SHORT REPORT

“Crossed homonymous hemianopia” and “crossed left hemispatial neglect” in a case of Marchiafava-Bignami disease

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Abstract
“Crossed homonymous hemianopia” and “crossed left hemispatial neglect” were observed in a woman with Marchiafava-Bignami disease. Two forms of “crossed homonymous hemianopia” were observed. Initially, Goldmann perimeter testing showed a left homonymous hemianopia with the right hand and vice versa. Later, confrontation tests showed a left homonymous hemianopia, whereas visual field testing using the Goldmann perimeter (kinetic quantitative perimeter) and the OCTOPUS (Interzeg AG, static automated perimeter) showed a right homonymous hemianopia with either hand. “Crossed left hemispatial neglect” was not seen with the left hand, but neglect of the left hemifield was seen with the right hand. CT and MRI showed a lesion occupying almost the entire corpus callosum. PET showed no significant differences between comparable areas of the left and right cerebral hemispheres. These findings indicate that both signs of interhemispheric disconnection were due to the callosal lesion. Moreover, the “crossed left hemispatial neglect” can be explained as being a consequence of the dominance of the right cerebral hemisphere for visuospatial recognition.

Case report
A 43 year old right handed housewife was found unconscious at home on 19 November 1987. She did not respond to her name and had been incontinent. She was taken to Tokyo Metropolitan Hiroo General Hospital. The patient had been a heavy drinker of Japanese rice wine for 20 years. She had complained of coldness and pain in the tips of her toes for three years, and had been aware of increasing forgetfulness over the preceding two months.

On admission, she was disoriented, her speech was abnormal and she was unable to obey verbal commands. There were no abnormalities of the ocular fundi, the pupils were round and isoropic, and the light reflexes were normal. Central type left facial paresis and mildly decreased muscle strength of the upper left and lower limbs were found. General muscle tone was mildly hypertonic. Deep tendon reflexes were brisk, but both plantar responses were flexor. The sensory system could not be assessed and there was urinary incontinence.

One week after onset, her level of consciousness was nearly normal, but deficits in temporal and spatial orientation remained. Her memory was still defective and her speech was dysarthric although improved. On confrontation tests a left homonymous hemianopia was found. The muscle strength of the left side of the face and left upper and lower limbs had improved, and muscle tone had returned to normal. Subsequently extinction of tactile stimuli of the left hand was found. There were digital disturbances of temperature and pain in all four limbs indicating a polyneuropathy. She regained control of her bladder and bowels. One month after onset, her level of consciousness was normal and she was cooperative enough to participate in neuropsychological testing.

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Neuroradiological finding

One month after onset, sagittal T1-weighted MRI (TR = 2080 ms, TI = 500 ms; Picker International, VISTR-MR 0·5 Tesla superconducting magnet) showed abnormal signal intensity (SI) of the entire corpus callosum except for the extreme anterior portion. Very low SI was seen to extend from the genu to slightly posterior of the centre of the trunk of the corpus callosum, around which there was a border region with SI somewhat lower than that of the normal corpus callosum. Varying degrees of low SI were seen throughout the trunk and splenium (fig 1).

Positron emission tomography (PET) was performed three and four months after onset. The cerebral metabolic rate for oxygen (CMRO₂) and cerebral blood flow (rCBF) were measured using the ¹⁸O-steady state method. No relevant differences between the cerebral hemispheres were found.

CROSSED HOMONYMOUS HEMIANOPIA

Two months after onset, a left homonymous hemianopia was noted both on confrontation tests (verbal response) and on the Goldmann perimeter with the right hand pushing the switch (fig 2A). Four months after onset, she was assessed using the Goldmann perimeter with the left hand pushing the switch. A definite right homonymous hemianopia was found; that is, both hands showed a "crossed homonymous hemianopia" (fig 2B). From eight months after onset, the Goldmann perimeter test and the OCTOPUS static automated perimeter test indicated a right homonymous hemianopia with either hand (fig 2C). Confrontation tests conducted at the same time consistently indicated a left homonymous hemianopia so that the initial crossed homonymous hemianopia with the left and right hands was found to be transient. Later, results of confrontation tests and those obtained by using more sophisticated instruments, such as the Goldmann perimeter test, continued to be contradictory.

At seven months, when instructed to imitate a simple finger pattern presented with one hand ipsilaterally, no deficit (34/36 with the right hand, 30/36 with the left hand) was found. She rarely failed to imitate simple finger patterns presented in the left visual field—where the examiner’s hand should not have been visible in confrontation tests. When required to imitate a contralateral finger pattern, she failed to imitate any pattern with either hand.

The response to placing a rod in the left visual field was also tested. When asked if she could see the rod, she said she could not, but when asked to grasp it, she was able to do so swiftly and accurately with the left hand. She wondered why she could grasp it, despite the fact that she couldn’t see it. When asked to grasp the rod in the left visual field with the right hand, she would repeatedly grope in mid-air—eventually sometimes hitting it. In contrast, when the rod was placed in the right visual field, she said she could see it and had no difficulty in grasping it with the right hand, but clearly had difficulties with the left hand.

Four years after onset, there is no change in the pointing pattern and she is still unable to grasp a rod placed in the contralateral visual field. However, she says she can now see objects in the left visual field and is able to indicate the number of fingers displayed to her in that field.

CROSSED LEFT HEMISPATIAL NEGLECT

In Albert’s line-crossing test, there was marked left-sided visual neglect with the right hand, but no indication of visual neglect with the left hand (fig 3). It was evident that there was neglect of the left hand side when copying figures with the right hand. Fig 4A shows the patient’s drawings of a Greek character (kanji) out aloud, she read out only the right half of the character and neglected the left half which in many cases modifies the right half, changing its meaning. The above findings were observed not only when the original was placed directly in front of her, but also when it was placed on her right or left side and she was instructed to draw with her right or left hand. The results were not considerably different from those found when the paper was placed directly in front of her. In drawing a woman’s face without a
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A 2nd month

B 4th month

C 8th month

Figure 2 Goldmann perimeter tests (2, 4 and 8 months after onset). Results on the left (right) hand side of the figure are those obtained with the left (right) hand pressing the switch. After two months, a left homonymous hemianopia is found with the right hand pressing the switch (A), whereas after four months a left homonymous hemianopia is found with the right hand pressing the switch while a right homonymous hemianopia is found when the left hand did so, that is "crossed homonymous hemianopia" (B). After eight months, a pattern similar to that after 4 months is seen with the left hand, but, with the right hand, the visual field defect has become a right homonymous hemianopia (C).

model, unilateral neglect was not seen with either hand (fig 5). Slight "crossed left hemispatial neglect" still remains four years from onset.

Other signs of the interhemispheric disconnection syndrome, that is, apraxia and tactile anomia of the left hand, were also observed. Agraphia of the left hand was found when attempting to write Chinese characters and Japanese script. The nature of the mistakes made were not due to scrawling with the non-dominant hand, but mainly due to para-graphia with perseveration. In a dichotic listening test there was clear extinction of the left ear. Facial recognition, identification of overlapping figures (Poppelreuter), colour naming, left-right discrimination, finger naming and simple verbal calculation were intact. The Wechsler Adult Intelligence Scale (WAIS) three months after onset, showed a verbal IQ of 73, a performance IQ below 60 and total score below 60. In the Western Aphasia Battery1 one year after onset, no significant abnormalities were seen concerning her ability to write except for her occasional refusal to do so. Construction tasks with the right hand were moderately impaired and those with the left hand were slightly better.
No other abnormalities were found and there was no aphasia.

**Discussion**

There was no difficulty in diagnosing Marchiafava-Bignami disease from the history of alcohol abuse, the pathognomonic findings on X-ray CT and MRI and the various signs of the interhemispheric disconnection syndrome, such as apraxia, agraphia and tactile anomia of the left hand.

The most characteristic feature of this case is the crossed homonymous hemianopia. After four months, a left homonymous hemianopia was found using the Goldmann perimeter with the right hand pushing the switch, but a right homonymous hemianopia was found with the left hand. This “crossed homonymous hemianopia” can be explained by a failure of unilaterally-presented visual information travelling across the corpus callosum to the contralateral motor system, to initiate a response. After eight months, confrontation tests indicated a left homonymous hemianopia, whereas the tests using instruments such as the Goldmann kinetic perimeter or OCTOPUS static perimeter with either hand indicated a right homonymous hemianopia. These results may have been due to different levels of hemispheric activation by the two kinds of tests. That is, in tests requiring verbal responses, the left hemisphere may be more highly activated, whereas in tests requiring only the tracking of a simple light source, the right hemisphere may be more highly activated. This might then explain why two distinct forms of crossed homonymous hemianopia were observed. When the crossed homonymous hemianopia was initially found, there may have been a complete lack of interhemispheric communication and the results would have reflected the functions of the isolated left and right hemispheres. The crossed homonymous hemianopia observed later would then have been a result of the different hemispheric activation induced by the different testing methods. After four years, the left homonymous hemianopia observed on confrontation and the right homonymous hemianopia observed with Goldmann perimeter testing are both less distinct, suggesting that there has been some recovery of interhemispheric communication, and that the crossed homonymous hemianopia will continue to improve. Despite the fact that for three years the patient said she “could not see” objects in the left visual field, she could readily and accurately grasp them with the left hand, and she was able to imitate finger patterns presented by the examiner to the left visual field with the left hand. From these results, we believe that this patient is neither able to verbalise objects seen in the left visual field nor is she conscious of them, in spite of the fact that there is essentially no disturbance of her visual field.

We have been unable to find any previous reports of crossed homonymous hemianopia.
detected by visual field tests using the Goldmann perimeter or comparable instruments, but several related syndromes have been reported. Brion and Jedynak1 reported a case of a callosal vascular lesion, due to a left paracallosal angioma fed by the posterior cerebral artery, showing a so-called "pseudo-hemianopsie". Notably, they found that when two objects were placed one each in the left and right visual fields, the object on the left was ignored. The presence of the stimulus on the left was sometimes denied, but their patient could readily and, simultaneously, grasp the objects with the left and right hands respectively, indicating that the object in the left visual field was seen. Our patient consistently denied that she could see the object in the left visual field, but was easily able to grasp it. This phenomenon was not due to extinction. Lhermitte et al4 reported three cases of suspected MBD, in which verbal responses could not be elicited following the presentation of a stimulus in the left visual field or placement of an object in the left hand, but when instructed to raise the left hand to indicate a response, the instruction was obeyed. They called this syndrome "pseudo-extinction", because it differed from the case reported by Brion and Jedynak which involved two stimuli in separate fields. However, Lhermitte's case and our case are similar as correct responses could be elicited by non-verbal means. Neither of these reports, however, mentions crossed visual field deficits. In a study of a case of MBD at necropsy, Lechevalier et al5 reported a "crossed avoiding reaction", in which a hand would actively avoid an object placed in the contralateral field. Their case was, however, different from our case as no abnormalities on the Goldmann perimeter test could be found. Bogen6 noted "double hemianopsia" as one of the signs of the IDS. He described this syndrome as the ability of the subject sitting opposite the examiner to point the examiner's finger when it was placed individually in the visual field of the subject's pointing hand, but the inability to point if the examiner's finger was placed in the visual field contralateral to the subject's pointing hand; at which time the subject would completely ignore it, as in homonymous hemianopsia. Moreover, when the examiner used both hands in both visual fields, the subject was able to point simultaneously to both fingers. Similar results were obtained in this case using the same examination technique, but such results leave unclear what differences there may be with callosal crossed visual ataxia. Bogen6 referred to this syndrome as being similar to homonymous hemianopsia, but he reported neither the results of confrontation tests nor the results of Goldmann perimeter tests. Irrespective of the fact that she could not see objects in the left hemifield, her ability to grasp each object accurately resembles cases of blindsight including the DB case described by Weiskrantz.

One of the most notable characteristics of our case is that, despite an absence of neglect when copying simple pictures, figures or Chinese characters with the left hand, there is a notable left hemispatial neglect with the right hand. Even in Albert's line-crossing test with either hand, only the right hand showed clear left hemispatial neglect. When reading Chinese characters, she omitted the left part entirely, and read only the right half of those characters whose right halves could be read as independent entities. Neither hand showed abnormalities during spontaneous drawing. These findings suggest that the deficit is in the process of visual input. This "crossed left hemispatial neglect" is not mentioned in neuropsychology texts8,9 or in reviews of inter-hemispheric disconnection syndrome.4,10 However, similar signs were reported by Sine et al11 in a case of left parasagittal frontoparietal haemorrhage with spasm of the anterior cerebral artery and by Goldenberg et al12,13 in a case of pericallosal haemorrhage of the anterior two thirds of the corpus callosum, both cingulate gyri and the white matter underlaying both medial frontal lobes secondarily to bleeding from an aneurysm of the anterior cerebral artery. Recently, Kashiwagi et al14 noted a similar case secondary to infarction of the anterior cerebral artery. Furthermore, Costello and Warrington15 reported both a right-sided visuospatial neglect and left-sided neglect dyslexia (misreading the beginning of a word) in a case of lymphoma occupying mainly the left occipital lobe including the splenium.

"Crossed left hemispatial neglect" can be explained as follows: in our case, neither hemispace is neglected in copying with the left hand, although the right hemisphere alone is functioning; in copying with the right hand, however, attention is paid exclusively to the contralateral right hemispace and the ipsilateral left hemispace is neglected because only the left hemisphere which is disconnected from the right, is functioning. "Crossed left hemispatial neglect" has not previously drawn attention as one of the signs of the interhemispheric disconnection syndrome.

In our case, PET was performed. No significant lateralisation, however, was found in terms of either rCBF or oxygen metabolic rate. PET and MRI results also indicate that the "crossed homonymous hemianopsia" and "crossed left hemispatial neglect" observed are not due to lesions of the cerebral hemispheres.

7 Weiskrantz L. Blindsight — a case study and implications.
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