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Meningeal Myelomatosis: CT and MR Appearances

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Summary: Meningeal myelomatosis is a rare feature of multiple myeloma. We report a case of IgG-k myeloma presenting as bilateral intracranial extraaxial masses.

Index terms: Multiple myeloma; Meninges, neoplasms; Brain, neoplasms

Multiple myeloma is a malignant proliferation of plasma cells in which meningeal myelomatosis is a rare finding; at least 40 cases have been reported (1–2). Men are affected more often than women by approximately 2:1, and those affected are 31 to 76 years old (1). In approximately one third of patients with meningeal myelomatosis, changes in mental status are the initial neurologic manifestation (1). Other reported clinical manifestations are lower extremity weakness, cranial nerve palsies, gait disturbance, headache, speech disorders, meningismus, seizure, vertigo, hemisensory loss, diffuse weakness, hemiparesis, muscle wasting, limb pain, and dysmetria (1). The diagnosis is usually made by finding myeloma cells in the cerebrospinal fluid. Previous reports show a disproportionate number of IgA (23%) and IgD (13%) tumors in patients with meningeal myelomatosis, which might indicate a propensity for these two rare subtypes to spread to the meninges (1). The remainder are IgG (23%), IgM (3%), light chain only (8%), and unspecified (33%). The median survival is 1 month in patients who had no initial response to therapy and 5 months in those who had an initial response (1).

CT findings of meningeal myelomatosis have been reported as peripheral, markedly hyperdense masses with associated parenchymal edema and mass effect (3). MR findings were reported for a case similar to ours in which a solitary extraaxial parietal mass was the presenting feature (2). The extraaxial masses of our patient were homogeneous on T2-weighted images, in contrast to the previously reported case, in which the extraaxial mass had heterogeneous signal (2). In our patient, diffuse homogeneous enhancement of the masses oc-
occurred without any nonenhancing areas. The postcontrast T1-weighted image of the comparison case had a central nonenhancing focus (2). Meningeal myelomatosis has also been reported to show abnormal leptomeningeal enhancement in the cerebellar sulci (2) and can show abnormal enhancement of the cranial nerves (1). Other extraaxial mass lesions that can be isointense with gray matter on long-repetition-time and short-repetition-time images and can enhance homogeneously with intravenous contrast administration include meningioma, lymphoma, and carcinomatous meningitis.

In conclusion, extraosseous myelomatosis is an uncommon clinical form of multiple myeloma that is more aggressive and resistant to therapy. Meningeal involvement, reported in approximately 40 cases, demonstrates rapid progression. The intracranial finding of an extraaxial mass has been reported in two cases that had characteristics distinctly different from
our case on CT and MR imaging. Meningeal myelomatosis should be considered in the differential diagnosis when slightly hyperdense subdural masses are seen on CT and when homogeneous lobulated meningeal masses that are isointense with gray matter on long-repetition-time and short-repetition-time images show diffuse homogeneous enhancement on MR imaging.

References

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