van der Hoeven et al. from Hagaziekenhuis, The Hague, and Leiden The Netherlands, present the case of a woman who developed severe nightly thoracic pain during pregnancy without neurological deficits upon examination. Spontaneously after childbirth, the pain was markedly reduced. Further investigation showed that her pain was caused by an intramedullary ependymoma in the cervicothoracic spinal cord. Gross total resection was accomplished, and the patient has been free of pain ever since. With this case, the authors want to draw attention to a rare, but possibly very disabling, cause of increasing nightly thoracic pain during pregnancy. Spontaneous improvement after childbirth could erroneously cause postponement of further investigation [1)].

2016

Although a hemorrhage within spinal ependymoma on imaging studies is not uncommon, it has rarely been reported to be a cause of acute neurological deficit. A 24-year-old female patient who developed acute paraplegia as a result of hemorrhagic spinal ependymoma immediately after a cesarean delivery under spinal regional anesthesia [2)].

2015

Cheng et al., report an intramedullary spinal tumor consisting of an ependymoma and a hemangioblastoma (HB). A 37-year-old woman presented with progressive bilateral lower limb sensory and motor deficits. Magnetic resonance imaging showed a single intramedullary mass in the thoracic cord (T4-T6 level). Clinically, the patient had no von Hippel-Lindau disease and neurofibromatosis type 2. Metastatic carcinomas including renal cell carcinoma were altogether negative. Complete surgical resection was performed. Histologically, the tumor consisted of a mixed ependymoma and HB. Tumor cells of ependymoma displayed a rather uniform appearance with round to oval nuclei having salt-and-pepper-like chromatin, forming perivascular pseudorosette structures with radially arranged, tapering cell processes extending to intratumoral blood vessels. Stromal cells of HB had vacuolated or homogeneously eosinophilic cytoplasm and variable sized hyperchromatic nuclei within a background of capillaries. Immunohistochemically, tumor cells of ependymoma were strongly positive for glial fibrillary acidic protein (GFAP), focally positive for epithelial membrane antigen (EMA) and D2-40 in a dot-like or ring-like pattern. Stromal cells of HB showed immunoreactivity for S100, vimentin, inhibin-α, D2-40, EMA and cytokeratins (CK: AE1/AE3, CK19). A review of the literature, in conjunction with the present case, shows that ependymomas and HBs may have a close relationship with each other. [3)].

2013

A 36-year-old woman presented with headache, multiple cranial nerve palsies, visual hallucinations, confusion, hemiparesis, hemihipoestesia, episodes of disconnection, and toxic syndrome. Magnetic resonance imaging and positron emission tomography scan revealed leptomeningeal carcinomatosis in the brainstem, the cerebellum, and along the whole spinal cord. Various nodular, intradural extramedullary lesions were present at multiple dorsal and lumbar levels. Metastatic bone disease affected all the vertebral bodies and various extraspinal bones. An intradural and bone biopsy was performed at L4, providing the diagnosis of anaplastic ependymoma (World Health Organization grade III) with focal neuronal differentiation. Despite chemotherapy, the patient's symptoms quickly progressed, and she died 7 weeks after diagnosis.

There are no previous descriptions of ependymomas with this extensive leptomeningeal, spinal,

intracranial, and extraneural dissemination at clinical onset. Bone metastases in spinal ependymoma have not been previously reported [4].

2006

Mohammadianpanah et al.report a case of intramedullary ependymoma of the cervical spinal cord mimicking metastatic recurrent lymphoma and causing cord compression. A 50-year-old man developed intramedullary ependymoma of the cervical spinal cord 1.5 years following chemoradiation for Waldeyer's ring lymphoma. He presented with a 2-month history of neck pain, progressive upper- and lower-extremity numbness and weakness, and bowel and bladder dysfunction. Magnetic resonance imaging revealed an intramedullary expansive lesion extending from C4 to C6 levels of the cervical spinal cord. The clinical and radiological findings were suggestive of malignant process. A comprehensive investigation failed to detect another site of disease. He underwent operation, and the tumour was subtotally resected. The patient's neurological deficits improved subsequently. The development of the intramedullary ependymoma following treating lymphoma has not been reported [5].

A 33-year-old male presented to a chiropractic clinic complaining of chronic, recurrent low back pain. Subtle signs of muscle atrophy were noted in the left hand during the history taking. This muscle atrophy was reported as having a gradual onset spanning the past six months without any precipitating event. Cervical, thoracic and lumbar spinal radiographs were deemed unremarkable. Due to the progressive nature of the neurological deficit, the patient was referred for a neurological consultation. A magnetic resonance imaging (MRI) study was performed and revealed an expansive intramedullary lesion between C6 and T1 suggesting a differential diagnosis of spinal cord ependymoma or astrocytoma. The patient underwent surgical excision of the tumour. Pathological report confirmed a diagnosis of ependymoma [6].

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