Chest pain and hypertension are a common emergency indicating acute coronary syndrome or aortic dissection. However, they can also originate from the spinal cord (1, 2). A 70-year-old Japanese man was referred to us for acute chest pain (tight, squeezing pain exacerbated when bending his back, the laterality of which could not be described). On arrival, his pain was not related to the C7 radicular dermatome, where we found no sympathetic nerve-related skin discoloration or perspiration. He had extreme hypertension (218/90 mmHg) but with bradycardia (42 bpm, regular) and hyperhidrosis in the face and chest. Cardiac test results were normal. He soon developed paraparesis and was found to have loss of pain sensation in the lower half of body (false localizing sign) (2). A Foley catheter was inserted, and a large amount of urine came out, evidence of urinary retention; this normalized his blood pressure and heart rate quickly (autonomic dysreflexia) (1, 2). A cervical magnetic resonance imaging scan showed an epidural hematoma at the right C7 level but without vascular malformation (Picture). Abnormal von Willebrand factor or other coagulation factors were not detected. Steroid pulse therapy ameliorated his clinical symptoms completely.

The authors state that they have no Conflict of Interest (COI).

References