and an iso- to low signal at T1 weighted image (T1-WI). The lesion became enhanced at sagittal T1-WI with contrast (Fig. 1). Based on a presumed diagnosis of a ruptured disc with possible sequestration or granulation tissue formation, the patient underwent surgery. A right hemilaminectomy of L3 was performed, and a retracting thecal sac revealed a highly engorged vascular structure. When the structure was discovered, the surgery was stopped for further evaluation. A spinal angiography was performed but no abnormal finding was observed (Fig. 2). Due to continued patient discomfort second surgery was performed. Near-infrared indocyanine green videoangiography (ICG-VA) showed a delayed mass filling. Coagulation of the vascular supply and en bloc removal was performed (Fig. 3). Histological examination revealed a vascular lesion composed of small to medium sized veins with irregular calibers, which is consistent with an arteriovenous hemangioma (Fig. 4). The patient's postoperative recovery was uneventful and her pain improved.

**Discussion**

The typical symptoms of epidural lesions other than disc herniation of the lumbar region are low back pain or radiculopathy.
An indocyanine green videoangiography can help surgeons understand the vasculature surrounding the mass and facilitate the en bloc removal of the hemangioma. Fluorescence angiography with indocyanine green provides real-time information regarding the patency of vessels. An ICG-VA enhances the flow direction delineation capability, flow velocity and sequence of dye filling in different components of complex spinal vascular lesions.

Due to the high vascularization of hemangiomas, a misinterpretation may result in unexpected intraoperative hemorrhage. The incomplete surgical removal of a spinal hemangioma because of diffuse bleeding or minimal exposure during disk surgery might result in the persistence of clinical symptoms or recurrence. Reoperation for remnant or recurrent spinal hemangioma is very difficult due to peridural or periradicular adhesion and unclear margins; as a result, complete resection cannot be guaranteed. Therefore, proper preoperative planning and complete resection during the operation is essential. For this, a preoperative suspicion of spinal hemangioma is important.

As in our case, obscure radiologic findings make diagnosis difficult. An angiography needs to be considered to distinguish spinal epidural hemangiomas from disc herniation. But, like this case, an angiography may not always confirm the diagnosis of an arteriovenous hemangioma. Clinicians should be aware that an angiography cannot provide conclusive evidence of the presence of an arteriovenous hemangioma.

If spinal epidural hemangiomas are unexpected encountered during surgery, an ICG-VA can be helpful to diagnose and surgery. This technique provides accurate information about the flow dynamics through the anatomy of vascular lesions in real time.

**CONCLUSION**

Further study is required to recognize and to provide a differential diagnosis of spinal epidural hemangiomas. If the lesion is like a ruptured disc in MRI, we should consider spinal epidural hemangioma as one of differential diagnosis.

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Fig. 3. A: The hyperemic vascular mass beneath the thecal sac. B: An ICG videoangiography shows delayed filling into the mass. ICG: indocyanine green.

Fig. 4. Histologically, the lesion reveals several anastomosing venous structures with irregular wall thickness (hematoxylin eosin ×40). A Masson’s trichrome stain highlights abnormally thickened veins (inset) (×40).