Epidural Diffuse Large B-Cell Lymphoma Masquerading as Persistent Spinal Pain Syndrome: A Case Report

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Why this case matters

- Persistent spinal pain syndrome type 2 (PSPS-T2) follows 10–40% of lumbar surgeries and is a leading indication for spinal cord stimulation (SCS).
- After spine surgery, new pain is easily attributed to scar.
- 40–70% of spinal metastases are first attributed to benign causes.
- Neurologic misdiagnosis of lymphoma can delay diagnosis by 4–18 months.

The patient

Woman in her 70s

- Left L5 laminectomy about 2 years earlier
- Progressive back and left radicular pain; positive straight-leg raise; walks with a rollator
- Neurologic exam intact; no bowel or bladder symptoms
- No lasting relief from NSAIDs, physical therapy, or epidural adhesiolysis; no further surgical plan
- COPD, rheumatoid arthritis, fibromyalgia, knee osteoarthritis

Diagnosis

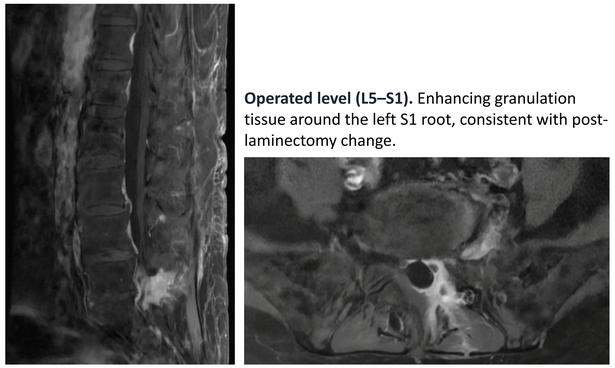
Stage IV DLBCL

germinal-center B-cell subtype, double-expressor (MYC + BCL2)

Extranodal sites: L4–L5 epidural and marrow, left iliacus, right pelvic sidewall, calvarium with dura, coracoid.

Scar or something else? Serial contrast-enhanced lumbar MRI

Prior MRI ~18 months before

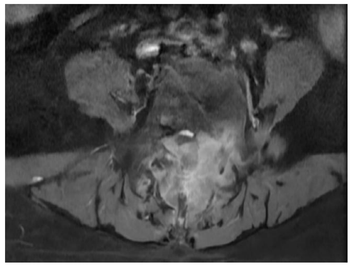


Operated level (L5–S1). Enhancing granulation tissue around the left S1 root, consistent with post-laminectomy change.

Repeat MRI emergency department visit



Non-operated level (L4). Bulky enhancing epidural and marrow tissue, severe canal stenosis.



Sagittal (left) and axial (right) post-contrast images in each pair.

Clinical course

~2 years before	~18 months before	~1 year before	Day 0	Day 3	Admission	Treatment
Left L5 laminectomy	MRI: granulation tissue at L5–S1	Caudal epidural + Racz adhesiolysis: 2 weeks of relief	Pain clinic: SCS evaluation initiated	ED: intractable back, hip, and joint pain	Repeat MRI → CT-guided biopsy: DLBCL	Dexamethasone after biopsy, then R-CHOP; pain and mobility improved

Features atypical for PSPS-T2

- **Progressive pain** despite multimodal therapy
- **New bilateral hip and multifocal joint pain**
- **Inflammatory labs:** ESR 71 mm/hr, CRP 2.7 mg/dL, platelets 474 $\times 10^9$/L
- **Coracoid fracture** concerning for pathologic involvement
- **New enhancement at L4,** a level never operated on
- **Low morning cortisol** (4.9 µg/dL) after an unregulated supplement: possible covert steroid

Conclusion

Epidural lymphoma can mimic PSPS-T2; it was identified during pre-implant evaluation, before any neuromodulation.

Scar should settle. New or enlarging enhancement is not scar until proven otherwise.

Re-image when the story changes. Progressive or multifocal pain reopens the diagnosis.

Biopsy before steroids when lymphoma is possible and it is safe to wait.

SCS needs a known pain generator.

DLBCL, diffuse large B-cell lymphoma; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone.

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