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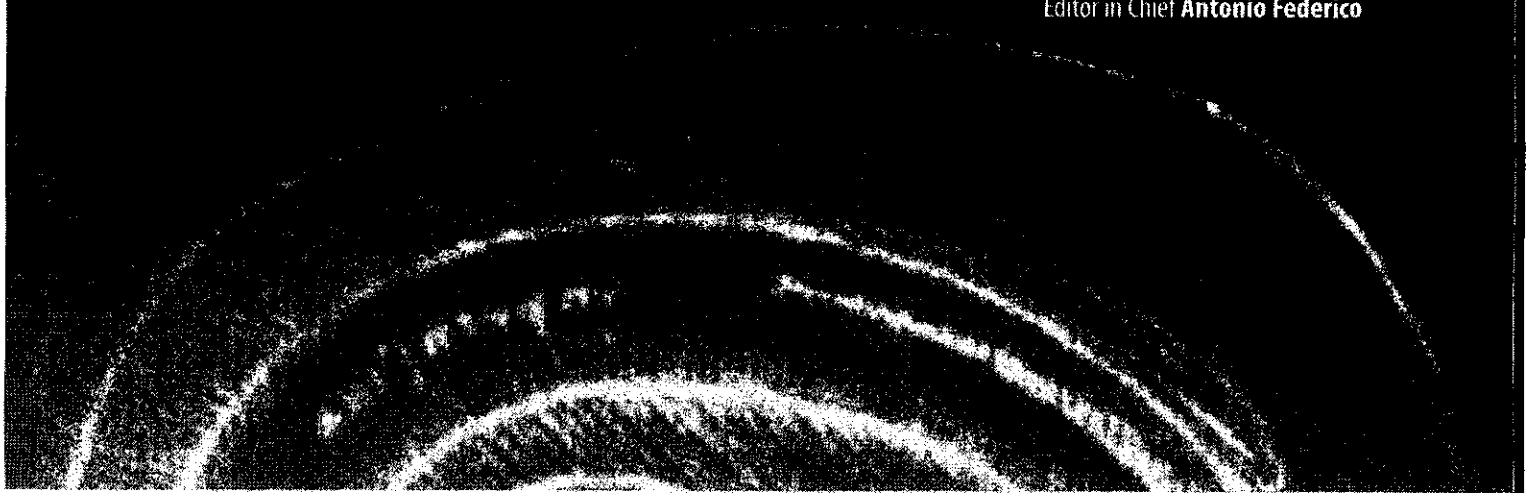
Neurological Sciences

Official Journal of the Italian Neurological Society



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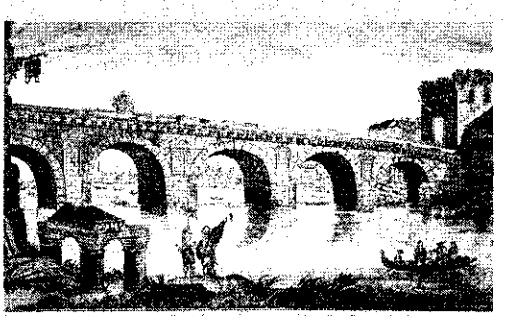
XLIII Congress of the Italian Neurological Society

Rimini, Palacongressi
6-9 October 2012



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Neurological Sciences

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Continuation of
The Italian Journal
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Neurological Sciences

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Case 2-a 35 year-old man with RRMS, previously treated with 3 courses of mitoxantrone, interferon and natalizumab for 24 months - stopped due to anti-JCV seropositivity-, was given fingolimod because of two close relapses despite glatiramer acetate treatment. Blood tests and ECG (SR, 83 bpm) were unremarkable at baseline. Three hours after the first fingolimod dose, bradycardia occurred (nadir 47 bpm) persistently for 7 hours. The patient was monitored during the following two drug administrations: ECG showed no abnormalities, but HR dropped from 65 to 51 bpm after 6 hours. Although both patients were asymptomatic, fingolimod was discontinued.

Conclusions: Fingolimod is a promising treatment for RRMS, although serious adverse cardiovascular events have been reported (2). Our cases underline that sometimes the negative chronotropic effect of fingolimod can be relevant and sustained (2,3), not only after the first administration.

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FOIX-CHAVANY-MARIE SYNDROME: A CASE REPORT

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Background: Foix-Chavany-Marie syndrome (FCMS) is a rare cortico-subcortical suprabulbar palsy of the lower cranial nerves. It is characterized by anarthria, dysphagia and bilateral facial weakness with preserved reflexes and automatic or emotional movements (automatic voluntary dissociation). It develops after bilateral lesions of the anterior opercula or subcortical insular regions, most often due to sequential cerebro-vascular accidents (1).

Case Report: LG, a 45-year-old Caucasian right-handed man, was admitted to the Rehabilitation Unit of San Paolo Hospital in Milan after a left hemispheric ischemic stroke. He has a medical history of hyperhomocysteinemia, medically treated arterial hypertension and a previous right hemispheric ischemic stroke from which he had completely recovered. At admission, the patient was awake and alert, understood spoken and written language but was unable to speak. He was only able to generate a groaning sound and was drooling continually. He was unable to perform voluntary facial or tongue movements. His swallowing function was mildly impaired: the voluntary phase of swallowing was compromised (he was unable to initiate the action), but the reflex phase was preserved. A nasal-duodenal tube was positioned. He had right hypertonic hemiplegia with Babinski's sign and right sensitive hemisyndrome with somatosensory impairment for touch and position. During the first week an episode of trismus was observed with spontaneous resolution. Brain MRI revealed a wide acute ischemic lesion in the left middle cerebral artery territory involving the frontal lobe, insula, operculum, and extending to oval centre, and a right frontal encephalomalacia. The patient underwent intensive rehabilitation treatment with only partial functional recovery.

Discussion: FCMS is classically associated with sequential infarcts of the bilateral anterior opercula or subcortical insular regions. Volitional but not reflexive movements of the face and the throat are affected. This confirms that supranuclear control of the jaw is largely bilateral. Voluntary corticofugal system originates in the frontal opercular area, whereas spontaneous emotional and automatic movements are presumably mediated by pathways involving other structures (such as basal ganglia). The involuntary motor system, which is older phylogenetically, has less plasticity towards the learning process than the neocortical voluntary system. This may explain the poor prognosis for voluntary swallowing and speech recovery in FCMS described in the limited data of literature. In the rehabilitation process, however, the precocious diagnosis of FCMS can lead to a more appropriate assessment and therapeutic approaches to speech and nutrition disturbances.

Reference:
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MULTIPLE RING-ENHANCING BRAIN LESIONS IN A GHANAIAN PATIENT: A CASE REPORT

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Objectives: To describe an immunocompetent patient from Ghana with sudden onset of headache and hemiparesis and MRI feature of multiple ring-enhancing brain lesions.

Materials and Methods. Case report: A 36-year-old man from Ghana was referred to our hospital for sudden left hemiparesis, headache and a brain CT scan showing multiple hypo-dense areas suggesting a possible vascular disease. Five days after the admission, a brain MRI showed two multiple ring-enhancing lesions with DWI increased signal. No structural or bioelectric abnormalities came out from EKG while patent foramen ovale, atrial septal aneurysms, or other conditions associated with embolic stroke were excluded by echocardiography. Complete blood count was normal and lymphocyte subpopulations did not show significant abnormalities. Standard clinical laboratory testing on CSF analyses were normal. Tests for tuberculosis, toxoplasmosis and HIV were negative. At day twelve, the patient complained of itch without skin lesions and in the meanwhile laboratory tests displayed elevated IgE level. Elisa test and enzyme-linked immunoelectrotransfer blot (EITB) assays were carried out for main cerebral parasites (Tenia Solium, Toxocara canis, Echinococcus and Trichinella). A week after, a new cerebral MRI showed multiple cystic lesions whose shape suggested a different stage of some of them. According to this MRI pattern and to clinical characteristics [1], a diagnosis of neurocysticercosis was hypothesized but serological test for tenia Solium was negative. As suggested by literature and considering the high rate of false negative in EITB tests for Tenia Solium in tatient with MRI images suggestive of a neurocysticercosis a treatment with albendanzolo and prednisolone was started.

Discussion and Conclusions: Multiethnic population and migrations represent a diagnostic challenge for neurologists. Difficulties in the reported case rise from the complex differential diagnosis of MRI multiple ring-enhancing lesions in the brain. In fact, these lesions may be caused by neoplastic, vascular or infectious diseases although in endemic regions neuro - cysticercosis and other parasitosis should be considered. The patient we describe, did not have, as it should be expected, a diffuse localization of the infection. As in this case, linking neuroimaging data to patient's history, physical examination and laboratory data are essential clues to make an accurate diagnosis.

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