Figure 2c. Axial T2- weighted image obtained at the same level demonstrating right posterolateral location of the mass.

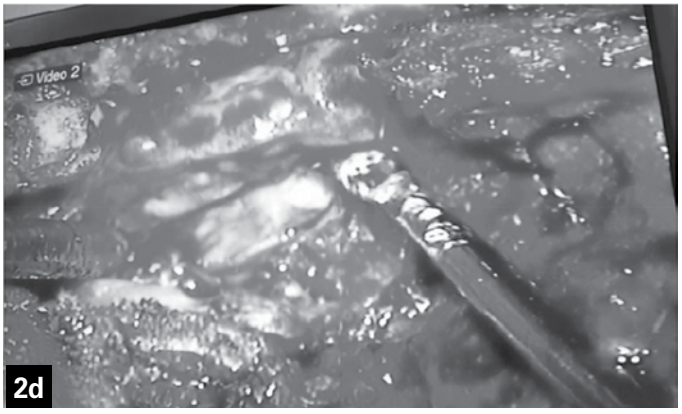

Figure 2d. Intraoperative view: showing an sequestrated disc fragment with loose adhesions to the dura.

DISCUSSION

Posterior epidural migration of a lumbar disc (PEM) is an uncommon event and less than 50 cases have been reported in the literature[1-12].

Posterior migration of a sequestered disc fragments is generally restricted by some anatomical constraints like PLL attachments, lateral and medial septums, epidural fat, epidural venous plexus and finally nerve roots[3,5,8,10].

In PEM of the lumbar disc, men outnumber the female with the ratio of 4 to1 and the patients of middle age are mostly affected[1,5,8,10-12].

The clinical picture of the event is either radiculopathy or cauda equina syndrome. Review of reported cases revealed that half of the cases were manifested with radiculopathy and the other half with cauda equina syndrome[1-5,8,12].

The plain radiographs does not give too much information, in particular with consideration of disc height which remains normal because of the rapidity of the events in PEM. MRI is the best tool for detection of a posteriorly migrated disc fragment. In T1 weighted images, PEM is demonstrated as an isointense mass, with the signal intensity relatively similar to the intensity of intervertebral disc. However, in T2- weighted images, its intensity is variable and can be shown as a hyperintense mass in about 80% of the cases and hypointense or isointense in the remaining 20% cases[1,3,9,].

In contrasted MRI, particularly if the a few days passes, it resembles a cyst like lesion with rim enhancement,. This phenomenon is due to wrapping of the sequestrated disc by newly formed vessels or neovascularization[3,5,8,10].

Since these radiological features mimic those of other common posterior epidural lesions, definite preoperative diagnosis cannot be made in all of the cases[3,10].

Differential diagnosis based both on clinical and radiological features include rapid expansion of a pre-existing synovial cyst, hemorrhagic juxtafacet cysts, gout, cystic schwannomas, tumors and abscess[1,3-5,6,8-10].

Decision for urgent surgery should be the first step toward the elimination of pain and averting neurological deficit, particularly in the subjects with cauda equina syndrome. Removal of the sequestrated disc fragment can be achieved through hemilaminectomy[1,5,6].

Hopefully, the outcome is good in majority of the patients suffering from this pathology. In particular, cauda equina syndrome resulting from PEM disc fragment has much more better prognosis than those with the same syndrome resulting from an anteriorly extruded disc fragment. Review of the literature revealed that majority of the PEM patients have recovered fully within weeks to a few months after surgery, probably because of abundant epidural fat which provides suitable space posteriorly[1,2,4,6,9].

In conclusion, PEM should be included in differential diagnosis of all patients with acute radiculopathy or cauda equina syndrome despite its rarity. Prompt surgical intervention is justified particularly in those with cauda equina syndrome. Obviously, surgery should not be postponed for unnecessary further radiological investigations.

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ERRATA

O artigo "Análisis comparativo de pacientes con estenosis degenerativa lumbar pura (EDLP) y estenosis secundaria a espondilolistesis degenerativa lumbar (ELDL) tratados quirúrgicamente en el período de 2008 a 2011 en el Hospital Metropolitano de Quito-Ecuador" publicado revista Coluna/Columna, na edição Volume 11, número 2, Abr/Jun 2012, pág.156-9, por solicitação do autor foi alterada a ordem dos autores. Onde se lê: Jaime Moyano[1], Edison Ahtty[1], Madelin Bilbao[2], Sebastián De la Torre[3], o correto é: Sebastián De La Torre[1], Jaime Moyano[2], Edison Ahtty[2], Madelin Bilbao[3].