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# Rehabilitation 中国临床康复

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## 专题论坛

### 脑卒中后二次损伤

脑卒中后肺炎	刘长庭
痉挛的治疗	刘卫
废用性肌萎缩研究进展	郑淑燕
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本刊以传播现代临床康复医学的新理念、新技术、新方法为宗旨,使读者及时了解疾病早期康复介入,临床康复的理论、实践、基础研究以及相关医学其他方面的最新进展。

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编辑部 024-22714352

024-22714435

传真:024-22830178

投稿 E-mail: wszdin@mail. sy. ln. cn

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## 名誉主编

耿德章

## 主编

刘昆

## 副主编

王茂斌 门振兴 梁东明

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王莉莎

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#### 精神心理康复

#### 儿科康复

## Value of MRI in the evaluation of lipid storage myopathy

Zheng Xianying 郑贤应, Murong Shengxing 慕容慎行, Li Yinguang 李银光, Ni Xihe 倪希和, Cai Jiangping 蔡江萍

Zheng Xianying, Murong Shengxing, Li Yinguang, Ni Xihe, Cai Jiangping,  
Intraneural Department, First Affiliated Hospital, Fujian Medical University,  
Fuzhou 350001, Fujian Province, China

## Abstract

**AIM:** To investigate the magnetic resonance imaging (MRI) findings of lipid storage myopathy (LSM), evaluate the clinical value of MRI for LSM. **METHODS:** Eight cases with LSM biopsy-proved underwent MRI of pelvis and thigh, spin echo sequence, fast spin echo sequence and short tau inversion recovery (STIR) were utilized. **RESULTS:** The signal intensity of diseased muscle of 8 cases with LSM was hyperintense on T2-weighted images (T2WI) and T1-weighted images (T1WI), and hyperintense signal intensity on T2WI and iso-intense on T1WI was seen on 2 patients as well. **CONCLUSION:** MRI can provide objective data for clinical diagnosis, therapeutic evaluation and follow-up. It can also help to decide the accurate localizations for biopsies. **SUBJECT WORDS:** lipidoses; muscular disease; magnetic resonance imaging

## INTRODUCTION

Lipid storage myopathy belongs to inflammation of muscle cells caused by self immunity. (lipid storage myopathy, LSM). Domestic researches about its evaluation with MRI were unavailable. Our objective was to investigate MRI findings of LSM and its value in the evaluation of LSM.

## MATERIALS AND METHODS

## Materials

9 LSM patients admitted from April 1998 to April 2002 were included in our study. These patients include 5 men and 5 women aging 4-36 years (mean age: 24.9 years). Course of disease varied from 9 months to 12 years, averagely 6.8 years. 1 subject suffered from the first onset and the remaining were the recurrent cases. All patients had myasthenia clinically and were relived in 3 cases 2-4 years ago. Creatine phosphokinase (CPK) were 217-3 297 IU/L, averagely 950 IU/L (reference value: 25-200 IU/L), lactic dehydrogenase (LDH) 303-3 080 IU/L, averagely 1 132 IU/L (reference value: 109-245 IU/L). Electromyography showed myogenic diseases. Diagnosis was confirmed pathologically.

## Methods

Scanning instrument superconductive that is MRX machine Flexart 0.5 T was provided by Toshiba Company. Positive alternating body and tail coils were used. All patients received axis scanning of pelvis, bilateral legs and thighs and parallel examination, no enhanced scanning was performed. Scanning sequences included self echo T1WI (TR 600 ms, TE 30 ms), fast self echo T2WI (TR 3 000 ms, TE 80 ms), short transverse recovery T2WI (TR 2 000 ms, TE 30 ms, TI 150 ms). Layer was 10 mm in thickness, and interval was 10 mm. Vision field was 35 cm × 35 cm, and matrix was 198 × 256.

## RESULTS

Positive findings were observed in 7 of 8 patients receiving examination. T2WI and T1WI showed spot or slice like signal. Signal of high density in STIR sequence magnified as that of low density such as extensive lesions, unclear boundary, and symmetry. Posterior muscles of thigh and adductor muscle groups showed T1 and T2 signal suggesting necrosis of muscle fibers. No positive findings was observed in 1 recovered patient with course of disease of 2 years. Hip muscles, posterior muscles of thigh, and adductor muscles groups

were all affected in 7 patients receiving examination.

Signal of the greatest gluteal muscle and biceps muscles of thigh were abnormal in 7 cases, signal of quadriceps was abnormal in 5 cases. No affected iliopsoas muscle was observed. musculus vastus intermedium was affected slightly, and the greatest gluteal muscle was affected seriously.

## DISCUSSION

LSM is resulted from disorder of fat metabolism of muscular fibers, and hence leading to fat accumulation. It often showed acute or subacute onset and is characterized by myasthenia of proximal end of limbs with or without myopain, myogenic lesions confirmed by EMG, muscle enzyme increase, course of recurrence and relief. Definite diagnosis is available after pathological examination. MRI showed that signal of normal muscles was located between bone cortex and subcutaneous fat and is mediate in intensity. For normal muscles, T2WI showed signal of high intensity similar to strips representing connective tissue filling space, while T1WI showed arc like signal of high density representing the little amount of fat-locating covering of muscles.

Muscles with LSM lesions showed 2 types of signals, short T1 + long T2, and T1 + T2, the former suggesting fat storage myopathy, and the latter suggesting necrosis of muscular fibers and magnifying as LSM. Necrosis is usually located in posterior muscles of thigh and adductor muscle groups and especially common among patients of acute phase. It is different from results of clinically pathological examination. Pathological examination found no necrosis of muscular fibers<sup>[1-2]</sup> and was probably due to differences in course of disease and tissue acquirement. Lesions of the greatest gluteal muscle, adductor muscles groups, and posterior muscles of thigh were especially severe.

PM is similar to LSM in clinical symptoms and should be differentiated from it. MRI showed two kinds of signals for PM, inflammation and edema signal of long T1 and T2 and fat signal of short T1 and long T. MRI is incapable of differentiating local necrosis and inflammatory infiltration. MRI findings of PM is characterized by inflammatory edema signal, fat lesions is only can be observed in advanced cases. MRI findings of LSM is characterized by fat accumulation, and local muscles fibers is only can be observed in acute patients. Fat accumulation is severe in greatest gluteal muscles, and moderate in posterior muscle thigh and adductor muscles, for LSM, and mild in quadriceps, and necrosis signal is observed in posterior muscles of thigh and adductor muscles in inflammatory edema signal can be observed in all muscles and is extensive, and basolamina may be affected, some fat signal is shown in posterior muscles of thigh.

Patients with long course of disease showed atrophy, and slightly affected quadriceps. Lesion range and locus can be observed, inflammation, edema, and fatty degeneration be compared by using MRI. Distribution and percent of lesions will provide basis for diagnosis of LSM. In addition, MRI will provide instruction for muscle biopsy and EMG examination.

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