Recurrent longitudinal myelitis as primary manifestation of SLE

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A 19-year-old woman presented with fever, neck pain, weakness of both legs, urinary retention, nuchal rigidity, quadriplegia, and a T6 sensory level. MRI showed hyperintensities (T2-weighted) of the entire spinal cord (figure), consistent with acute longitudinal myelitis (ALM). Laboratory studies confirmed the diagnosis of systemic lupus erythematosus (SLE) with antiphospholipid antibody syndrome (APS). A complete remission occurred after treatment with methylprednisolone and IV immunoglobulins. Symptoms recurred 13 months later; treatment was repeated, followed by cyclophosphamide.

The *continuous* involvement of spinal cord segments, or ALM, may be related to APS[1,2] and distinct[2] from acute transverse myelitis (ATM).[1] Patients with ATM or ALM should be tested for SLE and APS, with treatment to include early IV corticosteroids followed by cyclophosphamide.

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2. Deodhar AA, Hochenedel T, Bennett RM. Longitudinal involvement of the spinal cord in a patient with lupus related transverse myelitis. J Rheumatol 1999;26:446–449.

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Figure. MRI of the spinal cord after first admission (A) and during recurrent episode 13 months later (B). T2-weighted sagittal images reveal an abnormal intramedullary high signal intensity and enlargement of the spinal cord reaching from the upper cervical segments to the conus medullaris.

