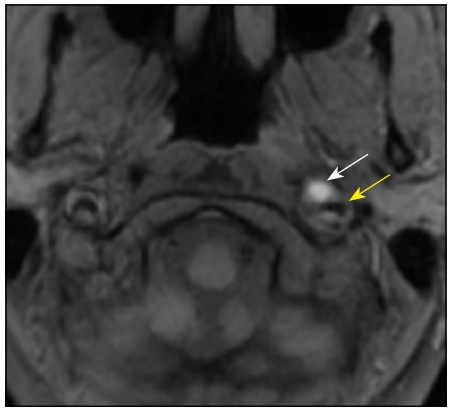

Figure 3. Gradient echo magnetic resonance image (axial section) showing haematoma in the wall of dissected left internal carotid artery (white arrow). Yellow arrow shows narrowed lumen of the dissected artery.

artery dissection focuses on preventing potential embolic ischaemic cerebral events from the dissection site. A Cochrane review has suggested that two thirds of embolic ischaemic strokes from a dissected internal carotid artery occur within a week, recommending early intervention. There is benefit in giving antiplatelet or anticoagulation therapy, but no clear advantage of one over the other. Surgical intervention increases death rates compared to antiplatelet therapy (Lyrer and Engelter, 2010). BJHM

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Caplan LR, Gonzalez RG, Buonanno FS (2012) Case records of the Massachusetts General Hospital. Case 18-2012. A 35-year-old man with neck pain, hoarseness, and dysphagia. *N Engl J Med* **366**: 2306–13

Lyrer P, Engelter S (2010) Antithrombotic drugs for carotid artery dissection. *Cochrane Database Syst Rev* (10): CD000255

LEARNING POINTS

- In patients presenting with lower cranial nerve deficit and neck pain, carotid artery dissection should be considered.
- This case illustrates the importance of neuro-anatomical knowledge in making a diagnosis.
- Management of these patients is unclear; current guidance suggests use of either antiplatelet or anticoagulation therapy in the acute setting.

A case of paraplegia post treatment for acute coronary syndrome

A 59-year-old woman presented to accident and emergency complaining of a 1-day history of central chest tightness. She had a normal cardiovascular examination. Her electrocardiogram revealed normal sinus rhythm and did not show any dynamic changes (*Figure 1*). Blood troponin levels were initially 28 ng/litre, but rose to 98 ng/litre 6 hours later (normal value <14 ng/litre). Antiplatelet agents (aspirin, clopidogrel and fondaparinux) were administered for a provisional diagnosis of acute coronary syndrome.

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Two days later she developed acute thoracic and lumbar back pain with loss of power and sensation in both lower limbs. She had a flaccid tone, power of 1/5 bilaterally and areflexia. Magnetic resonance imaging of the spinal cord revealed extensive spinal haemorrhage throughout the thoracic and lumbar spine (T11–L2) (*Figure 2*).

This case highlights the importance of correctly identifying patients with acute coronary syndrome and balancing the risks of treatment *vs* the risk of bleeding, to reduce major bleeding episodes. BJHM

Figure 1. Electrocardiogram on admission.

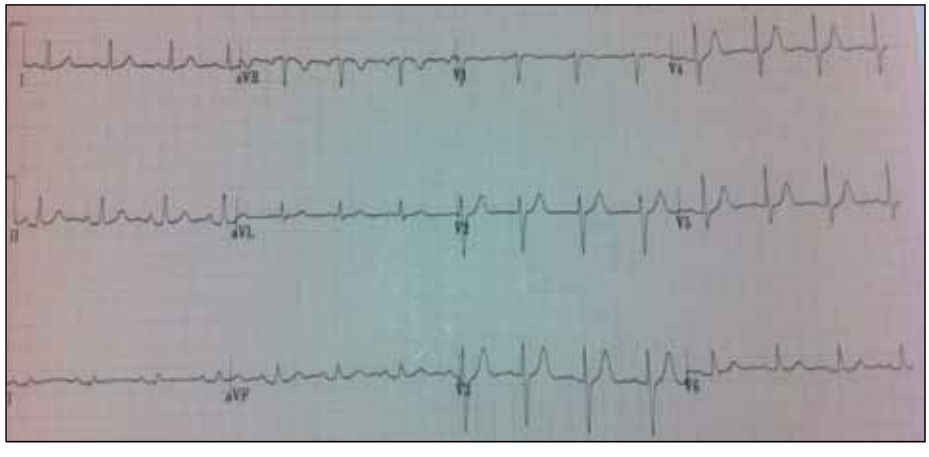

Figure 2. Magnetic resonance imaging of the spine, showing spinal haemorrhage throughout the thoracic and lumbar spine T11–L2.