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Neurology

LERICHE SYNDROME PRESENTING AS ANTERIOR SPINAL ARTERY SYNDROME

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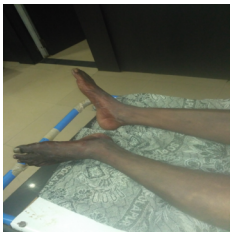
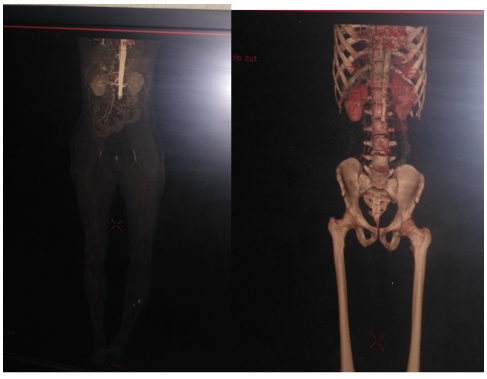
ABSTRACT Leriche syndrome is a rare clinical entity . A 35 year old male patient with history of chronic smoking and alcoholism presented with acute onset paraplegia with sensory and autonomic involvement ,was evaluated initially as transverse myelitis , but eventually patient developed dry gangrene and CT aortogram suggestive of aorto- iliac occlusive disorder. A careful clinical examination and high index of suspicion is therefore essential to avoid misdiagnosis of major vascular event which can result in significant mortality and morbidity

KEYWORDS : ASA -anterior spinal artery, AIOD-aorto-iliac occlusive disorder, LMWH- low molecular weight heparin

CASE REPORT

A 35 year old male patient presented to casuality with acute onset bilateral lower limb weakness, with sensory loss and bowel and bladder involvement for preceeding four hours with no history of trauma. . On examination , power of lower limbs (from hip) is grade 0/5 with absent reflexes. On sensory examination ,there is complete loss of sensations from the level corresponding to T 12 with stable vitals. For above complaints patient was provisionally diagnosed as acute transverse myelitis and planned for MRI spine. Routine blood investigations showed polycythaemia with haemoglobin 19 gm/dl with normal renal and liver function tests, serum electrolytes. Shortly afterwards with in a span of 2 days , patient developed gangrene of both lower limbs which was gradually progressive. on careful prodding patient had intermittent lower limb pain on exertion now with painful paraplegia. Doppler study of both lower limbs showed bilateral echogenic thrombus in both femoral arteries extending into iliac artery with reduced flow. Immediately patient was started with low molecular weight heparin, antiplatelets and statins. CT aortogram showed complete occlusion of infrarenal aorta with thrombosis upto common femoral arteries.





In view of acute onset long segment thrombus, cardiologist and cardio-thoracic vascular surgeon opinion was taken. As patient developed gangrene surgery was not planned and they adviced for thrombolysis. After thrombolysis , antiplatelets and LMWH were continued along with adequate hydration. Despite of all above measures, his overall condition remained dismal with persistent paraparesis.

DISCUSSION

usually occlusive disorder in the lower extremities classically occur in three anatomic segments: the aortoiliac segment, femoral-popliteal segment, and the infrapopliteal or tibial segment of the arterial tree. Lesions in the distal aorta and proximal common iliac arteries classically occur in white male smokers aged 50–60 years. Disease progression may lead to completeocclusion of one or both common iliac arteries, which can precipitate occlusion of the entire abdominal aorta to the level of the renal arteries.

The pain from aortoiliac lesions may extend into the thigh and buttocks and erectile dysfunction may occur from bilateral common iliac disease. Rarely, patients complain only of weakness in the legs when walking, or simply extreme limb fatigue. The symptoms are relieved with rest and are reproducible when the patient walks again. Femoral pulses are absent or very weak as are the distal pulses. Bruits may be heard over the aorta, iliac, and femoral arteries.

Thrombosis of aorto-iliac segments is usually a chronic condition presenting with lower limb claudication, but even with presentation of acute onset paraparesis with bowel bladder involvement and sensory involvement ,one should have the suspicion of long vessel occlusive disorder and for every case , peripheral pulses should be examined carefully. Major risk factors are dyslipidaemia, male gender, smoking, diabetis mellitus, and hypertension.

CONCLUSION

Though the case presenting here hasn't improved completely, through this case report we would like to emphasize the need for careful history seeking risk factors and thorough clinical examination especially of peripheral pulses examination. For any case of acute onset paraplegia, AIOD should be differential diagnosis and in view of high mortality and morbidity, it should be sought out immediately even with the help of imaging techniques if needed.

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