10. Lafuente N, Mateo A, Izquierdo B, Gutiérrez N. Parálisis del sexto par craneal derecho como complicación de bloqueo epidural. Rev Esp Anestesiol Reanim. 2008;55:251-3.
11. Reina MA, Álvarez-Linera J, López A, Benito-León J, De Andrés JA, Sola RG. Aportaciones de la Resonancia magnética en la cefalea pospunción dural y en pacientes que cursan con hipotensión de líquido cefalorraquídeo. Rev Esp Anestesiol Reanim. 2002;49:89-100.
12. Béchard P, Perron G, Larochelle D, Lacroix M, Labourdette A, Dolbec P. Case report: epidural blood patch in the treatment of abducens palsy after a dural puncture. Can J Anaesth. 2007; 54:146-50.
13. Zuzewicz W, Marks E. Recurrent abducens nerve damage after epidural anesthesia. Wiad Lek. 1982;35:1563-5.
14. Arcand G, Girard F, McCormack M, Chouinard P, Boudreault D, Williams S. Bilateral sixth cranial nerve palsy after unintentional dural puncture. Can J Anaesth. 2004;51:821-3.
15. Carson D, Serpell M. Choosing the best needle for diagnostic lumbar puncture. Neurology. 1996;47:33-7.

E. Durán-Ferreras

Unidad de Neurología, Servicio de Medicina Interna, Hospital Infanta Elena, Huelva, Spain

E-mail: eduardoduranferreras@gmail.com

Eagle syndrome or Stylohyoid syndrome?

¿Síndrome de Eagle o síndrome estilohioideo?

Dear Editor:

We have read the article written by Cano et al. on Eagle syndrome and carotid dissection[1] with great interest. We therefore allow ourselves to make an observation due to the fact that the diseases caused by an elongated stylohyoid process generate great controversy with respect to the criteria used for their diagnosis, as well as differential diagnoses. According to Camarda et al.,[2] the classification for cervicopharyngeal pain associated to the elongation of the stylohyoid process is divided into three distinct entities: the first is Eagle syndrome per se, which requires the presence of neck surgery, such as tonsillectomy or trauma, together with the presence of clinical tenderness of the elongated stylohyoid process, plus an imaging examination revealing the elongation of the stylohyoid process to provide an accurate diagnosis.[3,4] The second entity is stylohyoid syndrome, in which the patient reports symptoms, but there has been no prior surgery or trauma; nevertheless, imaging studies reveal the presence of an elongated stylohyoid process or ossification of the ligament, at a young age or adulthood (around 40 years of age). In the third entity, pseudostylohyoid syndrome, the patient describes the classical symptoms of Eagle syndrome, but there is no clear clinical or radiographic presence of any elongation of the stylohyoid process or ossification of the ligament, nor is there a history of prior surgery or trauma. The symptoms are the consequence of aging, causing the tissues to lose elasticity, often manifested in the form of tendonitis and inflammatory reactions at the level of the territory innervated by the glosspharyngeal nerve, which causes pain.[5]

What is particularly striking about the case reported is that the patient has not undergone tonsillectomy or any other neck surgery; nor has she suffered any prior trauma, thus establishing her diagnosis as stylohyoid syndrome, excluding Eagle syndrome in the differential diagnosis because it is characterized by the fact that the patients have undergone tonsillectomy or present trauma in the area,[6,7] a fundamental situation for the manifestation of the characteristic symptoms displayed in the classical presentation. In the case reported, the patient indicates the typical symptoms and the imaging studies document the existence of an elongated stylohyoid process, in addition to debut in adulthood (approximately 40 years of age).

It is important to point out that the elongated stylohyoid process does not necessarily translate into Eagle syndrome or stylohyoid syndrome, since most people who exhibit this anatomical variation refer no symptoms whatsoever. In those cases in which its presence gives rise to symptoms, the diagnoses possibly associated with an elongated stylohyoid process or calcification of the stylohyoid ligament must be based on an accurate clinical history and meticulous clinical examination, both physical and by imaging, including the utmost precision in recording and interpreting the data, in addition to consultations with specialized professionals who can collaborate in solving the case and thus, achieve a correct diagnosis and treatment of the condition affecting patients seeking a solution to their illness.

References

1. Cano LM, Cardona P, Rubio F. Síndrome de Eagle y disección carotídea. Neurologia. 2010;25:266-7.
2. Camarda AJ, Deschamps C, Forest DI. Stylohyoid chain ossification: A discussion of etiology. Oral Surg Oral Med Oral Pathol. 1989;67:508-14.
3. Weidenbecher M, Schick B, Iro H. Styloid syndrome and its treatment. Laryngorhinootologie. 2006;85:184-90.
4. Plagkou M, Anagnostopoulou S, Kouladouros K, Plagkos G. Eagle's syndrome: a review of the literature. Clin Anat. 2009;22: 545-58.
5. Bafaqeeh SA. Eagle syndrome: Classic and carotid artery types. J Otolaryngol. 2000;29:88-94.
6. Eagle WW. Elongated styloid processes: report of two cases. Arch Otolaryngol. 1937;25:584-7.
7. Leong SC, Karkos PD, Papouliakos SM, Apostolidou MT. Unusual complications of tonsillectomy: a systematic review. Am J Otolaryngol. 2007;28:419-22.

L.M. Cantín, * I. Suazo Galdames

Departamento de Ciencias Básicas y Biomédicas, Universidad de Talca, Talca, Chile

*Corresponding author.
E-mail: mcantin@utalca.cl (L.M. Cantín).