CC:, BLE weakness.,HX:, This 82y/o RHM was referred to the Neurology service by the Neurosurgery service for evaluation of acute onset paraplegia. He was in his usual state of health until 5:30PM on 4/6/95, when he developed sudden ""pressure-like"" epigastric discomfort associated with bilateral lower extremity weakness, SOB, lightheadedness and diaphoresis. He knelt down to the floor and ""went to sleep."" The Emergency Medical Service was alert and arrived within minutes, at which time he was easily aroused though unable to move or feel his lower extremities. No associated upper extremity or bulbar dysfunction was noted. He was taken to a local hospital where an INR was found to be 9.1. He was given vitamin K 15mg, and transferred to UIHC to rule out spinal epidural hemorrhage. An MRI scan of the T-spine was obtained and the preliminary reading was ""normal."" The Neurology service was then asked to evaluate the patient.,MEDS:, Coumadin 2mg qd, Digoxin 0.25mg qd, Prazosin 2mg qd.,PMH:, 1)HTN. 2)A-Fib on coumadin. 3)Peripheral vascular disease:s/p left Femoral-popliteal bypass (8/94) and graft thrombosis-thrombolisis (9/94). 4)Adenocarcinoma of the prostate: s/p TURP (1992).,FHX: ,unremarkable.,SHX:, Farmer, Married, no Tobacco/ETOH/illicit drug use.,EXAM:, BP165/60 HR86 RR18 34.2C SAO2 98% on room air.,MS: A&O; to person, place, time. In no acute distress. Lucid.,CN: unremarkable.,MOTOR: 5/5 strength in BUE. Flaccid paraplegia in BLE,Sensory: T6 sensory level to LT/PP, bilaterally. Decreased vibratory sense in BLE in a stocking distribution, distally.,Coord: Intact FNF

and RAM in BUE. Unable to do HKS.,Station: no pronator drift.,Gait: not done.,Reflexes: 2/2 BUE, Absent in BLE, plantar responses were flexor, bilaterally.,Rectal: decreased rectal tone.,GEN EXAM: No carotid bruitts. Lungs: bibasilar crackles. CV: Irregular rate and rhythm with soft diastolic murmur at the left sternal border. Abdomen: flat, soft, non-tender without bruitt or pulsatile mass. Distal pulses were strong in all extremities.,COURSE:, Hgb 12.6, Hct 40%, WBC 11.7, Plt 154k, INR 7.6, PTT 50, CK 41, the GS was normal. EKG showed A-Fib at 75BPM with competing junctional pacemaker, essentially unchanged from 9/12/94.,It was suspected that the patient sustained an anterior-cervico-thoracic spinal cord infarction with resultant paraplegia and T6 sensory level. A CXR was done in the ER prior to admission. This revealed cardiomegaly and a widened mediastinum. He returned from the x-ray suite and suddenly became unresponsive and went into cardiopulmonary arrest. Resuscitative measures failed. Pericardiocentesis was unremarkable. Autopsy revealed a massive aortic dissection extending from the aortic root to the origin of the iliac arteries with extensive pericardial hematoma. The dissection was seen in retrospect on the MRI T-spine.