Case report 415

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Fig. 1. A technetium phosphate bone scan shows a localized area of increased activity in the mid line in the mid cervical region.

Fig. 2. A computed tomogram following a metrizamide myelogram obtained in the area of the lower cervical spine shows a multilobulated calcific and bony mass with a distinct cortex. Areas of attachment to the spinous process are present. No evidence of involvement of nerves or the spinal cord is apparent.

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Clinical information

This 33-year-old man was admitted to the hospital with a firm, nontender mass in the posterior aspect of his neck. He first noted the mass two years before admission when he began to experience constant, non-throbbing pain exacerbated by lifting weights. The patient attributed the mass to muscle spasm. Six months prior to admission, however, the patient noticed that the mass was growing and began to experience paresthesias in the 4th and 5th digits of his right hand. No other complaint was elicited. His general health was good and the past history was unremarkable.

On physical examination, a protruding, solid, nontender mass, approximately 7×4 cm, was palpated on the posterior portion of the neck with no evidence of discoloration of the skin or formation of fistula. A plain roentgenogram showed a large, amorphous, calcific and bony density in the soft tissues of the neck posteriorly. The technetium phosphate bone scan showed increased radionuclide activity in the same area (Fig. 1). A myelogram showed no evidence of neural involvement. Computed tomography, following the myelogram, showed a large, corticated, lobular density in the soft tissues of the neck posteriorly, with attachment to the spinous processes of C4, C5 and C6 (Fig. 2). A sagittal view of a magnetic resonance image at (TR = 797 mS and TE: 40 mS) showed an oval, posterior mass with mixed signal intensity, extending from C3 to C7 (Fig. 3). A T2-weighted image (TR = 2200 mS and TE: 80 mS) in the sagittal view showed the same oval mass with a bright, intense signal with lobulation and septation (Fig. 4).

An operation was performed.

Fig. 3. In this magnetic resonance study (mixed T1 and T2 MR images, TR = 797 M5, TE: 40MS) sagittal views show an oval posterior mass with mixed signal intensity present from C3 through C7

Fig. 4. Another MR study (a heavily weighted T2 image TR = 2200 MS and TE: 80 MS) in a sagittal view shows the same ovoid mass with an intense bright signal and lobulation