Parsonage-Turner syndrome (PTS) was first reported in 1948 as an acute neuritis of the brachial plexus and neuralgic amyotrophy with an unknown etiology.

A 28-year-old febrile woman suffered from continuous pain in the left neck and shoulder. MRI showed a high-intensity triangle on T2- and diffusion-weighed images of the left brachial plexus (Picture A). positron emission tomography (PET)-CT revealed a high uptake of fluorodeoxy glucose (FDG) in the same area (Picture B), leading to the diagnosis of PTS. The patient’s symptoms and triangle sign disappeared within two months (Picture A).

The sudden onset of shoulder pain and motor neuropathy related to the brachial plexus are the chief manifestations of PTS, being subsequently complicated by reflex changes and sensory abnormalities (1). The pain is self-limiting and the accompanying neuropathy improves spontaneously. The inci-
The incidence of PTS is approximately 1 per 100,000 people, and the disease is not frequently recognized by internists. The presence of a triangle sign on T2 images is a clue for the diagnosis of PTS (2).

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References