pontine tegmentum, due to occlusion of a single paramedian tegmental pontine perforating artery – an anatomic variant, the terminal bifurcation of which supplies both sides of midline. Ophthalmoplegia, due to bilateral '1½ syndrome', results from involvement of both abducens nuclei and medial longitudinal fasciculi; and facial diplegia from involvement of the genu of the intra-axial fasciculus of both facial nerves.

The combination of '1½ syndrome' and ipsilateral LMN facial palsy: 'the 8½ syndrome', is a well described brainstem stroke syndrome. A single case of 1½ syndrome with LMN facial diplegia, termed 'the 15½ syndrome' has been reported. To our knowledge, this is the first reported case of acute LMN facial diplegia and horizontal ophthalmoplegia: 'the 17 Syndrome' (7+7+1½+1½).

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THE 17 SYNDROME

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A 58-year-old man woke from uneventful right cerebellopontine angle surgery (grade I schwannoma resection) with severe, lower motor neurone (LMN) facial diplegia and near-complete nuclear horizontal ophthalmoplegia, uncorrectable by vestibulo-ocular reflex. Vertical gaze and convergence were normal. Examination was otherwise normal, excepting right sensorineural anacusis (a short HD video will be shown). CT brain revealed expected post-operative changes. MRI wasn't possible due to a pacemaker, inserted for symptomatic bradyarrhythmias. There has been no improvement after 12 months.

We attribute this presentation to infarction of a small neuroanatomically dense section of the paramedian dorsocaudal