

LETTERS TO THE EDITOR

A Rare Cause of Lumbar Radiculopathy: Perineural Cyst

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Dear Editor,

Lumbosacral perineural cysts are formed by the arachnoid membrane of the nerve root at the lumbosacral level. Sacral perineural cysts called Tarlov cysts were identified by Tarlov for the first time in 1938 [1]. Langdown et al. reported that Tarlov cysts, which are a relatively common finding on lumbosacral magnetic resonance imaging (MRI) scans, have a prevalence of 1–2%, and only 13% of these cysts are symptomatic [2]. Symptomatic perineural cysts, which are relatively less common when compared with Tarlov cysts, are found in the lumbar region where they cause nerve root compression, which then leads to radiculopathy mimicking disc herniation [3]. Herein, we report a case with lumbosacral radiculopathy due to a perineural cyst that

responded well to a transforaminal epidural steroid injection.

A 19-year-old male patient was admitted to the Physical Medicine and Rehabilitation Clinic presenting with complaints of lower back and left leg pain ongoing for 6 weeks. He had no history of trauma, heavy lifting, morning stiffness, night pain, fever, nor weight loss, and his pain was relieved by rest. His physical examination showed bilateral paravertebral muscle spasm, limited and painful lower back flexion. Straight leg raise test was positive at 40 degrees on the left and negative on the right. Achilles and patellar deep tendon reflexes were normal bilaterally. Sensory and motor examination revealed normal results except his left extensor hallucis longus strength of 4/5. His lumbar MRI scan revealed a 7 × 4-mm cystic lesion with well-defined contours (perineural cyst) in close proximity with the left L5 root (Figure 1A and B). We thought that the symptoms were due to this compression and did a left L5 fluoroscopy-guided transforaminal epidural steroid injection. His pain level before the procedure was 5/10 in visual analogue scale (VAS) that regressed to 0/10 after the injection.

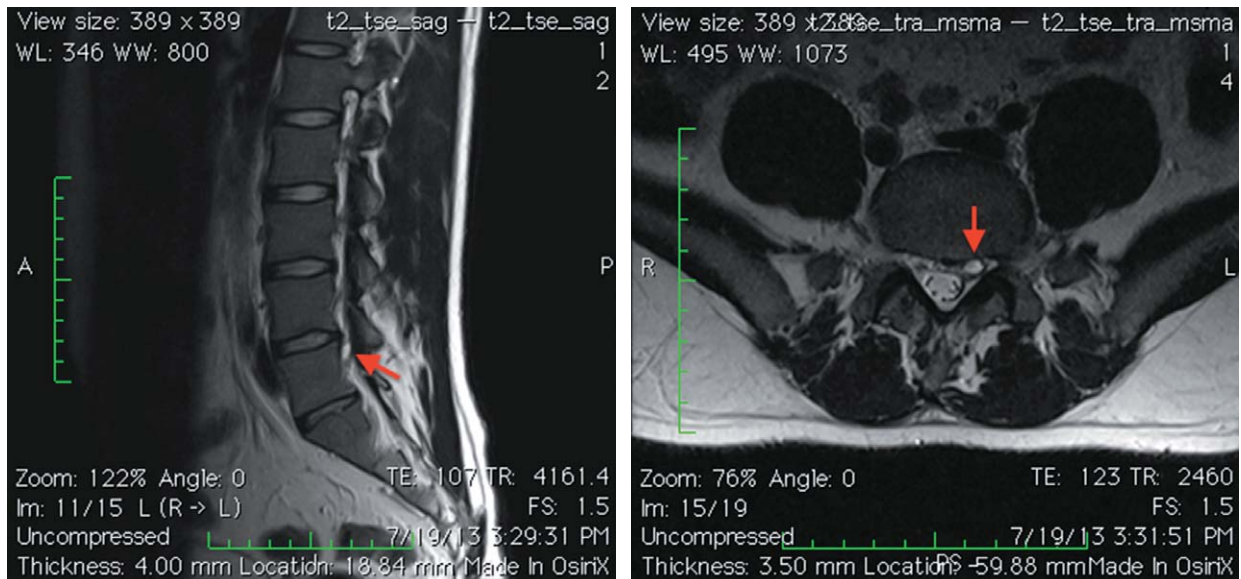


Figure 1 Lumbar spine T2-weighted sagittal (A) and axial (B) magnetic resonance imaging (MRI) scans showing a 7 × 4-mm cystic lesion (red arrows) with well-defined contours (perineural cyst) in close proximity with the left L5 root. [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

Peng et al.

We found three cases with lumbar perineural cysts mimicking lumbar disc herniation by causing nerve root compression in the literature search. Our case resembles the one published by Takatori et al., where the patient presented with pain at his lower back and left leg, and a perineural cyst compressing the nerve root at L5 on the left side was found during the MRI scan [3].

In our case, patient's complaints of left radicular pain and the fact that a perineural cyst was found at L5 level on the patient's left side during MRI scanning in accordance with his complaint suggest that presence of the cyst might be the source of his pain. However, in our case, the MRI scans revealed a bulging at L4–L5 level, but it was decided that this was not significant enough to cause the patient's symptoms.

Today, both surgical and conservative methods can be used for the treatment of lumbosacral perineural cysts; however, which method is more effective remains a matter of debate. There are studies which suggest that oral or epidural steroid treatments should be considered as the first choice of treatment in cases of perineural cysts presenting with complaints of lower back and radicular pain [4]. Supporting the findings of these studies, in our study, an hour after a left L5 transforaminal epidural steroid injection was administered to the patient, his pain level was decreased from 5 to 0 in VAS that remained for 6-month follow-up.

In conclusion, even though they are usually asymptomatic, it should be kept in mind that symptomatic lumbo-

sacral perineural cysts that can mimic disk herniation should be taken into consideration when obtaining a differential diagnosis between the causes of lower back and radicular extremity pain and that transforaminal epidural steroid injection might be a good treatment option for these cysts.

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Chronic Neck Pain and Episodic Vertigo and Tinnitus

The patient was managed by B Peng, X Pang, and H Yang. The report was prepared by B Peng.

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Dear Editor,

The term “cervical vertigo” was coined by Ryan and Cope [1] in 1955, which involves vertigo, tinnitus, hearing loss, and neck pain. To date, however, the syndrome remains only a theoretical possibility awaiting a reliable clinical test to demonstrate its independent existence. We present a case with cervical vertigo syndrome that is diagnosed and managed successfully to support its existence and provide direct clinical evidence.

In July 2012, a 54-year-old female presented with 24 years of history of chronic neck pain and episodic ver-

tigo and tinnitus unresponsive to extensive conservative therapies. The patient was free of any other neurological symptoms. Her general and otolaryngologic and neurological exams were completely normal. Cervical spine MRI scan indicated the cervical lordosis disappeared and cervical 5/6 disc protruded slightly (Figure 1). The computerized tomography angiography (CTA) scan of the cerebral vessels showed that the left vertebral artery was normal, whereas the right vertebral artery was absent (Figure 2).

Cervical discography was recommended to identify the pain-generating site [2,3]. The patient underwent provocative discography at C5/6 and C6/7 discs. The result of discography identified the C5/6 disc as the source of pain. Accordingly, C5/6 disc decompression was recommended using radiofrequency nucleoplasty [3,4]. Cervical disc nucleoplasty percutaneous disc decompression utilized patented Coblation technology for partial disc removal. The Coblation Mode was used at the tip of the Perc-DC Spine Wand (DC SpineWand, Arthro-Care Spine, Stockholm, Sweden). The patient felt the