ANSWERS

1. The patient has a small pupil and mild ptosis on the left, as well as weakness of the tongue muscles on the left side. The combination of Horner’s syndrome and ipsilateral hypoglossal palsy is typically caused by carotid dissection in the neck: the outward bulge of the artery caused by subadventitial dissection can lead to dysfunction of the surrounding sympathetic plexus as well as of the hypoglossal nerve, which runs across the carotid artery. Cranial nerves IX to XI may also be affected. In this patient the abnormalities spontaneously cleared within a few weeks.

Further reading

2. MRI showed moderate to severe asymmetric frontoparietotemporal atrophy, greater on the left than on the right. This image is characteristic of corticobasal degeneration.

Corticobasal degeneration is a progressive neurodegenerative disease and may present as a cognitive or typically asymmetrical motor disorder. Although definitive diagnosis can only be made at post-mortem, imaging can assist the clinician with diagnosis. Treatment options remain limited and mostly symptomatic.

Motor symptoms are characterized by clumsiness, jerky tremor, rigidity, bradykinesia, myoclonus or polymyoclonus, ideomotor apraxia (may include neglect and eventually alien limb syndrome), postural instability, limb dystonia and gait impairment. Cognitive symptoms are frontal lobe behaviour, aphasia, and impairment in executive functions. The average survival is 7–8 years.

In corticobasal degeneration, asymmetric parietal and frontal atrophy and dilation of the lateral ventricles – or at least two of these abnormalities – are frequently seen on brain CT or MRI. These brain images can, however, be normal in the early stages of the disease but PET or SPECT may show asymmetric reductions in resting levels of glucose metabolism and blood flow in the frontal, parietal, superior temporal regions, thalamus, and striatum.

Further reading