyelia, possibly as a complication of anticoagulant treatment.

Clinical Case

A 43-year-old woman, whose mother had SLE and 2 cousins had rheumatoid arthritis, presented a case of deep venous thrombosis of the left leg at 37 years of age and 1 month later, deep venous thrombosis of the right leg. Simultaneously, the patient presented symmetric polyarthritis, oral ulcers, hair loss, positive antinuclear antibodies, anti-dsDNA, anti-Sm, and IgG anticardiolipin antibodies, as well as hypocomplementemia, lymphopenia, and renal affection with an OMS stage IIb glomerulonephritis, with which a diagnosis of SLE and SAPS was reached. She received treatment with steroids at a low-to-medium dose, chloroquine 150 mg/day, azathioprine up to 100 mg/day, pentoxifilline, and anticoagulation with acenocumarine at variable doses, achieving an adequate control. Three years later she presented renal reactivation and was treated with 6 intravenous boluses of cyclophosphamide, showing improvement, managed afterward with prednisone 10 mg/day, azathioprine 100 mg/day, and acenocumarine. In April 2006 she consulted her rheumatologist because
of headache and paresthesias on the face, sudden pain on the neck and back, and, after some hours, a loss of muscle force on the legs, oppressive chest pain, anesthesia from the T4 level downward, acute urinary retention, sphincter incontinence, abdominal distension, and, finally, paraplegia. Upon hospitalization she presented lymphopenia, 160/µL; platelets, 248,000/µL; INR, 1.16. A transverse myelitis was suspected for which she was treated with 6 g of intravenous methylprednisolone and 1 g of intravenous cyclophosphamide, and sent to our hospital. When examined we found generalized, burning pain, without sphincter control, with conserved superior mental functions, with hair loss, unaffected cranial nerves, a sensitive level at T4, with right upper extremity muscle strength of 2/5 proximal and 4/5 distal; on the upper left extremity, 4/5 proximal as well as distal; the rest was paraplegic. She had no Achillean reflex; she presented a left Babinski sign but it was indifferent on the left side.

The blood count showed: hemoglobin, 9.4 g/dL; hematocrit, 28%; leucocytes, 5050/µL; lymphocytes, 210/µL; platelets, 65,000/µL. Blood chemistry was normal. A 24 hour creatinine clearance of 41 mL/min was documented; triglycerides, 325 mg/dL; liver function tests were normal; C3, 67.8; C4, 6.31; acute phase reactants with a erythrocyte sedimentation rate of 56 mm/h; and a C-reactive protein of 47.9 mg/L was found. Coagulation tests showed TP, 20.8; TPT, 23; INR, 2.1. Urine testing showed a pH of 6, leucocytes 0-5 per field, erythrocytes 10-15 per field, abundant bacteria, nitrates (+). An spinal tap found thick, port–red wine colored liquid without an increase in pressure, erythrocytes, 531,200; leucocytes, 310; proteins, 2756 mg/dL; LDH, 2616; glucose, 8 mg/dL; coagulability (–), hemoglobin (+++); MEX-SLEDAI, 7.

A cranial computerized tomography (CT) was normal. On the magnetic resonance (MRI) there was a medullar widening, a homogeneous intramedullar T1 and T2 homogeneous hyperintensity, corroborated on the axial cuts with heterogeneous images and medullar displacement. The most frequent localization in children is C5-T1, different from adults, more frequently found at a low cervical level. 7,8 Hematomyelia clinically presents as an abrupt medullar syndrome, with high-intensity pain, localized or in a radicular distribution, acute or related with a sensomotor deficit, which is associated to sphincter atony. It is rapid in its onset and evolution, making a prompt diagnosis and opportune treatment of the utmost importance. 4,9-11

Discussion

Intraspinal hemorrhage is infrequent and intramedulla hemorrhage or hematomyelia is the rarest form of intraspinal hemorrhage. 1-4 There are very few reports of hematomyelia in the medical literature, most in relation to anticoagulant treatment. The male:female ratio has been established at 1.5:1, and is described more frequently between the sixth and seventh decades of life, this attributed to a larger use of anticoagulant in this age group. 4 Among the predisposing factors, anticoagulation, trauma, arteriovenous malformations, tumors, and hemorrhagic diathesis can be included. 4-6 The most frequent localization in children is C5-T1, different from adults, more frequently found at a low cervical and thoracolumbar level. 7,8
Diagnostic suspicion of the disease is fundamentally based on clinical findings and must be considered in all patients presenting a case with medullar topographical localization installed in an acute or hyperacute manner, and in which a traumatic cause has been ruled out. Sudden pain accompanied by a medullar neurological deficit of rapid installation and a history of therapeutic risk factors firmly contributes to the diagnosis. Among the complementary tests that must be performed, MRI is superior to CT. Typical findings consist of hyperintense images both on T1 as on T2, medullar widening, and even an image showing medullar compression. Treatment of the intraspinal hemorrhage, apart from treating the cause, must consider complications left by the myelopathy and the attempt to surgically excise the lesion as soon as possible. Prognosis depends on the rapidness of surgical decompression and, overall, on the neurological state before the surgery, though the eventual possibility of complications must be considered, such as hemorrhage and irreversible lesions in patients in which a rapid evacuation is not carried out.

There are no reports in the literature of patients with SLE or SAPS and hematomyelia. A total of 8 cases of acute, spontaneous hematomyelia, 2 of them in newborns, 1 after a spinal tap, can be found, and the other one was secondary to obstetric trauma. Another 6 cases were related to anticoagulant therapy, as apparently our patient was and, finally, Matsumura et al described 2 cases of chronic, progressive, and idiopathic, surgically treated and with a good outcome, indicating that acute and chronic presentations have a different prognosis because the evolution of the patients with spontaneous hematomyelia associated to anticoagulation was generally poor as happened to our patient. It is important to point out that, among the published cases of hematomyelia associated to anticoagulation, most were in an adequate range of anticoagulation according to the INR.

Anticoagulant treatment was immediately suspended in our patient, though excessive anticoagulation was never evidenced. She underwent a hemilaminectomy which showed a thoracic hematoma with spinal degeneration and a bad subsequent course, not regaining muscle strength or sensibility.

Intramedullar spinal hemorrhage is extremely rare and anticoagulant treatment is an important risk factor for this complication. Clinical suspicion, an opportune diagnosis using MRI, and a timely intervention are essential in attaining a better neurological prognosis.

References