Case report

Acute transverse myelitis in COVID-19 infection

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SUMMARY
A 60-year-old man presented to hospital with bilateral lower limb weakness, urinary retention and constipation. He had been diagnosed with COVID-19 10 days prior. Clinical examination revealed global weakness, increased tone, hyperreflexia and patchy paresthesia in his lower limbs bilaterally. Preliminary blood tests performed revealed a mildly elevated C reactive protein and erythrocyte sedimentation rate but was otherwise unremarkable. MRI scan of his whole spine demonstrated hyperintense T2 signal centrally from T7 to T10, suggestive of acute transverse myelitis. A lumbar puncture showed elevated protein count but normal glucose and white blood cell count. Serological testing for other viruses was negative. His neurological symptoms improved significantly after treatment with intravenous methylprednisolone. This case highlights a potential neurological complication of COVID-19 infection.

BACKGROUND
There is growing evidence to support the potential for central nervous system (CNS) involvement in the context of acute and post-COVID-19 infection.1–3 It is important to recognise potential neurological manifestations and complications of COVID-19, some of which can be rapidly progressing and require urgent intervention.

CASE PRESENTATION
A 60-year-old man presented to hospital with progressive bilateral lower limb weakness, urinary retention and constipation.

Eighteen days prior, he developed fever and cough 1 day after returning from a flight from South America to Australia. Several of his colleagues were also diagnosed with COVID-19 after returning on the same flight.

On presentation to the emergency department, the patient was noted to have normal observations and was afebrile. His respiratory rate was 16 breaths per minute, oxygen saturation of 97% on room air, blood pressure of 154/88 (110) mm Hg, heart rate of 85 beats per minute and temperature of 36.7°C. Clinical examination revealed increased tone, hyperreflexia and reduced proprioception of the lower limbs. The patient also exhibited patchy paresthesia bilaterally to the level of the umbilicus. There was decreased ankle tone on digital rectal examination. There was no clinical evidence of major head or spinal trauma and the remainder of his cranial nerve and general neurological examination was unremarkable. These findings were consistent with an upper motor neuron lesion. The patient was admitted to hospital for further evaluation and treatment.

INVESTIGATIONS
Preliminary blood tests revealed a mildly elevated C reactive protein (CRP) (21 mg/L), elevated erythrocyte sedimentation rate (44 mm/hour), elevated D-dimer (0.79 g/L) and lymphopaenia (0.8×10⁹/L) (table 1).

CT scan with intravenous contrast of his lumbar sacral spine showed diffuse disc bulge at L5/S1 with mild thecal sac indentation but no significant central canal stenosis. CT brain with intravenous contrast did not show hydrocephalus, space occupying lesion, oedema or haemorrhage. CT chest showed scattered peripheral areas of ground-glass opacity and consolidation in both lungs (figure 1).

MRI scan of his whole spine demonstrated a long segment of T2 signal elevation centrally in the spinal cord from T7 to T10, without significant enhancement or the presence of a mass (figures 2–3). MRI brain and orbits did not show any indication of recent or ongoing inflammatory change to suggest a relationship to the MRI changes observed in the spine.

Cerebrospinal fluid (CSF) collected from lumbar puncture showed elevated protein count (0.79 g/L) but normal glucose (3.2 mmol/L) (table 1). CSF culture and blood cultures were negative. SARS-CoV-2 (PCR) from nasopharyngeal swab and CSF was not detected. Serology for SARS-CoV-2 demonstrated recent infection (SARS-CoV-2 IgG 640, SARS-CoV-2 IgA 160, SARS-CoV-2 IgM 20 by in-house immunofluorescent antibody testing). ACE levels were not detected in CSF. Antibodies for anti-myelin-associated glycoprotein IgM

Findings that shed new light on the possible pathogenesis of a disease or an adverse effect

Table 1  Laboratory findings

<table>
<thead>
<tr>
<th>Count x10^12/L</th>
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<tbody>
<tr>
<td>White blood cell</td>
<td>0.0051 (0.004-0.011)</td>
</tr>
<tr>
<td>Neutrophil</td>
<td>0.036 (0.002-0.008)</td>
</tr>
<tr>
<td>Lymphocyte</td>
<td>0.0008 (0.001-0.004)</td>
</tr>
<tr>
<td>Platelet</td>
<td>0.408 (0.150-0.400)</td>
</tr>
<tr>
<td>C reactive protein (mg/L)</td>
<td>21 (&lt;5)</td>
</tr>
<tr>
<td>Erythrocyte sedimentation rate (mm/hour)</td>
<td>44 (1-14)</td>
</tr>
<tr>
<td>D-dimer (mg/L)</td>
<td>0.7 (&lt;0.5)</td>
</tr>
<tr>
<td>Creatine kinase (unit/L)</td>
<td>53 (40-200)</td>
</tr>
<tr>
<td>Lactate dehydrogenase (unit/L)</td>
<td>226 (120-250)</td>
</tr>
<tr>
<td>Alkaline phosphatase (unit/L)</td>
<td>60 (30-110)</td>
</tr>
<tr>
<td>Gamma-glutamyltransferase (unit/L)</td>
<td>46 (5-50)</td>
</tr>
<tr>
<td>Alanine aminotransferase (unit/L)</td>
<td>49 (10-50)</td>
</tr>
<tr>
<td>Aspartate aminotransferase (unit/L)</td>
<td>22 (10-35)</td>
</tr>
<tr>
<td>Blood urea nitrogen (mmol/L)</td>
<td>4.4 (4.0-9.0)</td>
</tr>
<tr>
<td>Creatinine (μ/L)</td>
<td>71 (60-110)</td>
</tr>
</tbody>
</table>

Red cell <0.001 (<0.001) Polymorph 0.006 (<0.005) Mononuclear 0.004 (<0.005)

Bold values fall out of the normal range which have been listed in brackets.

ELISA, myelin oligodendrocyte glycoprotein (in-house assay) and neuromyelitis optica IgG (Euroimmun immunofluorescence) were negative in serum. Serology for mycoplasma, Epstein–Barr virus, cytomegalovirus, HIV, hepatitis B and C was negative. An autoimmune panel did not suggest primary autoimmune condition. Serum ferritin (711 μ/L) and interleukin-6 levels (7.8 pg/mL) were only measured day 10 of admission (28 days after symptom onset) and showed elevated ferritin but normal interleukin-6 (IL-6) level.

DIFFERENTIAL DIAGNOSIS

The presence of upper motor neuron signs in this patient prompted the need for a detailed neurological examination. He did not report a history to suggest significant head or spinal trauma. The progressive onset of his neurological symptoms made the diagnosis of a cerebrovascular accident less likely. His preliminary blood work and clinical observations did not suggest severe systemic infection. The patient’s medical history did not offer any further clues to his presentation. Neuroimaging was not suggestive of demyelinating condition such as multiple sclerosis. Taking into account his recent viral infection (COVID-19), we explored the possibility of post-viral acute transverse myelitis (ATM).

TREATMENT

The patient was treated with intravenous methylprednisolone 1g per day for 3 days. He also received intensive physiotherapy during his time in hospital. No antivirals, antibiotics or immune-modulatory drugs were given apart from the methylprednisolone.

OUTCOME AND FOLLOW-UP

Neurological symptoms improved shortly after completion of corticosteroid therapy. MRI whole spine was repeated on day 10, which showed almost complete resolution of the changes seen previously between T7 and T10. He regained full lower limb motor strength, the paresthesias completely resolved and the indwelling catheter was successfully removed. He was discharged to home on day 11 of admission.

DISCUSSION

The most common symptoms associated with COVID-19 infection include fever, cough, fatigue and dyspnea. More recent evidence has suggested an increased incidence of anosmia and dysgeusia with COVID-19 infection. This is thought to arise because SARS-CoV-2 virus may be able to directly invade the nervous system via the olfactory tract or the blood circulation during a proinflammatory state. Viral encephalitis, as another presentation of CNS involvement, has been...
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**Patient’s perspective**

I did not expect to contract COVID-19. I used to think that this virus only affected the lungs. When I had trouble going to the toilet, I thought I could have cancer. The next couple of days that followed were scary. I could not understand what was happening to my body. When I came into hospital, I struggled to understand my diagnosis but was relieved that I did not require an operation. The medication they gave me helped and my symptoms improved quickly. People need to know that COVID-19 can affect other organs as well.

**Learning points**

- Neurological complications may occur in the context of COVID-19 infection.
- Consider MRI scan when investigating upper neuron syndrome.
- Corticosteroid therapy in acute transverse myelitis can rapidly improve neurological symptoms.

We have presented a case of ATM in the context of recent COVID-19 infection. We did not detect SARS-CoV-2 RNA in the CSF and postulate that this presentation was likely due to an immune-mediated inflammatory process rather than direct invasion of SARS-CoV-2 into the CNS. A review of the literature revealed one similar case report of myelitis post-COVID-19 infection but did not include MRI or CSF analysis.

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