Denouement and Discussion

Diagnosis: Parsonage-Turner Syndrome

The image depicts a left-winged scapula resulting from shoulder girdle weakness. After plain radiographs showed no abnormalities, magnetic resonance imaging of the cervical spine and shoulder revealed high T2 signal intensity of the long thoracic, suprascapular, and axillary nerves and fatty atrophy of the muscles, confirming the diagnosis of Parsonage-Turner syndrome (PTS) (otherwise known as brachial neuritis, neuralgic amyotrophy, and idiopathic brachial neuritis).1,2

Parsonage-Turner syndrome is a condition that was first described in 1948 in a case series of 136 patients.3,4 Typically, PTS presents with abrupt onset of moderate shoulder pain followed by variable weakness of the shoulder girdle. Patients with PTS usually describe a sharp onset of pain that subsides in days to weeks and is slowly replaced with a dull ache. Weakness develops after the resolution of the initial pain, and there is usually normal sensation.1,2 Involved muscles are those innervated by the brachial plexus (C5-C8), most commonly the long thoracic, suprascapular, and axillary nerves.1,5 In our patient, a winged scapula was present because of paralysis of the serratus anterior muscle, which is innervated by the long thoracic nerve. Any component of the brachial plexus can be involved, with the lower trunk affected in up to 15% of cases.6 Case series have been reported of adult men presenting with phrenic nerve involvement, leading to dyspnea from diaphragmatic paralysis.6,7

The incidence of PTS is estimated at 1.64 per 100 000 in the general population and is highest in the third through seventh decades of life; rare reports have occurred in children as young as 3 months.8 There is a male predominance, with reported male to female ratios of 2:1 to 11.5:1.3,5,9-11 Although the cause of PTS is undetermined, it has been linked to vaccine administration and viral illnesses in 15% to 25% of cases.5,7,12,13 Specific cases after tetanus toxoid immunization and outbreaks in specific clusters have led most to believe that an immune-mediated process is the common pathway in this disease. Most cases are not preceded by trauma.5,7,13 Eighty percent of cases spontaneously resolve within 2 years, and patients with severe symptoms at onset may have a more protracted course of weakness.1,13 Management is focused on analgesia and physical therapy, with no need for surgery reported in the literature.1,5,14

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REFERENCES


**Correction**

Errors in Byline and Correspondence. In the Special Feature article titled “Picture of the Month ” by Iyer and Mistry, published in the March issue of the Archives (2009; 163[3]:275-276), errors occurred in the byline on page 275 and the name of the lead author in the Correspondence section on page 276. The names should have read: “Sujit S. Iyer, MD, MS; Rakesh D. Mistry, MD, MS” on page 275 and “Sujit S. Iyer, MD, MS” on page 276.