Pain in the Lower Limbs of a Patient with AIDS
(See pages 392–3 for the Photo Quiz)

Diagnosis: Spinal epidural lipomatosis.

The patient presented with signs and symptoms suggesting low lumbar nerve root compression. MRI showed abundant, generalized fatty tissue and specific images of fatty tissue accumulation in the spinal canal at L5 and the sacrum level, with thecal sac deformity at that same level (figures 1–4).

Spinal epidural lipomatosis is a highly uncommon condition in which excess fat accumulates in the epidural space. This accumulation may cause symptoms of myelopathy and compression of medullary cords or nerve roots. Few cases have been reported in the literature, and most of them are related to an exogenous Cushing syndrome [1] or to severe obesity.

The lipodystrophy syndrome associated with antiretroviral therapy is clinically characterized by a patient’s report of fat wasting in the face, arms, and/or legs (lipoatrophy), with or without fat accumulation in the abdomen, in the breasts of women, and over the cervical vertebrae (“buffalo hump”) [2], that is confirmed by physical examination.

Although protease inhibitors were initially blamed for this syndrome [3], it is now known that all therapeutic classes are implicated, and use of nucleoside analogues is particularly related to peripheral lipoatrophy [4–5]. We have only found 2 reported cases of spinal epidural lipomatosis in patients with HIV infection in the literature. One of the patients had received ritonavir, lamivudine, and zidovudine during the prior 4 months but also had an exogenous Cushing syndrome caused by long-term corticosteroid therapy for thrombotic thrombocytopenic purpura. This patient developed epidural lipomatosis...
Figure 2. MRI of sagittal plane–type short time inversion recovery with normal findings, showing CSF throughout the spinal canal.

Figure 3. T2-weighted MRI at L5–S1 level showing epidural lipomatosis. White arrow, occupation of the spinal canal, with intensity corresponding to fatty tissue; black arrow, thecal sac deformity.
Figure 4. T2-weighted MRI at L5-S1 level with normal findings. White arrow, thecal sac with CSF.

at L5–S1 and also at D1–12, requiring thoracic laminectomy with cord decompression [6]. The other patient was receiving indinavir therapy, and symptoms of paraparesis caused by epidural lipomatosis resolved on drug discontinuation [7]. Our patient had not received any protease inhibitor before receiving the aforementioned drugs, except for lopinavir, which the patient had received for 2 weeks more than 1 year before presentation and which caused diarrhea requiring drug discontinuation, and saquinavir boosted with ritonavir, which the patient had received >4 years before presentation.

Symptoms in our patient could not be controlled with medical treatment. Unfortunately, while waiting for neurosurgical assessment, the patient experienced nosocomial pneumonia with multiorgan failure and died.

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