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or deep collector veins forming the ‘caput medusae’. The superficial collectors drain into a venous sinus or cortical vein. The deep collectors join subependymal veins. Supratentorially, the deep collectors drain to the vein of Galen via the subependymal veins of the lateral ventricles. Infratentorially, the deep collectors drain into the subependymal veins of the fourth ventricle. Further drainage may be to through the anterior or lateral transpontine veins or the veins of the lateral recess of the fourth ventricle. Superior drainage is to the precentral cerebellar vein and thence to the Galenic system.

In this patient, the cerebellar DVAs drained into a subependymal vein in the fourth ventricle. Further drainage was atypical, through a subependymal vein that coursed through the aqueduct of Sylvius to enter the vein of Galen causing obstruction to cerebrospinal fluid (CSF) flow.

Venous angiomas have been very rarely associated with CSF obstruction. Aqueductal stenosis caused by the midbrain DVAs[4] and unilateral foramen of Monro obstruction by intraventricular DVAs, [5] have been described. This case illustrates the fact that draining deep collector veins of cerebellar DVAs can follow atypical drainage patterns and cause obstruction at the aqueduct of Sylvius.

As this condition is an obstructed hydrocephalus, an endoscopic third ventriculostomy is preferable over shunting as and when the symptoms deteriorate or the ventricle size increases.

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Recovery of increased signal intensity of the cervical cord on magnetic resonance imaging after surgery for spontaneous spinal epidural hematoma causing hemiparesis

Sir,

Spontaneous spinal epidural hematoma (SSEH) is a rare acute condition with no significant trauma.[1-3] Minor trauma, an acute increase in the venous pressure, blood hypertension, anticoagulants and bleeding diathesis are considered to be inducers of SSEH. Emergent surgery has been indicated in most cases of SSEH[1] although conservative therapy has been reported to be selected. We describe herein a case of SSEH presenting with
An 82-year-old man noticed severe pain in his neck and left arm and rapid progressive weakness in his left arm and foot. He was admitted to a nearby hospital with a diagnosis of cerebral infarction. The patient was referred to our hospital 16 h after the occurrence of symptoms. He had a previous history of hypertension, angina pectoris and asymptomatic multiple cerebral infarctions. He has been treated with aspirin.

Physical examination revealed no traumatic wound on his body. Neurological examinations revealed severe left hemiparesis with neither facial palsy nor sensory abnormality. All blood-chemical findings, including platelet count, prothrombin time and activated thromboplastin time, were normal. A plain computer tomography (CT) scan of the brain excluded an acute cerebral event. The CT scan of the cervical spine revealed a high dense lesion in the left side of the spinal canal on the level from the second cervical lamina (C2) to the sixth cervical lamina (C6), compressing the spinal cord. Magnetic resonance (MR) imaging revealed an iso-intense extradural lesion and increased signal intensity (ISI) of the cervical cord on T2-weighted image [Figure 1].

Laminectomy was performed and the epidural hematoma (EDH) was evacuated. During surgery, any abnormality of the vessels or dura was not observed. Histopathological examinations revealed that the specimen consisted of typical hematoma. The postoperative course was uneventful, with gradual recovery from left hemiparesis and MR imaging performed one day, one week and two months afterwards revealed apparent recovery of ISI [Figure 2].

Hemiparesis due to SSEH is a relatively uncommon symptom compared with tetraparesis and a few cases of hemiparesis due to SSEH have been reported. The patients with hemiparesis have often been misdiagnosed as cerebral infarction. We emphasize that SSEH should be considered in patients with hemiparesis especially when having neck and arm pain. It is considered that the neurological outcomes of patients with incomplete neurological deficit including hemiparesis are reversible, when appropriate managements are selected, though most cases of complete tetraparesis may be irreversible. Also in our case, severe hemiparesis improved after emergent evacuation of hematoma.

In a review of spinal EDH mainly caused by traumatic accident, ISI was found to be associated with poor outcome. In SSEH, no statistical difference has been observed between functional outcomes of patients with ISI and without ISI, although ISI tends to be related...
to a poor functional outcome.\textsuperscript{[2]} Also, in patients with mild cervical myelopathy, ISI was not related to a poor outcome of conservative treatment or severity of myelopathy, although there was some tendency that satisfactory outcome was obtained in patients with improvement of ISI and patients without ISI initially, compared to patients without improvement of ISI.\textsuperscript{[5]} In our case, ISI recovered dramatically after surgical decompression in association with recovery of hemiparesis. Even if ISI is present, intensive therapy should be applied because functional recovery may be expected, as in our case.

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