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Intramedullary capillary hemangioma of the thoracic spine: case report and review of the literature

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Abstract

Capillary hemangiomas are benign vascular neoplasms. When associated with the spine, these growths frequently involve the vertebral body, but rarely have they been reported to occur as intradural lesions, while even more rarely occurring in a true intramedullary location. We report a rare case of an intramedullary capillary hemangioma of the thoracic spinal cord and a review of the literature.

Introduction

Capillary hemangiomas are benign vascular neoplasms typically encountered in the skin. They occur most frequently in childhood as cutaneous or subcutaneous lesions characterized histologically by nodules of capillary-sized vessels lined by flattened endothelium.4 As the most common primary tumor of the spine, capillary hemangiomas are frequently encountered as interosseous lesions. The occurrence of these tumors in the central nervous system, however, is exceedingly rare and they are even less frequently encountered as intramedullary lesions.2 Despite the high prevalence of vertebral body hemangiomas, extraosseous extension causing neurological impingement remains uncommon.

In the present case, we report an intramedullary capillary hemangioma of the thoracic spinal cord, an exceedingly rare presentation with few previously reported cases existing in the literature.24

Case Report

The patient is a 47-year-old right-handed man with several months of non-specific mid-back pain, lower extremity hyperesthesia, and a more recent two week history of gait difficulties. His past medical history is significant for a prior left-sided intracerebral hemorrhage with consequent hemiparesis three years ago.

The patient’s baseline deficits associated with his prior left hemisphere stroke included dysarthria, right facial weakness, and a dense right hemiparesis. New deficits included 3-4/5 strength of the left lower extremity and a sensory level just above the nipples consistent with approximately a T3 spinal level. Reflexes were 3+ in the bilateral lower extremities. Babinski reflex was present bilaterally.

MRI of the thoracic spine both before and after the administration of intravenous Gadolinium demonstrated what initially appeared to be a homogeneously enhancing intradural, extramedullary lesion displacing the cord anteriorly with significant cord deformity (Figure 1). Our differential diagnosis included: nerve sheath tumor, meningioma, and ependymoma.

The patient was offered an excisional biopsy of the lesion. T2 and T3 laminectomies were performed, and the lesion location was confirmed using intra-operative ultrasound. Intradural exploration revealed a highly vascular, partially encapsulated cherry-red lesion that appeared to arise from the dorsal aspect of the spinal cord. In contrast to MRI findings, the tumor was found to be intramedullary in location. Overlying the tumor was a region of thickened arachnoid, but no demonstrable dural attachment. Several involved nerve roots were coagulated and divided. Further dissection revealed an extremely friable exophytic tumor arising from the region of the dorsal root entry zone of T3. Intra-operative frozen section was consistent with a possible hemangiopericytoma. Post-operative MRI showed no evidence of residual tumor.

On histopathology, the tumor grossly consisted of a partially circumscribed lesion with a brownish-tan appearance. H&E staining demonstrated a hypercellular, vascular neoplasm composed of cytologically bland spindled cells with minimal cytoplasm. These cells were arranged in vague lobules of short irregular spindle cells and dilated vascular spaces. Immunohistochemical findings are explained in Figure 2. Further evaluation demonstrated dilated, compressed vascular channels and focal extramedullary hematopoiesis. In total, the findings were consistent with capillary hemangioma.

Post-operatively the patient had good functional recovery. At three months follow-up the patient had only minor residual lower extremity dysesthesia with return of baseline motor function. The patient has remained stable 36 months post resection.

Discussion

Capillary hemangiomas involving the spinal cord are extremely rare, and are most frequently extramedullary in location.25,26 Many such lesions can be safely removed with proper imaging, surgical planning and technique. In the case of intramedullary capillary hemangiomas, however, on MRI the lesion can be interpreted as extramedullary,14,15 and the original differential diagnosis often fails to include capillary hemangioma.24,25 as was the case with our patient. As previously discussed by Roncaroli et al.27 and Nowak et al., the treating surgeon must be cognizant of intramedullary capillary hemangiomas to avoid misdiagnosis and potential excessive treatment.12 Although extremely rare, capillary hemangiomas of the spinal cord have a benign clinical course. Glioblastoma, such as ependymomas and astrocytomas, account for over 90% of intramedullary tumors.28 The distinctive gross appearance of capillary hemangiomas intraoperatively often eliminates the more common glial based lesions from the differential diagnosis. The remaining possibilities include lesions ranging from: hemangiopericytoma, hemangioblastoma, cavernous angioma, hemangiogliomatoma, arteriovenous malformations, venous angiomas, and capillary telangiectasias. Fortunately, histopathological analysis reliably distinguishes these lesions for diagnosis.

Although related most closely to the category of vascular malformations, capillary hemangiomas that appear within the spinal cord parenchyma may have their origins elsewhere.
## Table 1. Cases of intramedullary capillary hemangiomas previously reported in English.24-12

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Patient Age/sex</th>
<th>Imaging</th>
<th>Tumor size/Location</th>
<th>Symptoms/</th>
<th>Treatment Deficits</th>
<th>Outcome</th>
<th>Recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roncaroli 2000</td>
<td>M</td>
<td>not reported</td>
<td>size not reported; T11</td>
<td>1.5-year h/o abdominal pain, leg weakness</td>
<td>surgery</td>
<td>recovered</td>
<td>none reported</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>not reported</td>
<td>size not reported; T11</td>
<td>1-year h/o LBP, proximal leg weakness bilaterally, L-1 sensory level, loss of patellar reflex</td>
<td>surgery + radiotherapy</td>
<td>little improvement</td>
<td>2 years post-op</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>not reported</td>
<td>size not reported; conus</td>
<td>2 year h/o UMN, LMN signs bilateral lower extremities</td>
<td>surgery</td>
<td>leg weakness</td>
<td>1.5 years post-op</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>not reported</td>
<td>size not reported; T10</td>
<td>2 year h/o bilateral leg pain, leg weakness</td>
<td>surgery</td>
<td>recovered</td>
<td>none reported</td>
</tr>
<tr>
<td>Ianelli 2005</td>
<td>M</td>
<td>CT: dilated ventricles, MRI: T4-7 intramedullary enhancing lesion</td>
<td>size not reported; T 4-7</td>
<td>Abnormal head circumference; wide, full, tense anterior fontanel with diastatic suture. Mild irritability, lethargy apparent. No other neurological signs</td>
<td>surgery</td>
<td>neurologically intact</td>
<td>1 year post-op; no focal deficits</td>
</tr>
<tr>
<td>Kelleher 2005</td>
<td>M</td>
<td>MRI: T9 &amp; T10 extramedullary enhancing lesion</td>
<td>2.4x1.0x0.5 cm; T9-T10</td>
<td>7-months h/o thoracic pain; 2-week h/o bilateral lower limb weakness, decreased lower limb DTRs</td>
<td>dexamethasone and surgery</td>
<td>spastic gait</td>
<td>3 months post-op</td>
</tr>
<tr>
<td>Mawk 1987</td>
<td>not stated</td>
<td>CT: discoid mass in R buttock. Myelography: vascular cord lesion with complete myelographic block at L1-2</td>
<td>size not reported; conus</td>
<td>apraxia of legs, hemangiomatous malformation involving the skin and soft tissue of the buttock</td>
<td>surgery</td>
<td>rapid recovery</td>
<td>none reported</td>
</tr>
<tr>
<td>Andaluz 2002</td>
<td>M</td>
<td>MRI: intradural, extramedullary enhancing mass</td>
<td>2x1 cm, conus medullaris</td>
<td>3 month h/o LBP radiating to thighs. Decreased L flexor strength (4+/5), bilateral patellar and Achilles areflexia</td>
<td>surgery</td>
<td>recovered</td>
<td>none reported</td>
</tr>
<tr>
<td>Nowak 2000</td>
<td>F</td>
<td>MRI: intradural extramedullary enhancing mass</td>
<td>maximum diameter 1.0 cm; T12-L1</td>
<td>3 year h/o intermittent Lasègue’s sign; hypesthesia and activity related lumbosacralgia L thigh</td>
<td>surgery</td>
<td>residual paresis of L tibialis anterior</td>
<td>14 months post-op</td>
</tr>
<tr>
<td>Abe 2004</td>
<td>M</td>
<td>not reported</td>
<td>size not reported; T5</td>
<td>2 month h/o lower limb weakness, paraparesis</td>
<td>surgery</td>
<td>little improvement</td>
<td>7 years post-op</td>
</tr>
<tr>
<td>Roncaroli 2000</td>
<td>M</td>
<td>MRI: enhancing nodules on cauda equina, lower thoracic spinal cord, conus medullaris</td>
<td>lower thoracic cord, conus, cauda equina</td>
<td>9-month h/o bilateral leg weakness</td>
<td>surgery</td>
<td>no changes</td>
<td>1 year post-op; no new hemangiomas</td>
</tr>
<tr>
<td>Shin 2000</td>
<td>F</td>
<td>MRI: intradural mass at T8-T9; intramedullary and extramedullary components</td>
<td>1.3x2 cm; T8-T9</td>
<td>8-month h/o LBP, weakness of the lower limbs, paraparesis, sensory abnormality</td>
<td>surgery</td>
<td>recovered</td>
<td>no new hemangiomas</td>
</tr>
<tr>
<td>Hida 1993</td>
<td>M</td>
<td>MRI: Mass from C3-T1</td>
<td>not reported; C3-T1</td>
<td>tetraparesis, upper extremities hyporeflexia, lower extremities flexion spasm, decreased pain/tactile sensation below C3, bladder/ bowel dysfunction</td>
<td>surgery</td>
<td>recovered to baseline</td>
<td>not reported</td>
</tr>
</tbody>
</table>

Although several patients had imaging studies suggesting “extramedullary” lesions, they were ultimately found to have intramedullary capillary hemangiomas.

h/o = history of; UMN = upper motor neuron; LMN = lower motor neuron; LBP = lower back pain; DTR = deep tendon reflexes; R = right; L = left.
Similar to intramedullary lipomas (which account for 1% of intramedullary lesions), capillary hemangiomas of the spinal cord may represent a form of dysembryogenesis. Rather than being a true neoplasm, these lesions more likely arise from inclusion of mesenchymal tissue into the neural tube during primary neurulation. The available literature clearly demonstrates the benign nature of intramedullary capillary hemangiomas, and gross total resection appears to be curative with good outcomes and no reported recurrences (Table 1). Given the rarity of this lesion, its benign course and straightforward therapy, surgeon familiarity is important to ensure patients receive appropriate diagnosis and treatment.

References