The Management of Spinal Epidural Metastases

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L. Symon et al. (eds.), Advances and Technical Standards in Neurosurgery
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In 1959, in our first study on 24 cases of epidural metastases, we noted that a feeling of deep pessimism was apparent in all previous publications with regard to the outcome of these patients. The same feeling is still perceptible in most recent studies. Since 1959, several papers from our departments were dedicated to the problem of cancerous paraplegia, expressing in short our determination to find out the best management for these patients. We cannot adopt a defeatist attitude even if the final results still remain quite disappointing in many cases. In fact the main action for improving the results has always been and still is the promptness in making the diagnosis followed by the right therapeutic measure.

**Introductory Relevant Data**

For the first time in 1865, Charcot and his pupil Tixier, describing paraplegia in cancer patients, called it painful paraplegia because the pain often remained predominant during the course of the disease. Thus for little more than one century have vertebral metastases been clearly identified although the vertebral localization of malignant tumours commonly occurs. One might roughly estimate that 5% of cancer patients will show epidural infiltration, although all epidural infiltrations are not clinically evident. Considering all sites of metastasis, the vertebral localisation however appears less frequent than for example pulmonary or hepatic deposits. In this respect, like cerebral secondary lesions, the frequency of epidural infiltrations increases in parallel with longer survival of patients.

The high percentage of metastases among series of vertebro-spinal tumours is well represented in Tables 1 and 2, being above 50%. The frequency of epidural carcinomas is in parallel with the high occurrence of carcinomatous tumours in patients with malignant disease. According to Chade (1976) and Baldini (1979) carcinomas represent 90% of epidural metastases (Table 3).

The metastatic invasion of the vertebral axis is mainly osseous and secondarily epidural. Subdural and intramedullary localisations are rare: 5 cases out of 134 for Constans et al. (1973), 4 cases out of 105 for Kretschmer (1979). Edelson et al. (1972) found six cases of intramedullary lesions of 175 metastatic spinal cord lesions, a percentage of 3.4 which seems unusually high. All authors have noted that metastatic infiltration first affects the vertebral body before the epidural space and that the tumour remains confined