vasculitis. Investigations for autoimmune or infective causes were normal. Chest X-ray, echocardiogram, lumbar puncture and a temporal artery biopsy were diagnostically non-contributory. Body CT showed multiple lytic and sclerotic bone lesions, with abnormal lymphadenopathy in the left axilla. Fine needle aspiration of a node showed adenocarcinoma consistent with metastatic oestrogen receptor positive breast cancer. The final diagnosis was non-metastatic paraneoplastic optic neuropathy.

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THE WIDENING SPECTRUM OF PARANEOPLASTIC DISORDERS: TWO CASES

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Paraneoplastic neurological syndromes are non-metastatic disorders triggered by an altered immune response to a neoplasm. Uncommon presentations are increasingly reported, widening the recognised spectrum of these disorders. We present two patients with atypical neurological manifestations that heralded malignancy.

Case 1 A 79 year old woman presented with progressive asymmetrical (R>L) leg weakness. Examination confirmed significant paraparesis (MRC 2/5 bilaterally) with normal muscle bulk and tone, normal sensation and sphincter control, hyporeflexia and down-going plantars. MRI of the lumbosacral spine was normal. Nerve conduction studies showed an axonal and demyelinating motor neuropathy. CSF was acellular with high protein (2.5 gr/dl) and normal glucose. Body CT revealed a large retrosternal mass consistent with thymoma. Her paraneoplastic motor neuropathy was treated with intravenous immunoglobulin, which clinically stabilised her progression, and referred for surgical removal.

Case 2 A 72 year old woman presented with painless, progressive left-sided visual loss. Fundoscopy excluded arterial occlusion or