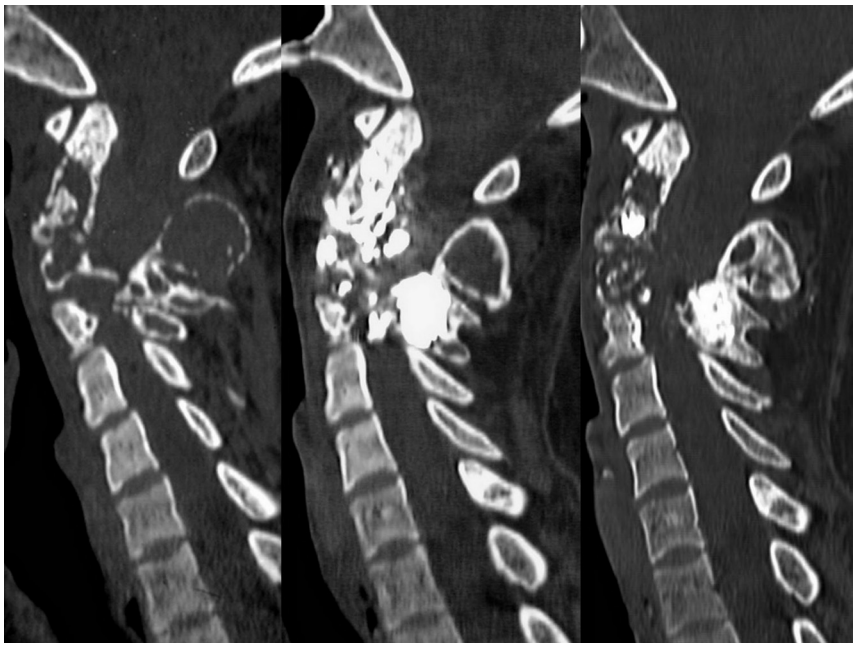
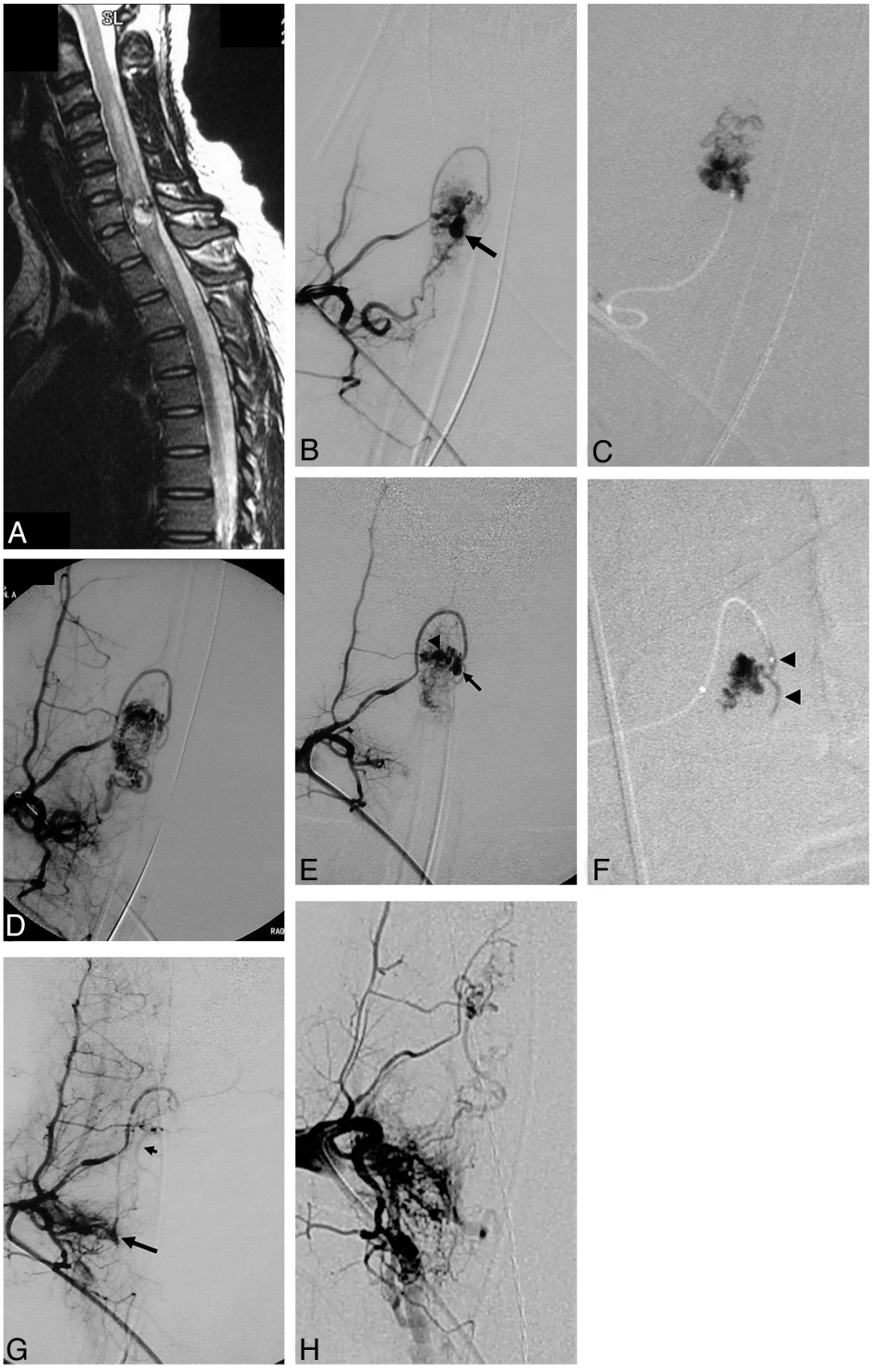


On-line Fig 1. Serial sagittal reconstructed CT appearances of the bone lesions of case 1. Left; Before the first treatment showing osteolytic expansile lesions involving C2 and C3 vertebrae. Middle: After the third *n*-BCA embolization showing filling of the osteolytic lesions with radiopaque *n*-BCA. There is reossification of the C2 spinous process. Right: Twenty months after the fourth *n*-BCA embolization showing resolution of the radiopacity of *n*-BCA and recurrent osteolysis of the C2 and C3 vertebrae. The C2 spinous process shows progressive reossification.



On-line Fig 2. Case 3. A 24-year-old woman presented with sudden onset of neck pain and paraplegia. MRI showed lower cervical hematomyelia and surrounding prominent vessels. Her neurologic condition improved significantly during 4 months with a remaining left-sided foot drop. Spinal angiography showed a SCAVM supplied by both the ASA and PSA with an associated intranidal pseudoaneurysm. She underwent *n*-BCA embolization through the PSA feeder with disappearance of the aneurysm. She remained neurologically unchanged and underwent follow-up spinal angiography 5 years later. This study showed development of a feeder aneurysm on the ASA as well as an intranidal aneurysm. On the basis of negative provocative testing, she underwent *n*-BCA embolization with disconnection of the ASA at the origin of the feeder. She remained neurologically unchanged and underwent follow-up spinal angiography 3.5 years later. The study showed no new development of aneurysms, but a right T1 paraspinal AVM became more prominent. She has been neurologically stable without recurrent hemorrhage during the 13 years since the initial treatment. *A,* T2-weighted sagittal MR image shows hematomyelia with associated edema and surrounding prominent vessels at the C7 level. *B*, Right dorsocervical artery angiogram demonstrates an SCAVM supplied by both the ASA and PSA with an intranidal pseudoaneurysm (*arrow*). *C*, Cast of *n*-BCA injected through the PSA feeder. *D*, Right dorsocervical artery angiogram after embolization demonstrates no visualization of the aneurysm and the PSA feeder. *E*, Right dorsocervical artery angiogram 5 years after the treatment demonstrates new development of an ASA feeder aneurysm (*arrow*) and an intranidal aneurysm (*arrowhead*). *F*, Cast of *n*-BCA injected through the ASA feeder. The ASA is occluded for a short segment (*arrowheads*). *G*, Right dorsocervical artery angiogram after embolization demonstrates no visualization of the aneurysm and disconnection of the ASA. There is minimal opacification of the early draining vein of the SCAVM (*small arrow*). There is also faint opacification of the paraspinal AVM (*large arrow*). *H*, Right dorsocervical artery angiogram 3.5 years after the second treatment demonstrates increased collateral supply to the SCAVM without new development of an aneurysm. There is also enlargement of the paraspinal AVM. ASA indicates anterior spinal artery; PSA, posterior spinal artery.

On-line Table 1: Presentation

	Hemorrhage	Neuro Def.	Pain	Others
SAMS (28)	18 (64%)	7 (25%)	3 (11%)	0
Non-SAMS (120)	60 (50%)	45 (38%)	9 (8%)	6 (5%)
Total (148)	78 (53%)	52 (35%)	12 (8%)	6 (4%)

Note:—Neuro Def. indicates non-hemorrhagic neurologic deficits.

On-line Table 2: Hemorrhagic events before the first angiography with intent to treat[a]

	Presentation	Before First Angiography/Treatment	Multiple Episodes
SAMS (28)	18 (64%)	22 (79%)	11 (39%)
Non-SAMS (120)	60 (50%)	70 (58%)	26 (22%)
Total (148)	77 (52%)	92 (62%)	37 (25%)

[a] SAMS had more hemorrhages ($P = .0173$, Fisher exact test) and tendency to have multiple hemorrhagic episodes ($P = .0872$, Fisher exact test) before the first angiography with intent to treat.