Acute coronary syndrome accompanied with flaccid paraplegia: a case report in a 70-year-old patient

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Introduction: Acute coronary syndrome (ACS) includes unstable angina, non-ST segment elevation myocardial infarction (NSTEMI) and ST-segment elevation myocardial infarction (STEMI).[1] Acute flaccid paraplegia is a clinical syndrome with symmetrical and dramatic onset of weakness in the lower extremities with many underlying causes and generally poor prognosis.[2]

Case report: We present a case of a 70-year-old female who was admitted to the Emergency Room with the sudden onset of chest pain, fatigue and nausea. 12-lead electrocardiogram showed horizontal ST-segment denivelation in V3-V6 leads, the baseline cardiac high sensitive troponin I was slightly elevated and there were no regional wall motion abnormalities detected by transthoracic echocardiography. Two hours after being admitted the patient experienced sudden paralysis of the lower extremities and a discrete loss of sensitivity below the Th10 dermatome. A computerized tomography (CT) scan of the brain, of the lumbosacral spine and a CT aortogram showed no abnormalities. A second troponin measurement was performed three hours after the initial measurement, and was significantly elevated. The patient was then admitted to the Coronary Care Unit under the diagnosis of NSTEMI, and the urgent coronary angiography was performed. Coronary angiograms revealed a proximal right coronary artery subocclusion and the patient underwent percutaneous coronary intervention with the implantation of 3 drug-eluting stents in the culprit lesion. On the fourth day of hospitalization, the patient was transferred to the Department of Neurology for the management of persistent paraplegia. Because of deteriorating of patient's condition, MRI of the thoracic and lumbar spine was not realized. The patient experienced acute respiratory failure due to cardiac insufficiency and sepsis (C-reactive peptide was 375 mg/L, procalcitonin 2.9 ng/mL and Escherichia coli was isolated in the urine culture) and was transferred to the Intensive Care Unit. The patient died on the 17th day of the hospitalization.

Conclusion: Although there is limited information and no similar cases in available medical literature, we suspect that the cause of paraplegia was concomitant ACS and spinal cord infarction and that the cause of death was acute respiratory insufficiency due to urosepsis and cardiac insufficiency. Autopsy was declined by the patients' family.

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LITERATURE

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