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Case Report

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ARACHNOIDITIS ASSOCIATED TO SJOGREN'S SYNDROME: A RARE ASSOCIATION OR A NEW CAUSATIVE FACTOR

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INTRODUCTION

Arachnoiditis is a relatively rare and under-diagnosed condition that can affect many patients differently. Most cases are incidentally discovered on radiologic imaging. Sjögren syndrome as a causative factor has never been reported in the literature.

The purpose of this report is to present a rare association of Arachnoiditis and Sjogren's syndrome.

CASE REPORT

A 72-year-old female with no significant past medical history was hospitalized in our department for atypical sciatica.

She had a 2 year history of chronic back pain at the lower thoracic and upper lumbar spines radiating to the legs, progressive paraparesis in both legs and paraesthesia with difficulty in walking. She also complained of dry eyes and mouth. The patient had No history of back surgery or trauma.

On neurological examination, her gait was abnormal, muscle power of the lower limbs showed weakness 3/5 (on the Medical Research Council Scale). Sensory examination revealed a patchy sensory loss along with impaired joint position. There was diminished deep tendon reflexes and positive Babinski's sign bilaterally. Co-ordination was also impaired in both lower limbs. Her cranial nerves were intact and she had no spinal tenderness.

The rest of her general medical examination was normal.

Her blood tests resuts count and lumbosacral and chest radiographs. Immunological work up was abnormal for anti-SSA auto antibodies.

EMG (electromyogram) showed a sensorimotor axonal neuropathy associated with a bilateral radiculopathy at L4 L5 level.

An MRI showined an ill defined lesion in the intradural space at Cauda Equina, which was hyperintens in T1W with focal gadolinium enhancement consistent with arachnoiditis. Analysis of the lumbar CSF showed a revealed pleocytosis (496 cells—lymphocytes: 94%), elevated protein values (13.15 g/l) and normal glycorrhachia.

There was a focal lymphocytic sialadenitis with a focus score of 4 in labial salivary gland biopsy samples.

On these bases, we diagnosed: Arachnoiditis associated to Sjögren syndrome (SS), classified according to the new American College of Rheumatology.

Further test were performed to investigate the cause of arachnoiditis. The screening for tuberculosis, syphlis, HCV, HIV and HBV infections was negative. At last arachnoid biopsy was performed. The histopathological examination of the biopsied mass revealed a fibrous tissue with no sign of infection cancer or lymphoma.

The origin of arachnoiditis was uncertain. The only explanation found was the associated Sjögren syndrome.

The patient received three pulse doses of Methylprednisolone (1 g/bolus) followed by oral prednisone (1 mg/kg/day progressively tapered to a dose maintenance regimen of 10–15 mg/day), and Azathioprin (150 mg/day). She also received Pregabalin to treat neurologic pain.

She showed partial improvement with disappearance of back pain and parasthesis but worsening of paraparesis and gait difficulties.

CONCLUSIONS

This report is to our knowledge, the first describing arachnoiditis occurring in SS. More research is needed to establish the aetiological relationship between those affections.