Progressive Noncompressive Myelopathy Mimicking Degenerative Cervical Myelopathy: A Diagnostic Challenge in Pain Medicine

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WHEN CERVICAL SPONDYLOSIS DOES NOT EXPLAIN THE EXAM

Progressive neurologic decline disproportionate to structural imaging should prompt evaluation for noncompressive myelopathy.

THE DIAGNOSTIC CHALLENGE

66-year-old man with treated tonsillar SCC, renal cell carcinoma, and DVT developed 6 months of progressive neurologic decline.

1. Ascending bilateral leg numbness
2. Asymmetric upper extremity sensory loss + impaired hand dexterity
3. Falls + gait instability
4. Urinary dysfunction
5. Dysphagia + hypophonia + choking

SYSTEMIC RED FLAG

50-lb unintentional weight loss

CLINICORADIOGRAPHIC DISCORDANCE

Cervical MRI

Longitudinal dorsal column T2 hyperintensity from C1–C6

Radiologic differential:

- subacute combined degeneration
- metabolic/toxic myelopathy

Coexisting multilevel cervical spondylosis caused moderate spinal canal stenosis.

Neurosurgical evaluation found no compressive lesion explaining the progressive decline.

WHY THE STENOSIS WAS NOT ENOUGH

Long-segment cord signal abnormality and progressive multifocal deficits were disproportionate to the moderate stenosis.

DIAGNOSTIC WORKUP

B12, copper, HIV, and paraneoplastic antibodies were unrevealing.
Seronegative paraneoplastic myelopathy remained a consideration.
EMG/NCS supported corticospinal tract involvement.

NEUROLOGICAL EXAMINATION

- Hyperreflexia
- Positive Babinski sign bilaterally
- Scissoring gait
- Diminished sensation below T10 and in both hands
- Generalized upper and lower extremity weakness

REHABILITATION COURSE

Functional decline progressed to maximal assistance for mobility and ADLs during inpatient rehabilitation.

Multidisciplinary concern:
progressive paraneoplastic myeloneuropathy with ALS-like features

REFERENCES

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TAKE-HOME: Recognize clinicoradiographic discordance to avoid diagnostic anchoring on degenerative cervical disease.