

Bilateral arm weakness, think extracranial! a case report of spinal cord infarction

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Out of all ischemic neurological injuries that we encounter on an almost daily basis in emergency departments, only 1-2% are spinal cord infarctions. As a leading cause of disability and one of the leading causes of death, stroke has always been a top concern emergency. In this report we present a case of a 52-year-old Asian female with a history of hypertension and cervical spondylosis, presenting with sudden bilateral arm weakness and numbness. She also complained of chronic neck pain but a recent numbness. Neurologic examination showed upper extremity power of 3/5 on the right and 4/5 on the left. In addition to a restricted active range of motion bilaterally. There was also tenderness of cervical spines C5 and C6, hyporeflexia in the upper extremities, and reduced tone bilaterally. Pulses were intact with good capillary refill time but were asymmetrical. For this reason, our vascular team did a bedside doppler of the upper extremities, which exhibited no abnormality. Examination of the lower extremities showed hyperreflexia, normal tone, and power, and no clonus with equivocal plantar reflexes bilaterally. No cerebellar signs were noted and gait was normal. Computed tomography (CT) and magnetic resonance imaging (MRI) of the brain showed no acute pathology. MRI of the spine was done which showed a constellation of findings consistent with an acute long segmental cervical cord infarct extending from C2-C3 to C5-C6. The patient was transferred to a stroke center where she was managed medically and discharged on Aspirin 100 mg once daily and Atorvastatin 40 mg once at bedtime with outpatient physiotherapy and neurology follow-up.