The man with hemi-cape dysesthesias

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A 28-year-old right-handed man presented with a 3-month history of persistent right arm, chest, and shoulder burning pain. He reported a history of a 20-foot fall onto his back 5 years prior, but did not identify any temporally related events at the onset of his progressive dysesthesias. He denied any history of headaches, neck pain, back pain, or bowel and bladder dysfunction.

Examination was normal except for decreased sensation to pain, temperature, and light touch of the right arm, right upper chest, and right scapular region. Reflexes were absent in the right upper extremity and 2+ in the left upper extremity and bilateral lower extremities with flexor responses bilaterally.

MRI of the cervical, thoracic, and lumbar spine with and without contrast confirmed the diagnosis of a cervical syrinx (figure). There was no evidence of a Chiari malformation, spinal cord malignancy, vascular malformation, tethered cord, or residual evidence of spinal trauma.

The classic findings associated with a cervical syrinx are loss of pain and temperature in a cape-like distribution. Contrary to this popular clinical dogma, patients can present with unilateral symptoms if the syrinx is eccentric.^{1,2} Reflexes are often absent at the level of the syrinx.²

The pathophysiology of traumatic syringomyelia is poorly understood.¹ Investigation of other potential etiologies, particularly Chiari malformations, spinal cord malignancy, vascular malformations, and tethered cord, is essential in guiding appropriate management.¹

Figure MRI of the cervical and thoracic spine

(A) Sagittal T2-weighted MRI cervical spine shows syringomyelia ascending to the level of the C1 vertebra. (B) Sagittal T2-weighted MRI thoracic spine shows syringomyelia descending to the level of the T6 vertebra. (C) Axial T2-weighted MRI cervical spine at the level of the C2 vertebra shows syringomyelia eccentric to the right.

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