

CASE 12

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A black male, 67, noted weakness, anorexia, intermittent headache and fever for three months prior to admission but sought no treatment. For three weeks prior to admission he noticed neck pain aggravated by movement and radiating into both shoulders and hands. On the day of admission he awoke with severe neck pain, paraplegia, and incontinence. Examination showed flaccid paraplegia, nuchal rigidity, weakness and questionable fasciculations of upper extremities. There were no deep tendon reflexes or pathologic reflexes in the lower extremities. Lumbar puncture opening pressure was 150 mm. The cerebrospinal fluid was cloudy and contained 1200 WBC per cu. mm. (98% neutrophils) and 320 RBC per cu. mm. Protein was 109 mg. per 100 ml. No organisms were seen. Hemogram showed hematocrit 35, hemoglobin 11.8 gm. per 100 ml., WBC 12,400 per cu. mm. (80% neutrophils). STS was negative. BUN was 22, and FBS was 99 mg. per 100 ml. Anesthesia was present below T6 level and hypesthesia extended from T4 to T6. Myelogram showed a block at T1. Laminectomy from T1 to T3 was done on the day of admission. The upper thoracic cord was softened and swollen. Death occurred two days later.

Past medical history included two myocardial infarctions from which he recovered without residuals and an automobile accident resulting in neck pain, but no other disability, three years prior to admission.

Autopsy showed hemorrhagic softening of the spinal cord from C6 to T4, left ventricular myocardial hypertrophy and toxic splenitis.

Slides are of myocardium and C8.