



## IMAGES IN INTENSIVE MEDICINE

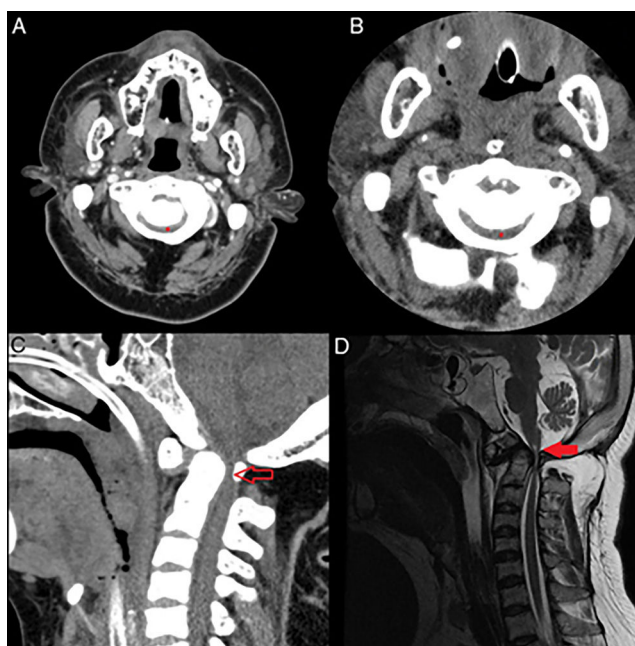
### SCIWORA, an injury to know and diagnose<sup>☆</sup>

### SCIWORA, una lesión a conocer y a perseguir

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Available online 20 May 2019



**Figure 1** (A) Computed tomography scan in 2008: axial acquisition at C1–C2 level showing spinal cord canal stenosis (6 mm) (grey asterisk). (B) Computed tomography scan in 2018: axial acquisition at C1 level showing spinal cord canal stenosis (6 mm) (grey asterisk). (C) Computed tomography scan: sagittal acquisition showing the already known canal stenosis at the craniocervical junction, with no apparent soft tissue lesions (vacant grey arrow). (D) Magnetic resonance imaging: T1-weighted acquisition showing canal stenosis with diffuse dural thickening and signal alteration in lower bulbar zone, together with cervical intramedullary image consistent with traumatic myelopathy (solid grey arrow).

A 34-year-old woman. *History*: perinatal anoxic encephalopathy; atloaxoid subluxation with critical canal stenosis (Fig. 1A) – neurosurgery being discarded in 2008 due to surgical risk. Seizure episode with head injury (head in cervical hyperflexion). The patient was assisted by out-hospital emergency care (112), initially in asystolia. Resuscitation was started, with recovery of pulse after lung isolation. In hospital: blood pressure 80/50 mmHg, heart rate 45 bpm, SatO<sub>2</sub> 100% and temperature 33 °C. The full body CT scan revealed no acute lesions and confirmed the already known atloaxoid subluxation (Fig. 1B and C). In the Intensive Care Unit: tetraplegia, areflexia, anal sphincter atonia and absence of respiratory effort in pressure support ventilation. The MRI scan revealed lesions consistent with acute cervical myelopathy (Fig. 1D). With a diagnosis of spinal cord injury without radiographic abnormality (SCIWORA), under noradrenaline perfusion and the administration of dexamethasone, the patient failed to recovery respiratory activity.

<sup>☆</sup> Please cite this article as: Viejo Moreno R, Benito Puncel C, Eguileor Marín Z. Sciwora, una lesión a conocer y a perseguir. Med Intensiva. 2019;43:392.

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