reported. Pain was associated with episodic swelling and redness for 1–2 hours which migrated to involve the soft tissue and was described as “mosquito bites.” On exam, her left foot was cool with mottled bilateral lower extremities and non-pitting edema. Passive range of motion of bilateral knees demonstrated extension to 20 degrees and normal ankle dorsiflexion. Modified Ashworth was 3/4 of the knees and ankles.

**Setting**: Academic Spine Center

**Results or Clinical Course**: Evaluation by rheumatology for rheumatologic, vascular, or autoimmune illness was without positive findings except prior JIA. Triple phase whole body bone scan abnormality was noted with increased blood flow and blood pool activity in the left lower extremity from the knee to the ankle. Increased activity was noted in both knees, ankles, and feet especially in the left distal tibial metaphysis and midfoot. Findings were consistent with osteopenia and complex regional pain syndrome (CRPS). MRI and x-ray were negative. Her pain was ultimately controlled with a combination of naproxen, pregabalin, amitriptyline, and hydrocodone-acetaminophen. She was taught relaxation and brushing techniques for desensitization. Her pain by visual analogue scale decreased from 8/10 to 3/10.

**Discussion**: Pain commonly occurs in patient with CP, however there is limited information on CRPS in this population. Treatment challenges depend upon the patient’s comorbidities. Our patient was not a candidate for sympathetic block due to her severe scoliosis with rod placement. The etiology of this patient’s CRPS remains unknown.

**Conclusions**: CRPS should be considered when evaluating patients with localized chronic pain and CP.

**Poster 468**

**Thoracic Radiculopathy Secondary to Symptomatic Tarlov Cysts: A Case Report.**

Anupam Sinha, DO (Rothman Institute, Philadelphia, PA, United States); Madhuri Dholakia, MD.

**Disclosures**: A. Sinha, No Disclosures: I Have Nothing To Disclose.

**Case Description**: A 79-year-old woman with a history of COPD presented with a chronic complaint of thoracic pain with radiation into the chest wall and stomach. She denied any extremity pain or weakness. She denied injury. Physical examination was negative for any musculoskeletal or neurologic deficit. Some reproducible pain was noted with thoraco-lumbar extension. MRI of the thoracic and lumbar spine revealed several perineural cysts in the lower thoracic and upper lumbar spine, the largest measuring 20mm x 20mm x 36mm occupying the T12-L1 neuroforamen. There was no effect upon the thoracic cord.

**Setting**: Outpatient orthopedic practice

**Results or Clinical Course**: Treatment options were discussed with the patient, including epidural steroid injections and surgical intervention, however the patient opted for conservative management with physical therapy.

**Discussion**: Tarlov cysts are cerebrospinal fluid filled sacs that are most often found in the sacrum. Also known as perineural cysts, they typically are asymptomatic, but may cause low back pain and nerve root impingement in rare cases. In most cases, Tarlov cysts require no treatment, however symptomatic cysts may need more aggressive management with cyst drainage and resection. While sacral cysts are fairly common, there are very few reported cases of symptomatic thoracic Tarlov cysts. We present a rare case of thoracic radiculopathy caused by large Tarlov cysts.

**Conclusions**: Thoracic Tarlov cysts are a rare occurrence. Clinicians should be aware of this pathology and its potential for causing axial and radicular pain.

**Poster 469**

**Combined Ultrasound and Fluoroscopic Guided Suprascapular and Interscalene Denervation for the Management of Chronic Shoulder Pain in a Patient with a History of Dislocated Total Shoulder Replacement and Huntington’s Chorea: A Case Report.**

Reina Nakamura (Overlook Hospital, Summit, NJ, United States); Kevin Dunn, MD; Andrew G. Kaufman, MD.

**Disclosures**: R. Nakamura, No Disclosures: I Have Nothing To Disclose.

**Case Description**: A 46-year-old man with a history of Huntington’s chorea and dislocated right total shoulder replacement presented with chronic right shoulder pain and severely limited range of motion for 6 months. Physical examination was significant for right shoulder held in fixed adduction and elevation. The trapezius, infraspinatus, teres minor, supraspinatus, and rotator cuff insertion was tender to palpation. There was essentially no active range of motion of the shoulder, and passive range of motion caused significant pain. There were skin changes of the axilla from poor hygiene. The patient failed conservative management with Tramadol Hcl, trigger point injections, and Botulinum Toxin injections. Opiate medications were avoided due to cognitive side effects and risk of fall. Finally, radiofrequency ablation of the right suprascapular and axillary nerve was performed under ultrasound and fluoroscopic guidance.

**Setting**: Tertiary care hospital

**Results or Clinical Course**: There was 75% improvement in pain and mobility of the hand immediately following radiofrequency ablation. 3 months later, he had 80% improvement in shoulder pain, with significantly better sleep and increased range of motion allowing cleansing of the axilla.

**Discussion**: To our knowledge, this is the first reported case utilizing radiofrequency ablation for chronic shoulder pain in the setting of dislocated total shoulder replacement in a patient with Huntington’s chorea.

**Conclusions**: Radiofrequency ablation is a safe and effective method of pain management when used with fluoroscopic and ultrasound guidance for shoulder pain in the setting of Huntington’s chorea and dislocated total shoulder replacement.

**Poster 470**

**Relief of Urinary Urgency, Hesitancy, and Male Pelvic Pain with Pulse Radiofrequency Ablation of the Pudendal Nerve: A Case Presentation.**

Christopher Bui, MD (WLAVA/UCLA, Los Angeles, CA, United States); Sanjog Pangarkar, MD; Scott I. Zeitlin, MD.

**Disclosures**: C. Bui, No Disclosures: I Have Nothing To Disclose.

**Case Description**: The patient is a 86-year-old man with a 30-year history of urinary hesitancy and urgency. The patient also had
pain in the area of the perineum but considered it a secondary issue. The patient was seen by a number of specialists, tried various medications, and underwent a variety of procedures to no avail. Therefore, the patient underwent a pulsed RFA of the pudendal nerve.

**Setting:** Academic Outpatient Pain Practice

**Results or Clinical Course:** The patient underwent a pulsed RFA of the pudendal nerve, the patient reported marked improvement in his pelvic pain as well as a drastic reduction in his urinary urgency and hesitancy.

**Conclusions:** Urinary urgency, hesitancy, and male pelvic pain are some of the most common symptoms affecting men. Pudendal nerve block by pulsed RFA is an effective treatment of pelvic pain. It may also hold some therapeutic value in the treatment of urinary urgency and hesitancy as our case demonstrated. Further studies are needed to help clarify both the anatomy of the pelvis as well as if pudendal blocks are effective in treating more than pelvic pain.

**Poster 471**

**Cervical Spine MRI Abnormalities in Asymptomatic Subjects.**

Stephen Kishner, MD (Louisiana State University School of Medicine, New Orleans, LA, United States); Brett J. Rothaermel, MD.

**Disclosures:** S. Kishner, No Disclosures: I Have Nothing To Disclose.

**Objective:** Neck pain is a common occurrence. Cervical spine MRIs are commonly used in the evaluation of neck pain. MRI abnormalities are commonly seen in asymptomatic subjects in the lumbar spine. The cervical spine, however, is not as well studied. The objective of this study is to evaluate asymptomatic subjects for cervical spine abnormalities.

**Design:** Subjects who deny any previous neck pain were evaluated. Cervical spine MRIs were completed. Data were tabulated and analyzed by decade of age.

**Setting:** All evaluations were done in the same clinic. All MRIs were interpreted by the same neuroradiologist.

**Interventions:** Interventions were a simple questionnaire with regards to demographics and past history of any neck or spine problems. An MRI of the cervical spine was completed and interpreted.

**Main Outcome Measures:** All spine abnormalities including central stenosis, disc bulges, disc protrusions, disc herniations, disc extrusions, disc space narrowing, lateral stenosis, annular tears, and degenerative disc disease were assessed and analyzed stratified by the age of the subjects.

**Results or Clinical Course:** 87 cervical spine MRIs were analyzed. Ages of the subjects were ≤ 29 years of age 23%, 30-39 years of age 31%, 40-49 years of age 29%, 50-59 years of age 15%, and ≥ 60 years of age 2%. The following abnormalities were seen on asymptomatic cervical spine MRIs: 31% of subjects had evidence of central stenosis, 34% disc bulges, 7% disc protrusions, 5% disc herniations, 1% disc extrusions, 15% disc space narrowing and 22% lateral stenosis, 1% annular tears, and 38% multilevel degenerative disc disease. There were correlations with advancing age with central and lateral stenosis, disc space narrowing, and multilevel degenerative disc disease.

**Conclusions:** Cervical spine MRI abnormalities are commonly seen in asymptomatic adults of all ages. These abnormalities include central and lateral stenosis, disc bulges, disc space narrowing, and multilevel degenerative disc disease. Evidence of cervical spine annular tears or disc extrusions, protrusions or herniations, however, are not generally seen on cervical spine MRIs in asymptomatic subjects.