A 63-year-old man presented with horizontal diplopia. Two years earlier he had a hemiparesis and sensory changes of the right side of the body which regressed in a few days. Examination did not reveal abnormalities other than oculomotor disturbances. With any type and any direction of lateral eye movements, the left eye remained fixed on the midline, while the right eye could only abduct from and return to the midline. In the vertical upward gaze, the right eye showed skew deviation with vertical divergence. Convergence was preserved. The pupillary reflexes were full. Laboratory studies showed: white-cell count was 11.840/mm³, red-cell count was 6.240-000/mm³. Hb 19.8 mg/dl., HCT 58.9% MCV 89%, MCH 30.7%, MCHC 68.9% the platelets count was 311.000/mm³. With the ¹⁴C method, the circulating blood volume was found to be increased. A computed tomography scan showed an area of low density in the left parietal region with normal ventricular size; with contrast there were no changes. Chest radiographs were normal. Both carotid and basilar angiograms and ECG were normal. The EEG showed slight slowing in the left temporal area. Intravenous pyelograms revealed two left renal cysts. Two phlebotomies of 400 ml were made. One week later there was complete recovery of the ocular disorder. Two weeks after admission the patient was discharged from hospital with diprydamole treatment.

The “one-and-a-half” syndrome usually results from a single, unilateral and relatively small lesion of the dorsal tegmentum in the lower pons. At first the abducens nucleus (VI) and/or the pontine reticular formation are damaged by this lesion and an ipsilateral conjugate gaze palsy is produced. Next damage by the same lesion to the ipsilateral medial longitudinal fasciculus, which lies at the same level or just above the abducens nucleus, accounts for unilateral internuclear ophthalmoplegia.

The causes of the syndrome are varied. In our patient, the “one-and-a-half” syndrome resulted from a probable cerebral thrombosis in the vertebral-basilar system secondary to polycythaemia, a condition in which the liability to cerebral thrombosis is increased. As far as we know, the present case is the first description of a “one-and-a-half” syndrome secondary to polycythaemia, a potentially reversible cause.

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References

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Corynebacterium pyogenes meningitis

Sir: Corynebacterium pyogenes is a gram positive rod which is associated with suppurative or granulomatous lesions in various domestic animals with a few reported cases implicating human disease. We report what is believed to be the first case of C. pyogenes meningitis.

A 76-year-old man was admitted to hospital in a confused state. Over the previous twelve hours he had complained of severe headache, nausea and vomiting. His temperature was 38°C; pulse 98/min; blood pressure 180/110/mm Hg; respiration 24 per minute, and he responded slowly to commands. There was neck stiffness and photophobia with no other neurological signs. Acute meningitis was diagnosed and confirmed by lumbar puncture; (table). Chloramphenicol was prescribed as no organisms were identified on direct micro-

One-and-a-half syndrome due to polycythaemia

Sir: The “one-and-a-half” syndrome is a peculiar lateral gaze palsy. It combines two defects of horizontal eye movements: a lateral conjugate gaze palsy in one direction (one) and, in the opposite direction, a paralysis of adduction by one eye resulting from an internuclear ophthalmoplegia (and-a-half). Thus, one eye cannot deviate laterally from the midline and the other eye can only be abducted from the midline. The first reported clinicopathological case is that of Fisher. We have found 22 cases in the literature, with several causes: five have been proven and five were probable infarctions, two gliomas, two astrocytomas, one arteriovenous malformation, three haemorrhage, two probable cases of multiple sclerosis, one ependymoma and one metastatic tumour. We report a case of the one-and-a-half syndrome secondary to polycythaemia.


Accepted 16 April 1983

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