



Rehabilitation and Medical Management of a Patient with Transverse Myelitis Secondary to Sjögren's Syndrome: A Case Report

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Case Description

- 39-year-old woman with a year-long history of pain and numbness in her neck and right arm attributed to myofascial pain presented with progressive neck pain and right greater than left sided weakness.
- MRI revealed evidence of transverse myelitis extending from C2-T2. Cerebrospinal fluid analysis was indicative of inflammation, and she was started on methylprednisolone.
- Serologic testing revealed Sjogren's antibody Ro60 to be elevated. Thus, the cause of her neurologic deficits was attributed to primary Sjogren's Syndrome (pSS).
- She eventually underwent 5 rounds of plasma exchange because her initial course of steroids did not prove effective.
- She started a short course of rituximab per rheumatology, and she was maintained on prednisone until follow-up with neurology and rheumatology.
- Upon admission to acute inpatient rehabilitation, she was requiring at least moderate assistance for most mobility and self-care tasks, but she progressed to being independent in most areas prior to discharge.

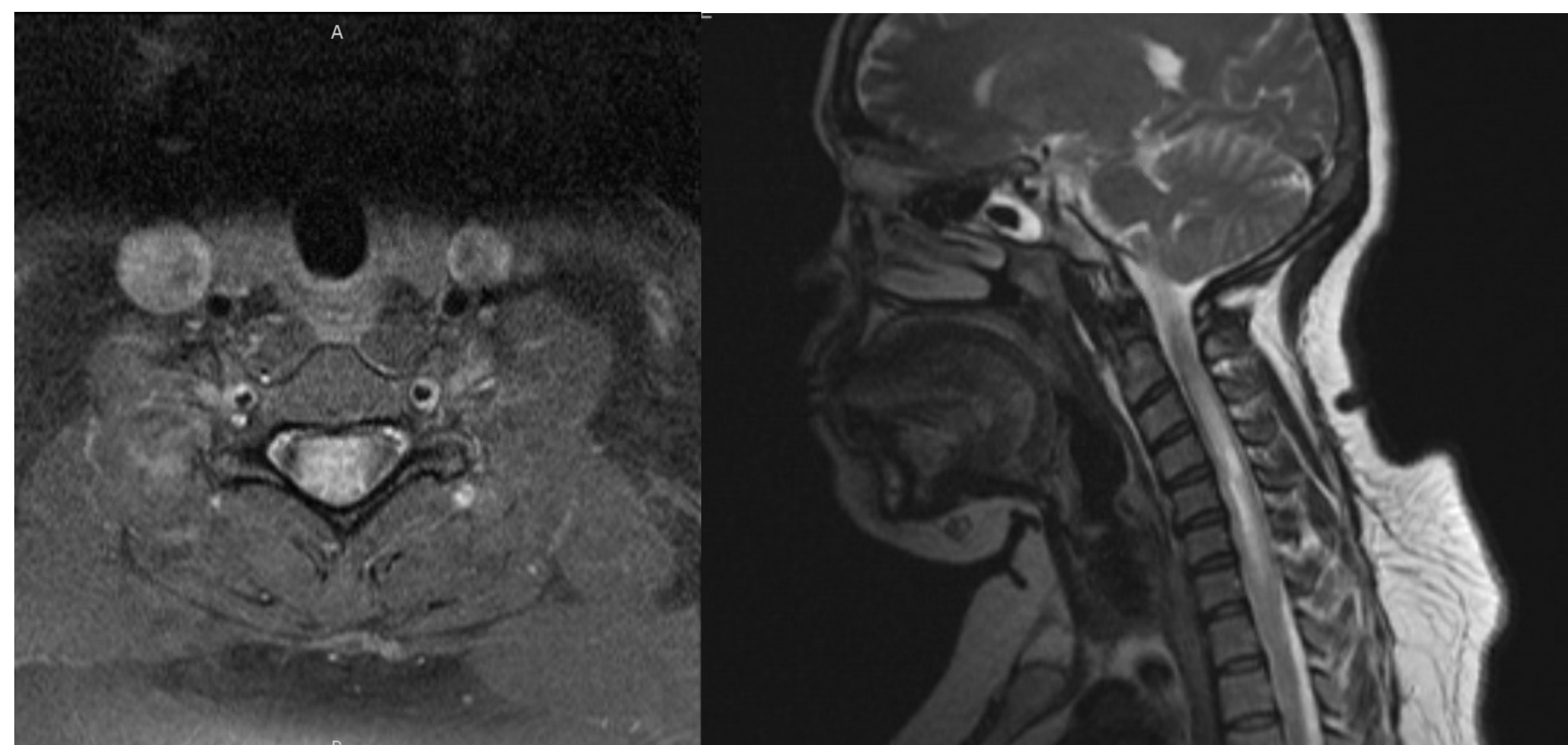
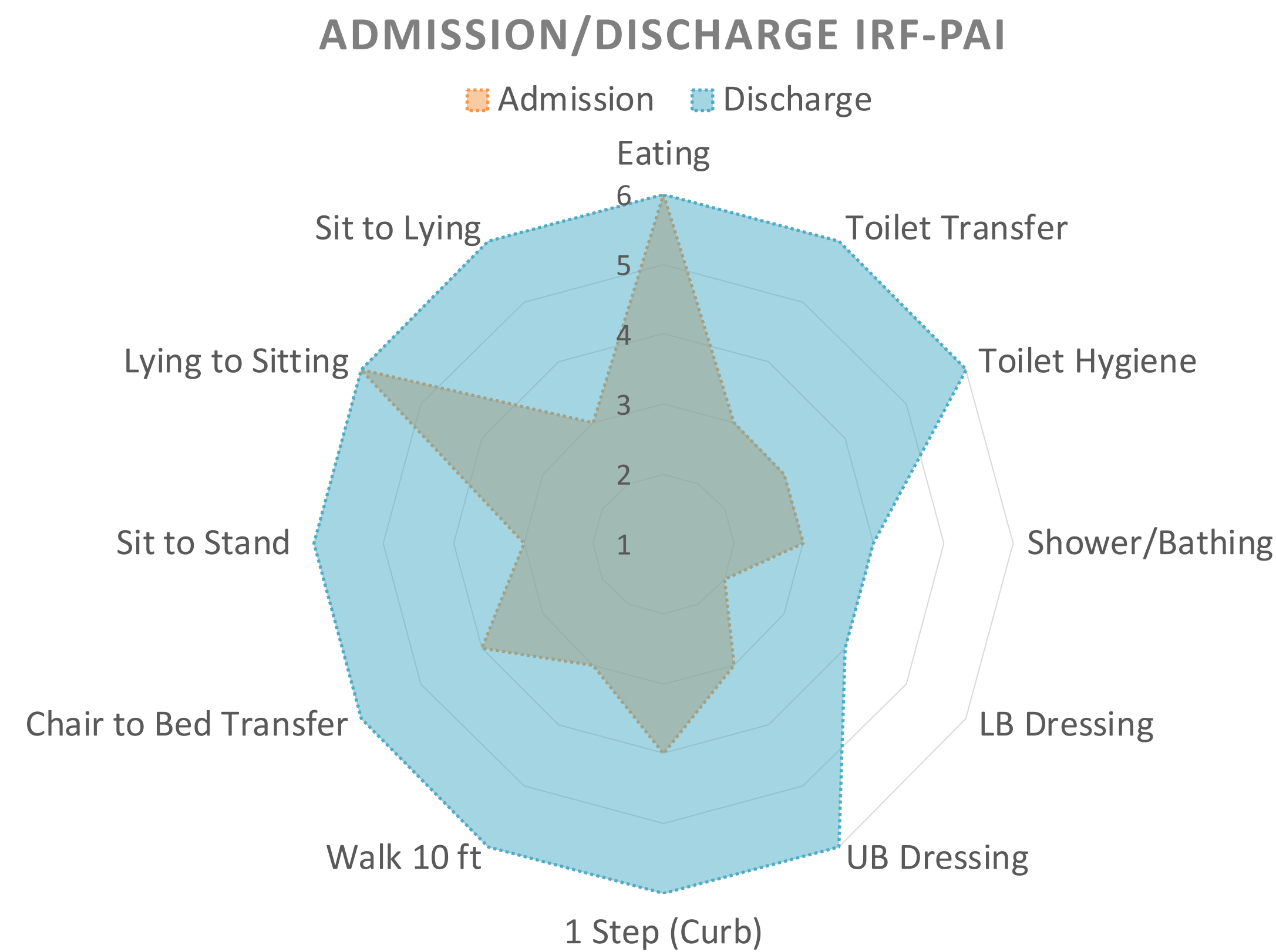


Image Description (MRI Cervical Spine)

Diffuse signal abnormality, enhancement, and marked enlargement of the cervical spinal cord extending from the level of C2 to T2. At both its caudal and cephalad margins, the enhancement has indistinct margins and primarily involves the central cord.



Discussion

- Cases of neurologic complications of pSS have been reported with a prevalence of up to 20% among those diagnosed with pSS.
- However, most cases are reported as affecting the peripheral nervous system (5-20%) instead of the central nervous system (1-5%).
- Given the rarity of CNS cases, treatment protocols are based mostly on expert opinion.
- Thus, it is a combination of IV corticosteroids, plasmapheresis, and long-term immunosuppression.
- The long-term immunosuppression and plasmapheresis are utilized mostly when empirically treating for NMO and NMOSD, which can overlap with pSS.

Conclusions

- Spinal cord injury secondary to rheumatologic disorders is an infrequent cause of non-traumatic spinal cord injury, but one that cannot be overlooked as it is treatable. Cases like this highlight how proper work-up, treatment, rehabilitation, and care coordination are crucial to ensuring the best functional outcomes for patients.

References

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