

Chiari-like malformation and syringomyelia

Clare Rusbridge

Introduction

Syringomyelia is a condition characterised by fluid filled cavities (syrinxes or syringes) within the central spinal cord and the resulting damage produces clinical signs of pain and neurological deficits. Since the increase in availability of magnetic resonance imaging (MRI), syringomyelia is an increasingly common diagnosis in veterinary medicine (1, 2) The most common cause of syringomyelia in the dog is Chiari-like malformation (Fig 1), a condition analogous to Chiari Type I and O malformation in humans (3, 4).

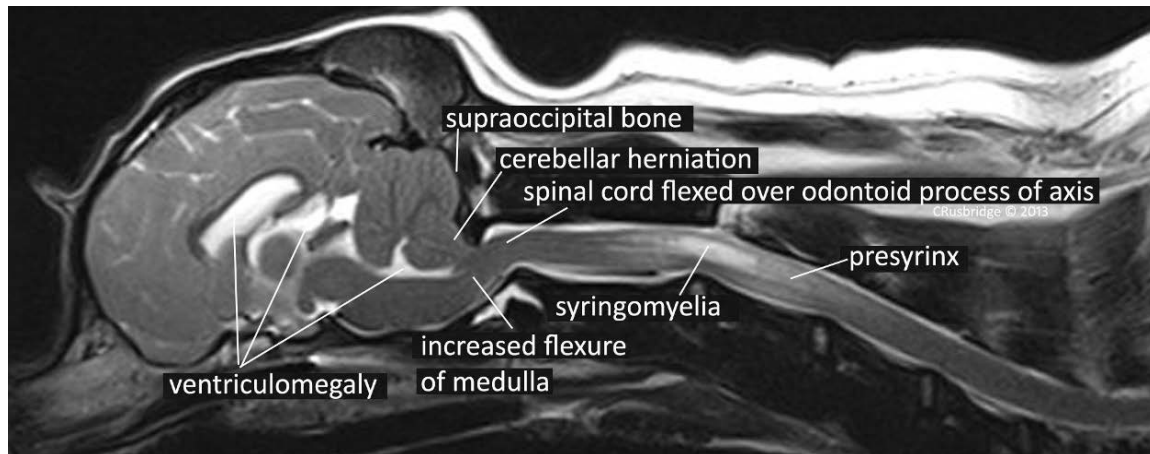


Figure 1 Midline sagittal T2-weighted MRI images of the brain and cervical spinal cord from 1 year old female CKCS with Chiari malformation and syringomyelia and presenting with pain.

Pathophysiology of syringomyelia

A satisfactory explanation of how syringomyelia develops has yet to be elucidated. There is not even a consensus as to whether syrinx fluid is derived from extracellular or cerebrospinal fluid (CSF) (5-8)]. Syringomyelia is a disorder of CSF and therefore understanding the pathogenesis of this enigmatic disorder is dependent on understanding CSF flow dynamics, biochemistry and factors that influence its absorption and production.

The majority of CSF is produced by the four choroid plexuses (one in each ventricle of the brain), which circulates through the ventricular system and the subarachnoid spaces of the brain and spinal cord (9, 10). Drainage of CSF is partly into the blood through arachnoid granulations and villi and partly along lymphatic drainage pathways, mostly associated with the cribriform plate of the ethmoid bone (11). It has also been suggested that the spinal central canal may play a part in drainage of CSF and/or excess extracellular fluid as there is functional communication between the central canal and the subarachnoid space at the terminal ventricle (12, 13). One of the major functions of CSF is as a mechanical buffer however it does not just provide a physical cushion and reduces tension on nerve roots but also accommodates the pressure of the systolic pulse and reduces the weight of this heavy organ. Without the CSF a human could not stand upright and within the CSF a 1500g brain weighs only 50g (14).

According to the Munro-Kellie doctrine the central nervous system and its accompanying fluids are enclosed in a rigid container whose total volume remains constant. Therefore when the heart beats and there is increase in volume of intracranial blood, CSF is displaced from the cranial to the spinal subarachnoid space through the foramen magnum thus avoiding a deleterious increase in intracranial pressure. The spinal dural sac is distensible, further increasing the compliance of the system and minimising rises in central nervous system pressure (15). Disturbance of the normal free flow of CSF through the foramen magnum appears to be a major factor responsible for the formation of a syrinx in the cervical spinal cord (2, 16, 17). However there may be other possible factors influencing the pathogenesis of a syringomyelia such as failure of absorption or drainage of extracellular fluid (18), intracranial hypertension (19-21), imbalance in the production and absorption of CSF

(22) disruptions of the blood-spinal cord barrier or alterations of aquaporin expression (23) . The currently most accepted theory of pathogenesis of syringomyelia is that obstruction to CSF flow in the subarachnoid space results in a mismatch in timing between the arterial pulse peak pressure and CSF pulse peak pressure. Earlier arrival of peak CSF pressure compared to peak spinal arterial pressure encourages flow of CSF into the perivascular space. The perivascular space changes in size during the cardiac cycle and is widest when spinal arteriole pressure is low. If at that time peak CSF pressure is high then the perivascular space could act as a 'leaky' one-way valve (8, 24-27). From the perivascular space, fluid flows into the central canal ultimately resulting in a syrinx (28-30). However this theory also leaves many unanswered questions and further study is required.

In the dog syringomyelia is associated with a number of different pathologies with a common theme of CSF flow obstruction. The most common cause is Chiari-like malformation, which is a complex abnormality characterised by overcrowding of the craniocervical junction and obstruction of CSF flow through the foramen magnum. It is unclear why some dogs with Chiari-like malformation develop syringomyelia and some do not (31, 32) . Numerous studies, mostly in Cavalier King Charles spaniel (CKCS) and Griffon Bruxellois (Table 1) have identified many "pieces of the jigsaw" however key parts are still missing. No study has identified a single anatomical feature that consistently predicts syrinx development and it is likely that the pathogenesis of syringomyelia is a multifactorial process.

Table 1. Pathogenesis of Chiari-like malformation and syringomyelia: summary of the existing knowledge base. Abbreviations used in tables: CKCS – Cavalier King Charles spaniel; SM – syringomyelia; CM – Chiari-like malformation. CCD – central canal dilatation.

Anatomical feature	Study Finding(s)	Significance relating to syringomyelia	Reference
Brachycephalicism	Brachiocephalic breeds have early closure of the spheno-occipital synchondrosis. In CKCS closure is even earlier	Premature closure of the spheno-occipital synchondrosis will result in a short cranial base predisposing brain overcrowding	(33, 34)]
	CKCS have shorter braincase in relation to width compared to other brachycephalic dog breeds		(35)]
	Griffon Bruxellois with CM have shortened basicranium and supraoccipital bone, with a compensatory lengthening of the cranial vault, especially the parietal bone	Basiocranial shortening results in compensatory changes in the rostral cranial fossa but caudal cranial fossa overcrowding persists	(21)
Caudal cranial fossa volume	CKCS with CM and SM have a shallower and smaller volume caudal cranial fossa compared to CKCS with CM only and other control breeds	Smaller caudal cranial fossa volume predisposes caudal cranial fossa overcrowding	(36, 37)]
	CKCS have a strong relationship between hindbrain volume and volume of the rostral part of the caudal cranial fossa and a weak relationship between hindbrain volume and volume of the caudal part of the caudal cranial fossa. In Labrador retrievers and other small breed dogs this relationship is reversed.	Small breed dogs and Labrador retrievers compensate for variations in hindbrain volume by modifying growth of the occipital skull. In the CKCS, increased cerebellar size is not accommodated by increased occipital bone development and the tentorium cerebelli compensates by bulging in a rostral direction	(36, 38)]

Parenchymal (brain) volume	The absolute and relative volume of the CKCS skull is similar to other brachycephalic toy dog breeds but CKCS have a greater volume of parenchyma within the caudal cranial fossa.	Mismatch in skull and brain volume is associated with development of SM.	(39)]
	CKCS with early onset SM have a larger volume of parenchyma within a smaller caudal cranial fossa compared to older CKCS with CM only		(37, 40, 41)]
Cerebellar volume	CKCS have relatively increased cerebellar volume compared to other control breeds and this is associated with development of SM.	Caudal cranial fossa overcrowding is associated with development of SM	(42)]
	Increased cerebellar volume in CKCS is correlated with increased crowding of the cerebellum in the caudal part of the caudal cranial fossa		
Cerebellar herniation	Commonly seen but presence or size does not predict SM	Obstruction of CSF channels though the foramen magnum contributes to the pathogenesis of SM but there must also be other predisposing factors.	(31, 43)]
	Positive association with the size of foramen magnum and size of cerebellar herniation	Overcrowding of the caudal cranial fossa causes supraoccipital bone resorption (occipital dysplasia)	(31)]
	The length of the cerebellar herniation increases with time The size of the foramen magnum also increases		(44, 45)]
Cerebellar pulsation	CKCS with CM and SM have significantly greater pulsation of the cerebellum compared to CKCS with CM only and other control breeds	Abnormal cerebellar pulsation could lead to a mismatch in the timing of the arterial and CSF pulse waves predisposing SM	(26, 27, 46)]
CSF flow	Higher peak CSF flow velocity at the foramen magnum with a lower CSF flow velocity at C2–C3 predicts SM	Alterations in the CSF velocity profile predispose SM	(47)]
	Turbulence at the foramen magnum and at the C2–C3 disc significantly associated with SM		
	In CKCS ventricle dimensions are positively correlated with syrinx width	SM is related to CSF disturbances	(37)]

Ventricle dimensions			
	Are not correlated with seizures (nor is caudal cranial fossa overcrowding)	Epilepsy and CM in CKCS should be considered unrelated	(48)]
Jugular foramina	CKCS with CM and SM have narrowed jugular foramina in comparison with CKCS with CM only	Venous narrowing at the jugular foramina associated with small skull base can lead to elevated venous pressure and impaired CSF absorption	(21, 49)]
Venous sinus volume	CKCS with CM and SM have reduced venous sinus volume in comparison with CKCS with CM only	Reduced venous sinus volume could result in intracranial hypertension and impaired CSF absorption	(41)]
Site of syrinx	In CKCS, SM tends to develop first within the C2–C4, T2-T4 and T12-L2 spinal-cord segments. These are regions where the subarachnoid space narrows and/or there is a change in the angulation of the vertebral canal	According to the Venturi effect, increased fluid velocity through a narrowed flow channel decreases hydrostatic pressure in the fluid, meaning that there may be a tendency for the spinal cord to be “sucked” outward in these regions which may contribute towards SM. However other studies have suggested that the contribution of the Venturi effect is insignificant	(2, 27, 50)]
	In CKCS 76% of dogs with a syrinx at C1-C4 also had a syrinx in the C5-T1 and T2-L2 regions and 49% had a syrinx in the L3-L7 region	In CKCS MRI imaging of the cranial cervical region only has high sensitivity for detection of SM however the extent of the disease may be underestimated	(50)]
Atlantoaxial subluxation	Occasional comorbidity with CM	No significant association with SM	(51)]
Size of C2 spinous process	Significantly smaller in CKCSs than in non-CKCS breeds		
Atlanto-occipital overlapping	Commonly seen in association with CM especially in non-CKCS breeds (Fig 6)	Additional compression of CSF channels may contribute to development of SM but a consistent association has not been proven.	(52, 53)]
Dorsal impingement subarachnoid space / spinal cord at C1-C2	Commonly seen in association with CM (Fig 7)		(31, 36, 52)]
Ventral impingement of subarachnoid space / neural tissue by dens	Commonly seen in association with CM (Fig 1)		(31, 36, 52, 54)]
Width of spinal canal	Increased width of spinal canal at C2- C3 and C3 in CKCS with SM	Questionable clinical significance	(55)]
Angulation at C2-C3	No correlation		
Syrinx size and symmetry	Pain is positively correlated with SM transverse width and symmetry on the vertical axis,	Dogs with a wider asymmetrical SM more likely to experience discomfort A syndrome of neuropathic pain is more likely when there is asymmetrical dorsal horn involvement	(56, 57)]

Prevalence and incidence

Chiari malformation

Brachycephalicism and miniaturisation are risk factors for Chiari-like malformation (35). The condition is most commonly reported in toy breed dogs, in particular CKCS, King Charles spaniels, Griffon Bruxellois, Affenpinschers, Yorkshire terriers, Maltese, Chihuahuas, Pomeranians, Boston terriers and Papillons (52). Chiari-like malformation has also been recognised in cross-breed dogs particularly CKCS crosses. Partly because of its popularity as a pet, the CKCS is overrepresented and Chiari malformation is considered ubiquitous in this breed (1, 31, 43). Up to 65% of the Griffon Bruxellois breed has Chiari-like malformation (21, 58); data for other breeds is not available. Chiari-like malformation may also be seen in cats and is again more common in brachycephalic varieties such as the Persian. The incidence of *symptomatic* Chiari-like malformation is not known and is difficult to determine because the most common clinical sign is pain. Pain is a complex amalgamation of sensation, emotions and (in humans) thoughts and manifests itself as pain behaviour (59) which in a dog may not be recognised by owners or their veterinarians (Table 2). In addition pain associated with Chiari-like malformation is rarely constant or focal. In humans the key features of Chiari-related headaches are their relationship to any Valsalva-like manoeuvre, their brief duration - often lasting only seconds – and their posterior, suboccipital location (60). In a dog this might manifest as a yelp on a rapid change of position, for example being picked up. It is difficult to attribute non-specific and brief signs to a specific aetiology especially when a condition is common in a breed and can be asymptomatic. The reported number of human patients with asymptomatic Chiari malformation type 1 varies between a third and a half of those diagnosed with the condition by MRI (61-65).

Syringomyelia

Due to the relationship with Chiari-like malformation, prevalence of syringomyelia is also high in brachycephalic toy-breeds (52). Again not all animals with syringomyelia are symptomatic and like Chiari-like malformation it is difficult to obtain reliable incidence data. In humans the reported frequency of syringomyelia in people who have Chiari malformation type 1 malformation ranges from 65 to 80% (70) and the frequency of asymptomatic syringomyelia has been reported as being 23% (71). Syringomyelia has a varying age of onset, there is 46% prevalence in (allegedly) asymptomatic breeding CKCS but prevalence (symptomatic and asymptomatic) increases with age and may be as high as 70% in dogs over six years of age (1). In the Griffon Bruxellois 42- 52% of dogs have syringomyelia and this is not always in association with a classical Chiari-like malformation (21, 72).

Table 2 Clinical signs of Chiari-like malformation and syringomyelia

Clinical signs	CM	SM
Pain Behaviour		
Vocalisation	Owners may describe spontaneous vocalisation, especially when the dog stands up, jumps or when it is picked up. However the expression of pain by vocalisation is an unreliable sign and the absence of vocalisation is not a reliable indication that the dog is comfortable	
Withdrawn	Dogs with CM with or without SM may be described as “quiet” or “lazy” or may have decreased participation in activities such as playing and walking (Fig10)	
Avoidance of rapid changes in posture	It is common for dogs with CM with or without SM to avoid jumping, stairs and appear to dislike being picked up	
Reduced exercise	Signs may be exacerbated by excitement and exercise, it is thought because of increased systolic pulse pressure. Dogs with higher neuropathic pain score have decreased willingness to exercise (66)].	
Scratching	Ear / back of skull scratching and/or rubbing	Dogs with a wide asymmetrical syrinx are more likely to have phantom scratching induced by excitement or from a non-noxious stimulus, such as touch or wearing a collar (Fig 5). Scratching is typically unilateral and to a small area on the neck and /or shoulder region. The dog does not make skin contact (67)].

Fear / anxiety / excitability	Neuropathic pain has an important impact on an individual's quality of life and neurobehaviour (68)]. Dogs with higher neuropathic pain scores are more likely to have (66)] <div><div>1) Stranger-directed fear (act fearfully when approached by an unfamiliar person).</div><div>2) Non-social fear (act fearfully when in unfamiliar situations or when sudden loud noises occurred, e.g. thunderstorms).</div><div>3) Attachment behaviour (more 'clingy' to the owners) separation-related behaviour (more 'afraid' when left alone)</div><div>4) Excitability (increased attention-seeking behaviour and more excitable in positive, reward-associated situations)</div></div>	
Sleep disturbance	Dogs with higher neuropathic pain score are more likely to have disturbed sleep (66)]. Sleeping with the head in unusual positions may be reported (Fig 11).	
Other neurological signs		
Sensitivity	Dogs with symptomatic CM often appear to have sensitivity to palpation of the cervical and thoracolumbar spine.	As with CM but dogs with spinal dorsal horn damage may have allodynia, i.e. signs of discomfort from a non-noxious stimulus, such as touch or grooming
Scoliosis	No	Dogs with a wide syrinx and dorsal grey column damage may have cervical torticollis and cervicothoracic scoliosis (Fig 3).
Gait abnormalities	CKCS with CM may have subtle gait abnormalities, relating to cerebellar or spinocerebellar tract dysfunction (69)].	Dogs with a wide syrinx may have thoracic limb weakness and muscle atrophy (due to ventral horn cell damage) and pelvic limb ataxia and weakness (due to white matter damage or involvement of the lumbar spinal cord by the syrinx) (2).
Exotropia	Common	Common (related to CM)

Clinical signs

Chiari like malformation

It is recognised increasingly that Chiari-like malformation alone can cause significant morbidity and reduced quality of life (73). As with humans with Chiari type I malformation the most important clinical sign in affected dogs is behavioural signs of pain (Table 2). It is common for dogs with Chiari-malformation to have exotropia (outward deviation of the eye) - typically a ventrolateral strabismus when gazing to the ipsilateral side (Fig 2).



Figure 2 *It is common for dogs with Chiari – like malformation to have exotropia or outward deviation of the eye (in this case the right eye) when gazing to the ipsilateral side.*

It is unclear whether this is oculomotor nerve/muscle palsy or related to orbit confirmation. Some human craniosynostosis syndromes (premature fusion or abnormal development of one or more cranial sutures) with a high prevalence of Chiari malformation (for example Apert's and Crouzon's syndrome) (22)] also have a high prevalence of strabismus (74). Other neurological signs are detailed in Table 2. In some instances of neurological dysfunction it is difficult to be convinced of a true association with Chiari-like malformation. For example there is a high incidence of epilepsy in dogs with Chiari-like malformation, especially in CKCS. In one report, 32% of the study population had seizures (43) and in a long term study of 48 CKCS, with syringomyelia associated neuropathic pain and where dogs with a history of seizures had been excluded from the original cohort, 12.5 % of the study population developed epilepsy in the follow up period (73). Consequently it has been suggested that there may be an association between Chiari-like malformation and epilepsy in the dog. An association has also been suggested in humans but again it is unclear whether the association is coincidental (75). A recent study compared ventricle size and caudal cranial fossa overcrowding in CKCS with and without seizures and found no significant differences (48)]. Electroencephalogram evaluation, performed in three epileptic CKCS, suggested paroxysmal abnormalities were mainly located over the frontal and temporal regions (48). Similar changes have been reported in humans with seizures and Chiari type I malformation (76)]. Further study is required to investigate if there is a connection between Chiari malformation and epilepsy. Vestibular dysfunction, facial nerve paralysis and deafness may also be seen but, as with epilepsy, no direct relationship has been proven and this association may also be circumstantial.



Figure 3 A two year old female CKCS with cervicothoracic scoliosis and torticollis as a consequence of syringomyelia. The torticollis may be confused with a head tilt associated with vestibular dysfunction. This error of neurological localisation may result in a poor choice of diagnostic tests for example performing MRI of the brain and ears rather than the cervicothoracic spinal cord. It is thought that the abnormal posture is due to asymmetrical grey matter destruction by the expanding syrinx resulting in an imbalance of afferent proprioceptive information from the cervical neuromuscular spindles

Syringomyelia

Enlarging syrinxes cause progressive neurological damage through a combination of direct pressure on neural tissue, and ischemia. The location of functional impairment depends on the site of neuronal damage and may include scoliosis (Fig 3), gait abnormalities and other signs, which are detailed in Table 2. However the most important and consistent clinical sign of syringomyelia is neuropathic pain. Pain is positively correlated with syrinx transverse width and symmetry on the vertical axis, i.e. dogs with a wider asymmetrical syrinx are more likely to experience discomfort, and dogs with a narrow symmetrical syrinx may be asymptomatic

Figure 4 Transverse T2 weighted MRI at the level of C2 from a CKCS presenting with scratching to the right cranial cervical region and signs of neuropathic pain. There is an asymmetrical syrinx involving the area of the right spinal cord dorsal horn and extending into the area of the superficial lamina I and II.



Pain is particularly associated with asymmetrical dorsal horn involvement especially when there is extension into the superficial lamina I and II (Fig 4) which receive primary afferents for nociception (77) and itch (78). Axons from projection neurons with cell bodies in lamina I cross the midline and ascend in the contralateral white matter (for example the spinothalamic tracts) to brain stem and thalamic targets. Different types of

excitatory and inhibitory interneurons selectively innervate these projection neurons. They are also influenced by descending serotonergic axons originating from the raphe nuclei (77)]. It is hypothesised that disruption to the complex synaptic circuitry in the dorsal horn is primarily responsible for the development of neuropathic pain in syringomyelia (56, 67)].



Figure 5 “Phantom scratching” in a CKCS. This is typically unilateral and to the neck and shoulder region. Here the scratching left hind limb can be seen as a movement blur. The dog does not make skin contact. This action can be elicited or exacerbated by excitement, exercise, touch and wearing of neck collars and harnesses. (Picture courtesy of Ms J Harrison, Passionate Productions.)

The pathogenesis of the phantom scratching (Fig 5) is not well understood. It has been presumed it is a response to allodynia (discomfort or pain from a non-noxious stimulus) and / or dysaesthesia (a spontaneous or evoked unpleasant sensation) and part of the neuropathic pain that these dogs appear to experience (56, 67)]. However it is possible that damage to inhibitory neuron circuits has permitted overexpression of a hyperactive reflex. This may explain why mutilation is not a feature of the disease and why a minority of dogs with phantom scratching do not appear to suffer pain. The lack of purposeful contact with the skin and the rhythmic action is reminiscent of the “scratch reflex” described by Sherrington in 1906 (79)]. He induced this in dogs that had undergone complete transection of the caudal cervical spinal cord. After approximately three months, stimulation of the skin in the scapular region induced a scratching action in the ipsilateral pelvic limb. The rhythmic action had a frequency of 4-8 times per second with the limb scratching towards but not making contact with the skin. Like dogs with syringomyelia there was a receptive field where stimulation of the skin induced ipsilateral pelvic limb action. Sherrington hypothesised that there was a spinal cord central pattern generator for scratching and that this had evolved as a protective response against clinging parasites and other irritants (79)]. It is now well established that there are spinal cord central pattern generators for scratching (80)]. Similar scratching action can be elicited in cats with by application of tubocurarine to the dorsal surface of the cervical cord at C1 (and to a lesser extent C2) with the scratch being elicited by rubbing the pinna and the skin behind the ear (81). Tubocurarine blocks Renshaw cells, inhibitory interneurons found in the spinal cord ventral horn (82)] that are rhythmically active during activity such as locomotion and scratching (83)], innervate motor neurons and receive inhibitory and excitatory synaptic inputs from commissural interneurons and from ipsilateral locomotor networks (84)]. Hypothetically a syrinx, particularly in the C1 / C2 region could lead to damage to these intricate networks resulting in a scratch reflex when the appropriate dermatome is tactilely stimulated.

Diagnosis

MRI is essential for diagnosis and determining the cause and extent of syringomyelia (Fig 1). Chiari-like malformation is a complex disorder and although there is less phenotypic variation than with humans, there can be differences between breeds and individuals within the same breed. In particular the conformation of the craniocervical junction varies. A consistent feature is hindbrain and sometimes forebrain, overcrowding with narrowing or obstruction of the CSF channels. The caudal fossa is small and has a more horizontally orientated tentorium cerebelli (36, 85)]. The medulla often has a kinked appearance (85)]. The supraoccipital bone indents the cerebellum, which loses its normal rounded shape (36, 85)]. Dilatation of the entire ventricular system secondary to cerebrospinal fluid obstruction is common (85)]. In classical Chiari-like malformation the cerebellum and medulla extend into or through the foramen magnum, which is occluded with little or no CSF around the neural structures. However in some individuals the size of cerebellar herniation may be minimal (21)]. A flexed head position increases the size of cerebellar herniation and is useful to determine the extent of disease (86)]. However care is essential when obtaining these dynamic views in case there is concomitant atlanto-axial subluxation and/or airway obstruction. The most important craniovertebral

junction abnormality associated with Chiari-like malformation is atlanto-occipital overlapping, which has been reported as similar to basilar invagination in humans (52, 53)] (Fig 6).

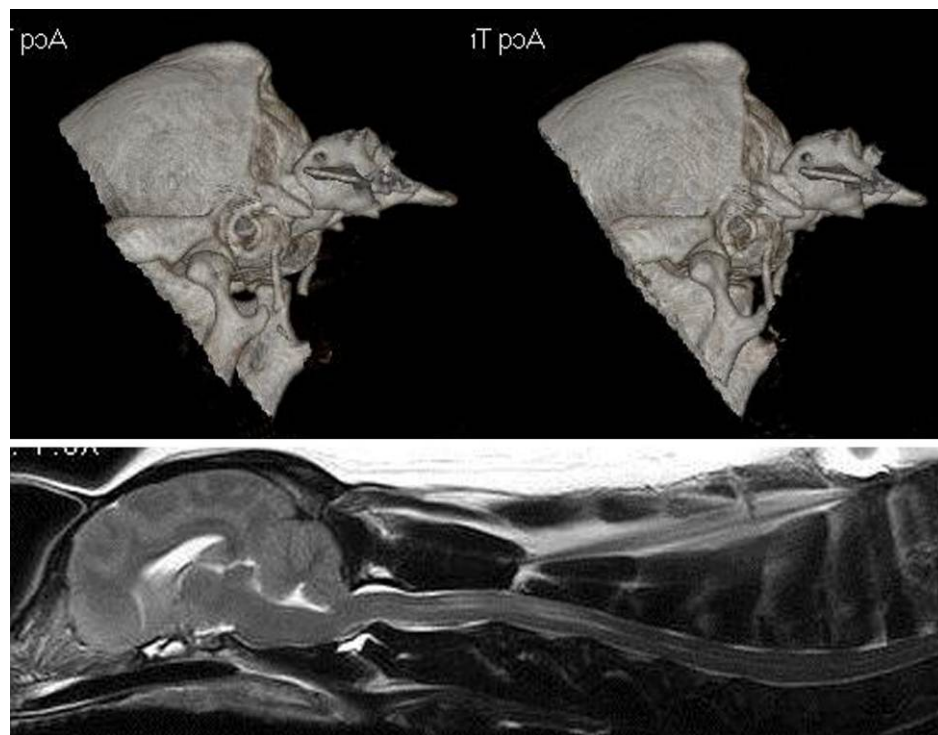


Figure 6 – Computer tomography (CT) of the caudal skull and atlas (top) and midline sagittal T2 weighted MRI of the brain and cervical spinal cord (bottom) of a 3.5 year old male CKCS presenting with pain. The MRI reveals Chiari-like malformation, ventriculomegaly with a mild syringomyelia and suggested atlanto-occipital overlapping. This was confirmed by CT. It can be seen that in the extended position the atlas is overriding the dorsal rim of the foramen magnum.

Both conditions are characterized by increased proximity of the cranial cervical spine to the base of the skull; (87)] however, a defining characteristic of basilar invagination is displacement of the odontoid process of the axis through the foramen magnum with compression of the medulla by the dens (87)]. In the dogs there may be flexure of the cranial cervical spinal cord over the odontoid process but this is more subtle than the human condition. (Fig 1) (31, 36, 52, 54)]. Other less common canine craniovertebral junction anomalies include atlantoaxial subluxation (51, 88)] and dorsal angulation of the dens (54)]. Occipital dysplasia (i.e. widened foramen magnum) also may be seen; (45)] however, this is probably an acquired condition due to overcrowding of the caudal cranial fossa, mechanical pressure from the cerebellum and supraoccipital bone resorption (89)]. It is also common to see dorsal impingement of the subarachnoid space and/or spinal cord at C1-C2 due to fibrosis and proliferation of the ligamentum flavum and dura (31, 36, 52)] (Fig 7).

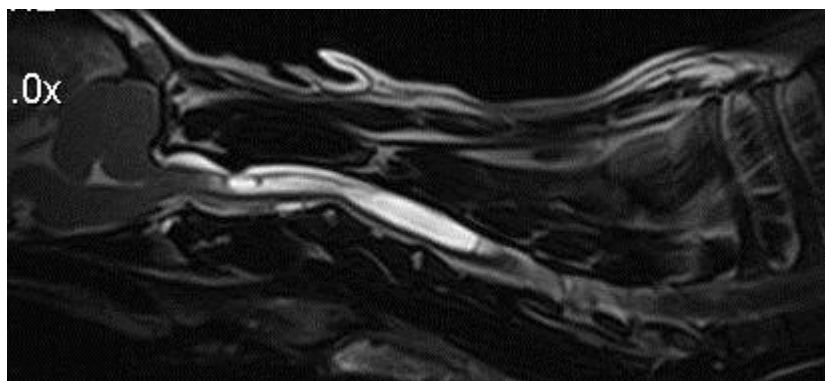


Figure 7 Midline 3D T2-weighted SPACE (sampling perfection with application optimized contrasts sequence with different flip angle evolutions) MRI of the caudal skull and cervical spinal cord. There is dorsal impingement of the spinal cord at C1-C2. The syringomyelia appears to start at the level of spinal cord impingement.

Brachycephalic dogs are also predisposed to quadrigeminal cysts (90)]. By occupying space within an already crowded caudal cranial fossa this may aggravate the obstruction at the foramen magnum and increase the likelihood of syringomyelia developing, although most quadrigeminal cysts are incidental findings (Fig 8).

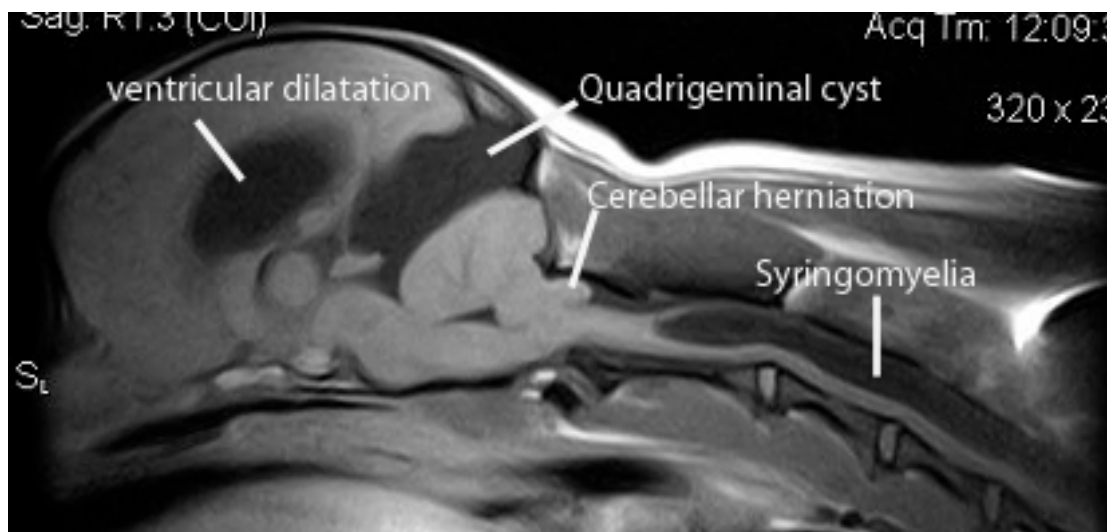


Figure 8 Midline sagittal T1-weighted MRI images of the brain and cervical spinal cord from 1 year old female Cavalier King Charles spaniels presenting with pain. There is a large quadrigeminal cyst in an already crowded caudal cranial fossa. There is a large hindbrain herniation and holochord syringomyelia

Syringomyelia is indicated by fluid-containing cavities within the cervical spinal cord. When evaluating the patient with syringomyelia then the spinal cord from C1-L4 should be imaged otherwise the extent of disease may be underestimated (50)]. The cranial cervical and cranial thoracic segments are typically most severely affected. Maximum syrinx transverse width is the strongest predictor of pain, scratching behaviour and scoliosis (56)].

Differential Diagnosis

The most important differential diagnoses are other causes of pain and spinal cord dysfunction such as intervertebral disc disease; central nervous system inflammatory diseases such as granulomatous meningoencephalomyelitis; vertebral abnormalities such as atlantoaxial subluxation; neoplasia; and discospondylitis. Intervertebral disc disease would be an unlikely cause of pain in a brachycephalic toy breed aged less than 4 years old. When scratching or facial/ear rubbing is the predominant clinical sign, ear and skin disease should be ruled out. The classic scratching behaviour for syringomyelia is to one distinct area. It is a common incidental finding for CKCS to have a mucoid material in one or both tympanic bullae and in the majority of cases this is not associated with clinical signs of pain although it may cause hearing loss (43, 91)]. Some cases with scoliosis appear to have a head tilt which could be confused with vestibular dysfunction (92)] (Fig 3). CSF analysis may be abnormal in dogs with syringomyelia possibly due to syrinx induced cell damage and an inflammatory response in these dogs. A comparative study of CSF in CKCS with syringomyelia showed a higher protein and cell content, as compared to those with a Chiari-like malformation and no syrinx (93)].



Figure 11

Unusual sleeping positions. Left panel CKCS with Chiari malformation and syringomyelia that routinely slept with his head flexed and wedged behind a solid object. Picture courtesy of Ms P Persson

Right panel CKCS with Chiari malformation and syringomyelia that preferred to sleep with her hindquarters lower than her head and with her head on a cooler surface. To achieve this, her head is on a wooden table and her hindquarters are balanced on a cushion and the back of a sofa. (Picture courtesy of Mrs S Smith)

Treatment

Medical and surgical treatment options exist for dogs with Chiari-like malformation with syringomyelia and a possible approach to management is illustrated in Fig 9. The main treatment objective is pain relief.

Surgical management

There are no clear guidelines as to when surgery is indicated over medical management because robust outcome studies have not been performed. Some authors have suggested that early surgical intervention may improve prognosis but this hypothesis has not been vigorously tested (94)]. The author is most likely to recommend surgery for painful dogs with Chiari-like malformation but without marked syringomyelia and/or dogs with syringomyelia where medical management does not give adequate pain relief. The reason why surgery has not been recommended universally is that no technique reported thus far has resulted in long term syrinx resolution (94-98)]. In addition surgery does not necessarily improve long-term prognosis as 25-47% of the operated dogs have recurrence or deterioration of the clinical signs within 0.2-3 years after surgery (94-96)]. However, it should be remembered that it is probable that previous reports of surgically managed cases include dogs with more severe clinical signs so a valid comparison between medical and surgical management cannot be made at this time.

The most common surgical management is craniocervical decompression, establishing a CSF pathway via the removal of part of the supraoccipital bone and dorsal arch of C1 [(96, 97). Depending on the surgeon this may be combined with a durotomy, with or without patching with a suitable graft material and with or without a cranioplasty, using titanium mesh or other prosthesis (94, 95)]. Craniocervical decompression surgery is successful in reducing pain and improving neurological deficits in approximately 80% of cases and approximately 45% of cases may have a satisfactory quality of life two years postoperatively. The clinical improvement is probably attributable to improvement in CSF flow through the foramen magnum. A syringosubarachnoid shunting procedure using a five French equine ocular lavage catheter has also been described. Clinical improvement in approximately 80% of cases was reported but like other reported surgeries there was no evidence of long-term syrinx resolution on post-operative MRI and dogs still expressed signs of neuropathic pain post-operatively (98)].

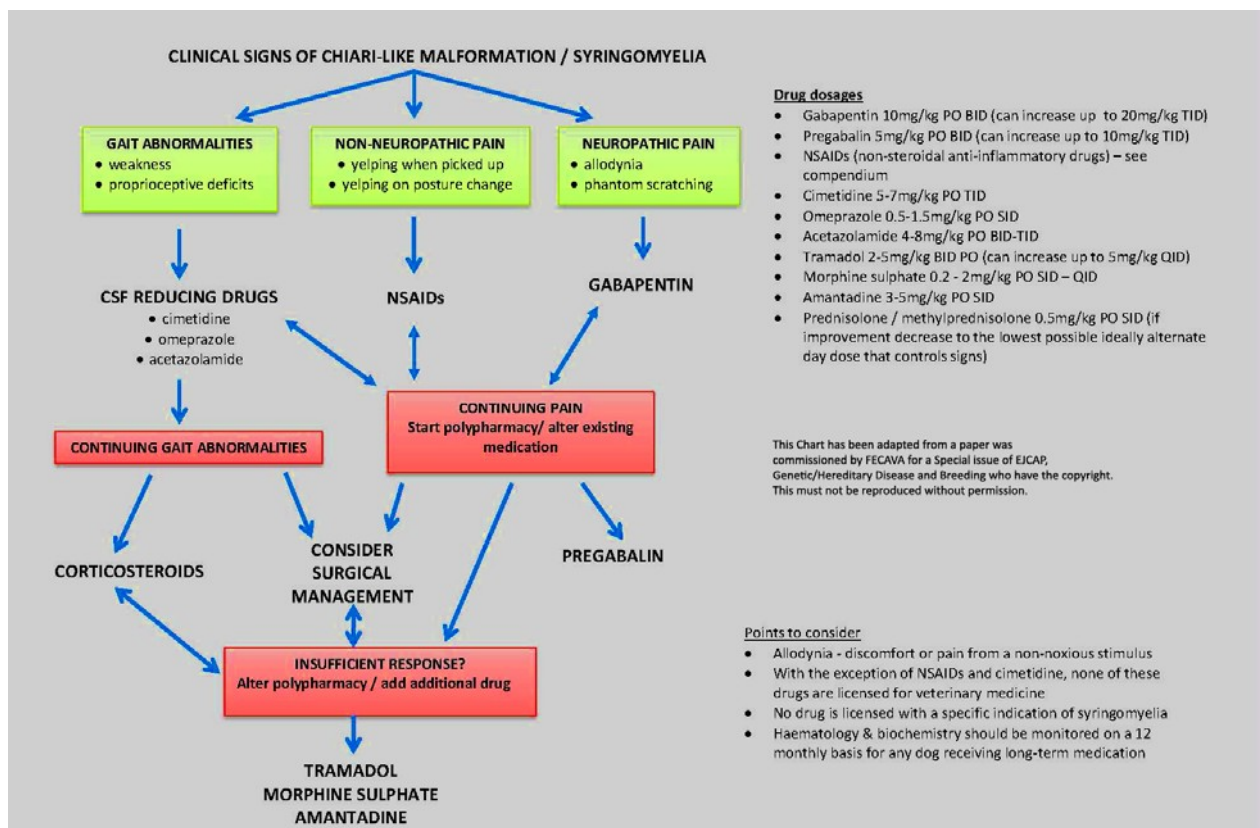


Figure 9 – Treatment algorithm for medical management of Chiari-like malformation and syringomyelia

Medical management

Due to the persistence of syringomyelia and/or spinal cord dorsal horn damage, it is likely that the post-operative patient will require continuing medical management for pain relief. Also, in the majority of canine patients, medical management alone may be chosen for financial reasons or owner preference. There are three main type of drugs used for treatment of Chiari-like malformation with syringomyelia: drugs that reduce CSF production (acetazolamide, cimetidine, omeprazole or furosemide); analgesics (non-steroidal anti-inflammatory drugs and anti-epileptic drugs that have analgesic properties); and corticosteroids. As yet there are no scientific studies to prove the efficacy of these drugs in the management of neuropathic pain in dogs and recommended management is based on anecdotal evidence only (Fig 9).



Figure 10 It is common for dogs with CM with or without SM to be described as “quiet” or to have decreased participation in activities. This syringomyelia affected dog’s depressed demeanour is apparent. In a veterinary consultation room there may be decreased interaction with the dog preferring to lay in sternal recumbency with their head on the floor

Drugs reducing cerebrospinal fluid production

The process of CSF production by the choroid plexus epithelial cells involves the enzymes carbonic anhydrase C, sodium and potassium ATPases, and aquaporin-1 and results in the net transport of water, sodium chloride, potassium and bicarbonate ions from the blood into the ventricles (99)]. **Acetazolamide** reduces CSF production by inhibiting carbonic anhydrase C and by reducing the amount of aquaporin-1 through an alteration in protein transcription (100)]. The use of acetazolamide for management of Chiari-like

malformation and syringomyelia has been described (67, 85)] and is also used in management of benign intracranial hypertension in humans (101)]. However long term use of acetazolamide is often limited by adverse effects, including lethargy, abdominal pain and bone marrow suppression (85)].

Omeprazole is a specific inhibitor of H(+)-K(+)-activated ATPase however it is not clear if this is the mechanism by which it reduces CSF production (102)]. In experimental models using a ventriculocisternal perfusion technique, omeprazole reduces canine CSF production by 26% (103). Histamine (H₂)-receptor antagonists such as **cimetidine** and **ranitidine** are proposed to reduce CSF production by competitive inhibition of H₂ receptors located on the choroid plexus epithelial cell, or by a direct effect on the capillaries of the choroid plexus (104)]. However there is also evidence that histamine may act physiologically by increasing the electrical activity of vasopressin-secreting neurons (105)]. Vasopressin reduces blood flow to the choroid plexus, thereby decreasing CSF production (106)]. Cimetidine has been shown to be superior to ranitidine to reducing CSF production in an experimental cat model (104)]. The usefulness of omeprazole or cimetidine for Chiari-like malformation, with or without syringomyelia, is unclear. They are often prescribed in the hope that this may limit disease progression, a variable that is difficult to assess in a scientific study of clinical cases. Some owners report a significant improvement in clinical signs of pain. Adverse effects from these drugs are infrequently reported. Cimetidine retards P450 oxidative hepatic metabolism so caution is advised if using this preparation concurrently with other drugs metabolised by the liver and with both cimetidine and omeprazole, periodic monitoring of haematology and serum biochemistry is advised. Absorption of gabapentin may be reduced with concurrent cimetidine administration however the effect is thought to be clinically insignificant (107). It has been suggested that chronic hypergastrinemia, caused by omeprazole, may increase the risk of gastric carcinomas, at least in laboratory rodent models but this has not been reported in any other species (108, 109)].

Use of the diuretic **furosemide** for management of Chiari-like malformation and syringomyelia has also been described (67, 85)] and is also used in management of benign intracranial hypertension in humans (101)]. Furosemide may not be ideal in toy breed dogs that also have a high likelihood of mitral valve disease (110)] and where the most common cause of death is congestive heart failure (111)]. Furosemide can result in significant increase in plasma aldosterone concentration and renin activity in healthy dogs (112)]. This early activation of the renin-angiotensin-aldosterone system might be deleterious in an animal predisposed to heart disease (113)]. Moreover, long-term use of diuretics can lead to a diuretic-resistant state, which necessitates the use of higher doses, further activating the renin-angiotensin-aldosterone system (114)].

Analgesics

NSAIDs are inhibitors of Cyclooxygenase-1 and/or Cyclooxygenase-2 and suppress inflammatory pain by reducing generation of prostanoids, in particular prostaglandin E₂. Prostaglandin E₂ also contributes to the genesis of neuropathic pain (115)]. Anecdotally, non-steroidal anti-inflammatory drugs (NSAIDs), e.g. meloxicam, carprofen, firocoxib, mavacoxib, can be useful in management of Chiari-like malformation and syringomyelia. However, monotherapy with NSAIDs is unlikely to provide sufficient analgesia if there are signs of neuropathic pain. Therefore, in these situations, the addition of drugs with an anti-allodynic effect is recommended (67)]. All primary afferents in the spinal cord dorsal horn use glutamate as their main fast excitatory neurotransmitter. Nociceptive afferents are divided in two groups - those that contain neuropeptide (for example substance P and calcitonin gene related peptide and those that do not (77)].

Substance P containing primary afferents play an important part in nociception and neuropathic pain and have a high density in laminae I and II of the spinal cord dorsal horn (77)]. Therefore drugs that affect the firing of these neurons are useful in the management of neuropathic pain. **Gabapentin** and **pregabalin** modulate voltage-gated calcium channels resulting in a reduction of glutamate and substance P (116)]. Anecdotally, pregabalin is most efficacious for treating Chiari-like malformation and syringomyelia in dogs but gabapentin can also be useful and is more economic. In severe cases that still have clinical signs, despite polypharmacy, the addition of **opioids**, **tramadol** or **amantadine** can be useful. It should be borne in mind that, with the exception of NSAIDs, there are no licensed oral analgesics in veterinary medicine.

Corticosteroids

Corticosteroids are believed to provide long-term pain relief because of their ability to inhibit the production of phospholipase-A₂ (117) and to inhibit the expression of multiple inflammatory genes coding for cytokines, enzymes, receptors and adhesion molecules (118)]. Corticosteroids are also reported to reduce sympathetically mediated pain (119) and decrease substance P expression (120)]. Anecdotally, oral drugs such as **methylprednisolone** and **prednisolone** provide relief for some dogs with syringomyelia and can also be

useful where there are significant neurological deficits but adverse effects limit their usefulness for long-term therapy (85).

Progression and prognosis

The clinical signs of Chiari-like malformation and syringomyelia are often progressive. A long term study, over a mean of 39 ± 14.3 months, found that approximately three-quarters of CKCS with Chiari-like malformation and syringomyelia associated neuropathic pain will deteriorate when managed medically whereas one quarter remain static or improved (73)]. However, despite this progression, all the owners of the alive dogs in this study reported that their dog's quality of life was not severely compromised (73)]. 15% of dogs were euthanased because of severe neuropathic pain. Morphometric values (volume of the caudal cranial fossa, parenchyma within the caudal cranial fossa, and the sizes of the ventricles and syringes) were not correlated with prognosis. Dogs with higher neuropathic pain scores are more likely to have fear-related behaviour (Table 2), which can have a negative impact on the owner-perceived quality of life of a dog (66)]. Obesity is also positively correlated with a reduced quality of life but not greater neuropathic pain (66)]. In humans there is also a known association between increasing body mass index and CSF disorders such as idiopathic intracranial hypertension (121)] and syringomyelia secondary to Chiari type 1 malformation (122)]. It has not been established if the obesity is the cause or effect of disease however in humans reducing weight can reduce syrinx size after unsuccessful surgical decompression and reduction in body weight is recommended for all overweight and obese patients (122)].

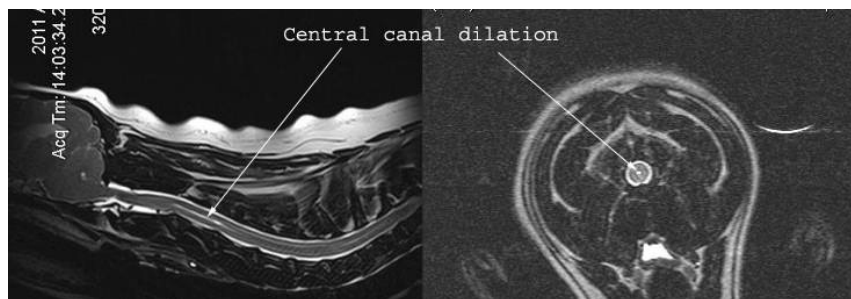


Figure 12 Midline sagittal T2 weighted MRI images from a 3 year old CKCS with Chiari-like malformation. A prominent central canal (arrow), or early syrinx, is seen particularly in the C2-C4 region. This dog was not reported to have any associated clinical signs. The MRI was performed with a view to

Genetic factors and breeding advice

The high prevalence, within closely related populations, suggests that syringomyelia is inherited in the dog and studies in the CKCS have shown it to be a complex trait, with a moderately high heritability ($h^2 = 0.37 \pm 0.15$ standard error) (123)]. Since the early 2000s it has been recommended that dogs of breeds predisposed to Chiari-like malformation and/or syringomyelia be MRI screened at least twice in their lifetime. Breeding recommendations based on syringomyelia status and ages were formulated in 2006. These guidelines concentrated on removing dogs with early onset syringomyelia from the breeding pool whilst maintaining genetic diversity (3)]. Early results from this breeding program indicated that offspring without syringomyelia were more common when the parents were both clear of syringomyelia (offspring syringomyelia free; CKCS 70%, Griffon Bruxellois 73%). Conversely offspring with syringomyelia were more likely when both parents had syringomyelia (offspring syringomyelia affected; CKCS 92%, Griffon Bruxellois 100%). A mating of one syringomyelia-free parent with an syringomyelia-affected parent was risky for syringomyelia affectedness with 77% of CKCS and 46% of Griffon Bruxellois offspring being syringomyelia affected (124)].

In the UK there is a British Veterinary Association / Kennel Club Canine Health Scheme to MRI screen potential breeding stock for Chiari-like malformation and/or syringomyelia (125)]. MRI images are assessed by two scrutineers and graded for severity for both Chiari-like malformation and syringomyelia and, as syringomyelia is a late onset condition, the age of onset (Table 3). Results are submitted to a central database, in order to generate estimated breeding values for the UK Kennel Club Mate Select Computer program (126)]. As an accurate estimated breeding value database may take some time to compile, the recommended breeding guidelines have been revised (127)] (Table 4). European health schemes for Chiari-like malformation and syringomyelia also exist (128)].

Table 3 The aim of these breeding guidelines is to remove dogs with early onset SM from the breeding programme. Please note: it is believed that due to the complex nature of inheritance of CM/SM it is still possible that affected offspring may arise from parents which are clear from or are only mildly affected by SM.

Chiari-like malformation (CM):

Conclusion

Chiari-like malformation and syringomyelia is an inherited disorder with a high morbidity in many brachycephalic toy breeds. It is characterised by overcrowding of the craniocervical junction, obstruction of CSF flow through the foramen magnum and development of fluid filled cavities in the central spinal cord. Although some cases are asymptomatic, dogs with Chiari-like malformation and syringomyelia can present with neurological signs of which the most important is pain. Surgical and medical treatment options are available but these have limited success and from a welfare point of view it would be better to implement a breeding program limiting the occurrence of this disabling disease.

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