LETTERS TO THE EDITOR

Familial recurrent multiple cranial nerve palsies

Two brothers presented in their mid-40s, each with an isolated cranial nerve palsy. Both had a history of cranial nerve lesions. Of particular interest was the fact that one had an eighth nerve lesion, previously unreported, as part of a familial recurrent multiple cranial nerve syndrome. A 45 year old man presented in 1986 with a 14 day history of right frontal headache and three days of diplopia. He gave a history of a left seventh nerve palsy in 1968 and a right seventh nerve palsy in 1976, each episode lasting about six weeks and resolving spontaneously. Examination showed a right sided third nerve palsy with slight ptosis. His pupils were normal, as was his general neurological examination. Investigations including erythrocyte sedimentation rate and cerebral angiography were all normal. His cranial nerve palsies resolved within six weeks and he has had no further symptoms since.

In 1992, the 46 year old brother of the previous patient presented with a 10 day history of frontal headache, diplopia, and pain behind the left eye. He gave a medical history of several attacks of acute vertigo in 1975. These were associated with tinnitus and initially numbness of the right side of his face and right arm. These episodes occurred during a two week period with further attacks three months later. Ear, nose, and throat examination was normal. He was diagnosed as having Menière’s disease but the sequence of events was not typical; nor was the non-progressive nature of the symptoms, which resolved without recurrence within a few months.

Examination showed a fourth nerve palsy. Investigations including erythrocyte sedimentation rate, CT and cerebral angiography were all normal.

After three months he was asymptomatic and the palsy had resolved.

Familial recurrent multiple cranial nerve palsies have rarely been reported. Stone described recurrent seventh nerve palsies in three brothers, one of whom also had a third nerve palsy. Lisch described two families. In the first, a pair of twins had recurrent seventh nerve palsies and one of them also had an episode of “eye muscle paresis”. In the second family three generations had recurrent facial palsies and one member also had an “eye muscle palsy”. Currie described a family with a history of diabetes mellitus in which four siblings had recurrent seventh and fourth nerve palsies. Kee and Moller described a family in Denmark in which all known (seven) members of three generations developed pareses of their third, and sixth or seventh nerves.

The brothers described in our report have the following clinical features in common with the patients of Lisch and Kee and Moller: (1) No other neurological signs were present apart from the cranial nerve palsies. (2) There was no associated systemic upset. (3) Investigations including neuroradiology were normal. (4) Spontaneous resolution of all symptoms occurred within a few months. (5) The episodes of nerve palsy were often separated by many years.

Recurrent non-familial multiple cranial nerve palsies have been widely reported. In almost all such studies, the nerve most commonly affected is the seventh, the next being the third. Fourth and eighth cranial nerve palsies, which occurred in the brothers reported here, are rarely seen as part of a recurrent cranial polyneuropathy. An eighth nerve lesion has not previously been described in familial recurrent cranial nerve palsies.

Clinicians should be aware of the possibility of a familial predisposition to cranial nerve lesions. The connection between our brothers’ histories was only made as one of them, leaving the clinic on his day of discharge made the passing comment that he had just learned that his brother “had the same thing” some years before.

A WATTERS
M J MACDONALD
Department of Ophthalmology, Victoria Hospital, Kirkaldy KY2 5AH, UK

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Wallenberg’s syndrome with delayed onset after cervical spine fracture: a case report

Spontaneous and traumatic dissection or occlusion of the vertebral artery is uncommon and may be asymptomatic, so that the true incidence of this disorder is unknown. Typical symptoms are neck or occipital pain together with other non-specific symptoms such as vertigo, nausea, and vomiting. Although the neurological deficits may be delayed for hours or days, they help to indicate the appropriate clinical diagnostic procedure to be used to distinguish between a non-specific posttraumatic syndrome and brainstem ischaemia. The time lapse between the injury and onset of symptoms is important as appropriate treatment might successfully prevent the development of further unwanted clinical symptoms. Thus it would be helpful if symptoms, other than those already known, could be described to aid in the early diagnosis of this condition.

Case history
A healthy 30 year old engineer had an accident while riding a snowboard resulting in indirect trauma to the left vertebral artery. He immediately complained of neck and occipital pains. These were associated with motor and sensory impairments in the left arm. The radiograph of the cervical spine showed an anterior displacement of C5 over C6 and CT demonstrated a facet joint fracture at C6 on the left side (figure, A). The neurological examination showed symptoms of a left C6 root lesion with radicular pain, hypoesthesia, and mild paresis. There was no evidence of cerebellar or cortical involvement. Osteosynthetic stabilisation was performed with a hookplate (AO) on the day of the accident and 12 days later the patient left the hospital in a fit condition with signs of improvement of the left C6 deficit.

Nineteen days after the trauma he suddenly complained of vertigo, nausea, and vomiting. On readmission to the hospital neurological examination showed spontaneous nystagmus with a rotatory component to the right, miosis and ptosis of the left eye, bulbar speech, paresis of the left velum palatinum, and perioral hypoesthesia on the left side. The gait was atactic with propulsion to the left. Leftsided limb dysmetria was present; C6 symptoms were unchanged. The symptoms suggested ischaemia of the left dorsolateral medulla oblongata, a condition corresponding to Wallenberg’s syndrome.

A control CT of the cervical spine confirmed that the osteosynthetic material had not changed position and there was no encroachment on the vertebral canal by a screw. Ultrasound (colour duplex) of the extracranial arteries indicated a proximal occlusion of the left vertebral artery, which was confirmed by MR angiography with signal missing below C2 (figure, B).

The proximal occlusion was documented by four vessel angiography with no filling of the left posterior infracerebellar artery and without any other vessel injury or abnormality.
Herpes simplex virus type 2 ascending myeloradiculitis: MRI findings and rapid diagnosis by the polymerase chain method

Although neurotropic viruses are often suspected of causing spinal cord injuries, confirmation by early diagnosis is difficult. Ascending myelitis related to herpes simplex virus type 2 (HSV-2) infection has seldom been reported, and the diagnosis could be established only at postmortem examination. In patients with a subacute ascending myeloradiculitis, MRI showed spinal cord and sacral root involvement and the polymerase chain reaction allowed the rapid identification of HSV-2 DNA in the CSF.

A 76 year old woman was referred because of urinary retention and paraparesis. Several weeks previously, she had noted the progressive onset of anorexia, fever (38°C), weight loss (4 kg), and low back pain. Examination performed in another hospital showed negative bacterial cultures from blood and urine and CT of the thorax, abdomen, and lumbaroscalic spine was normal. Three days before admission she complained of right sciatalgia and rapidly developed lower extremity weakness and sphincter disturbances.

Neurological examination showed a flaccid paraplegia, a T10 sensory level, and a distended bladder. Weak deep tendon reflexes were absent in the lower limbs and plantar responses were both extensor. In the upper extremities strength was normal but reflexes were brisk and a bilateral Hoffman sign was noted. Mental state and cranial nerves were normal.

Non-enhanced T1 weighted images of the spine were normal. T2 weighted sequences showed a hyperintense patient, at the T10 level and within the conus medullaris. T1 weighted images with contrast injection showed an enhancement of both the posterior meninges and the roots of the cauda equina.

Her CSF contained 73 leucocytes/mm³ (97% lymphocytes), 132 mg/dl protein and 68 mg/dl glucose. Electrophoresis of CSF protein showed 26% y-globulins with an oligoclonal distribution and a raised IgG/albumin ratio (0.56; normal <0.25). A polymerase chain reaction was performed on CSF with a pair of primers that allowed the simultaneous detection of four viruses of the herpes group. A strong signal was obtained on ethidium bromide staining. Characterisation of HSV-2 DNA was achieved by restriction analysis of the amplified product. α-Interferon in CSF was normal. The patient had no history of recurrent herpes genitalis. There was no serological evidence for borreliosis, HIV-1 or HIV-2, HTLV-I, Q-fever, listeriosis, cytomegalovirus, measles, varicella zoster, or Epstein-Barr virus infection. CD4 counts were normal and no case for immuno-depression could be identified.

Parenteral acyclovir (30 mg/kg daily) was given for 10 days and the patient's neurological state remained unaltered. Two days after admission, sparse vesicular lesions appeared on the patient's buttocks, internal aspects of the thighs, and lower part of the abdomen. Ten days later, numbness in both hands appeared. Examination showed bilateral arm and shoulder weakness and the disappearance of upper limb reflexes. The patient then became confused and drowsy, developed hyponatraemia and hyperosmolar state on day 21 after admission. Necropsy examination was not performed. Subsequently, CSF cultures were reported as positive for HSV-2. Analysis of serum samples showed that the patient had a recent infection. An anti-HSV antibodies between admission and death. IgM antibodies were detected in one early serum sample. Analysis of the CSF and serum anti-HSV antibodies ratio showed the existence of specific intrathecal synthesis.

Various clinical syndromes have been linked to HSV-2 involvement in the nervous system. HSV-2 encephalitis typically occurs in immunocompromised patients, but may also be observed in 5% of herpetic encephalitis in children and adults. Acute, self limited meningitis is found in young adults with primary genital HSV infection. Sacral radiculitis with perineal dysesthesias, autonomic dysfunction, and sometimes mild lower limb weakness may also be associated with herpes genitalis in young adults. In most cases, neurological symptoms occur two to seven days after the genital eruption and patients recover within three weeks.

By contrast, HSV-2 involvement in the spinal cord is rare and HSV-2 encephalitis. HSV-2 extensive myeloradiculitis have been reported in patients with AIDS simultaneously infected with cytomegalovirus and two others in diabetic patients. HSV-2 necrotising myelopathy has also been found in association with malignancy. In all cases the outcome was fatal within four to seven weeks, and the diagnosis could only be made at necropsy, when HSV-2 was recovered from the spinal cord. There has been a single report of HSV-2 myelitis with a favourable outcome in which the virus was isolated from the CSF.

MRI clearly showed myeloradiculitis, on T2 weighted and gadolinium enhanced T1 weighted sagittal sequences. Although well correlated with the clinical features, however, MRI findings lack specificity.

The direct diagnosis of nervous system infection by HSV is difficult as isolation of the virus from CSF is most often unsuccessful. However, serological confirmation is too late. Recently, the polymerase chain reaction has proved to be a powerful tool in the rapid diagnosis of meningoencephalitis due to herpes viruses. In this case, it allowed us to identify HSV-2 in the CSF immediately.
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A Curt and V Dietz

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