



IMAGE ARTICLE

Type A Aortic Dissection Presenting with Paraplegia & Urinary Retention

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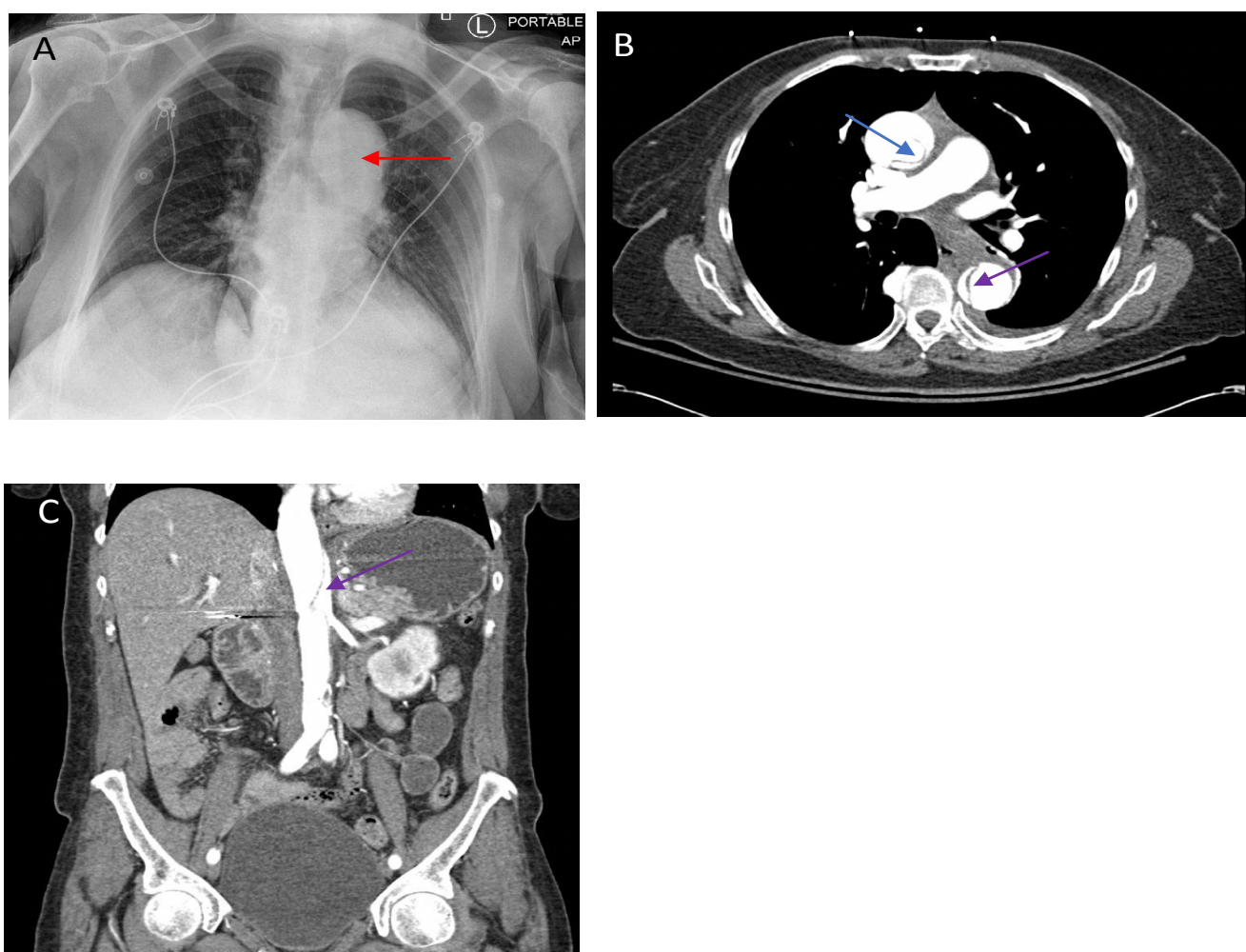


Figure 1: (A) Chest X-ray showed mediastinal widening (red arrow); (B,C) Computed tomographic angiography of the chest, abdomen and pelvis revealed type A aortic dissection, which involved the ascending aorta (Figure B, blue arrow), descending aorta (Figure B and C, purple arrow).

Introduction

A 60-year-old female with history of hypertension presented to the emergency department following a sudden fall while walking 3 hours prior. The patient was unable to move her both legs and unable to void. During evaluation, she also developed a sudden onset of sharp mid-sternal chest pain. Her blood pressure was 213/126 mmHg in right arm and 170/131 mmHg in left arm and heart rate was tachycardic at 110. Bilateral lower extremities motor strengths were not present with intact sensory functions. Ankle reflexes were absent bilaterally.

Chest X-ray showed mediastinal widening (Figure A, red arrow). Computed tomographic angiography of the chest, abdomen and pelvis revealed type A aortic dissection, which involved the ascending aorta (Figure B, blue arrow), descending aorta (Figure B and Figure C, purple arrow), right external iliac artery and left internal iliac artery. MRI spine was consistent with anterior thoracic spinal cord/cornus infarct at the level of T2.

The patient underwent successful emergent type A aortic dissection repair within 3 hours. Initially, bilateral lower extremities paraplegia remained unchanged and she continued to have neurogenic bladder requiring indwelling urinary catheter. Her lower extremities motor function started to improve 2 weeks after the surgery.

Acute aortic dissection can be a life-threatening condition which can result in spinal cord infarction [1]. In patients with acute neurologic symptoms which may be related with spinal cord infarction, aortic dissection should be considered and carefully investigated. A high clinical suspicion with prompt diagnosis can lead to emergent intervention and prevent morbidity and mortality [1-3].

Author Disclosures

All authors have reported that they have no relationships relevant to the contents of this paper to disclose.

Author Contributions

All authors have contributed equally to this paper.

References

1. Meszaros I, Morocz J, Szlavi J, Schmidt J, Tornóci L, et al. (2000) Epidemiology and clinicopathology of aortic dissection. *Chest* 117: 1271-1278.
2. Hagan PG, Nienaber CA, Isselbacher EM, Bruckman D, Karavite DJ, et al. (2000) The International Registry of Acute Aortic Dissection (IRAD): new insights into an old disease. *JAMA* 283: 897-903.
3. Colak N, Nazli Y, Alpay MF, Akkaya IO, Cakir O (2012) Painless aortic dissection presenting as paraplegia. *Tex Heart Inst J* 39: 273-276.