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NEUROLOGICAL PICTURE

doi: 10.1136/jnnp.2005.071522

Medial medullary infarction

A 60 year old man with hypertension and diabetes mellitus sought neurological consultation for sudden onset of numbness over the left side of body. On examination, he was conscious and had dysarthria. Right lingual paresis was observed on tongue protrusion (fig 1A). The other neurological findings included left lemniscal sensory impairment and mild left haemiparesis without facial involvement (fig 1B). The presence of crossed neurological signs—right (ipsilateral) hypoglossal palsy and left (contralateral) sensorimotor haemiparesis (with facial sparing)—localised the lesion to right medial medulla. Cranial magnetic resonance imaging (MRI) confirmed the clinical localisation (fig 2A, B). Intracranial portion of right vertebral artery was not visualised on the magnetic resonance angiogram (fig 2C). The topography of the lesion and the absence of flow in the right vertebral artery favoured infarction over demyelination as the likely aetiology. The neurological problem was ascribed to right medial medullary infarction due to occlusion of antero-medial medullary artery, originating from right vertebral artery. He eventually made good clinical recovery.

Our patient presented with the classical clinical triad of Dejerine's syndrome, that includes ipsilateral hypoglossal palsy, contralateral haemiparesis, and lemniscal sensory loss.¹ Involvement of right hypoglossal nucleus and nerve fibres in the dorsomedial portion of upper medulla, right pyramid,

and medial lemniscus rostral to the motor and sensory decussations contributed to the observed neurological signs. Intracranial vertebral artery occlusion more often manifests with lateral medullary syndrome. Rarely does it produce medial medullary infarction as observed in our patient.

Acknowledgements

The authors thank Mr Rajesh for technical assistance.

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Competing interests: none declared

Consent has been obtained for figure 1.

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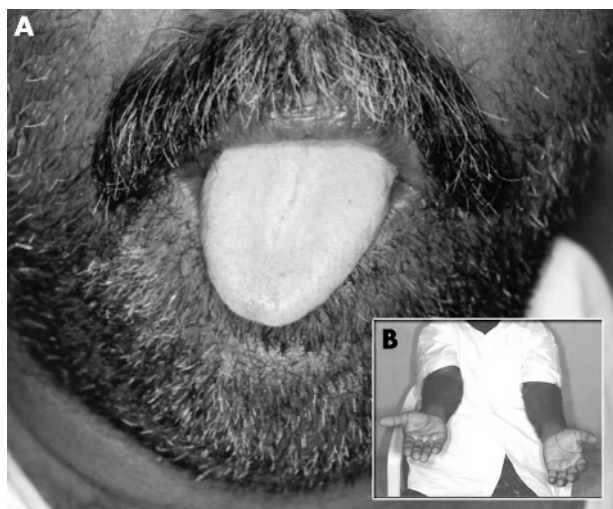


Figure 1 (A) Right hypoglossal palsy elicited on tongue protrusion; (B) Left pronator drift evident on forward arm abduction.

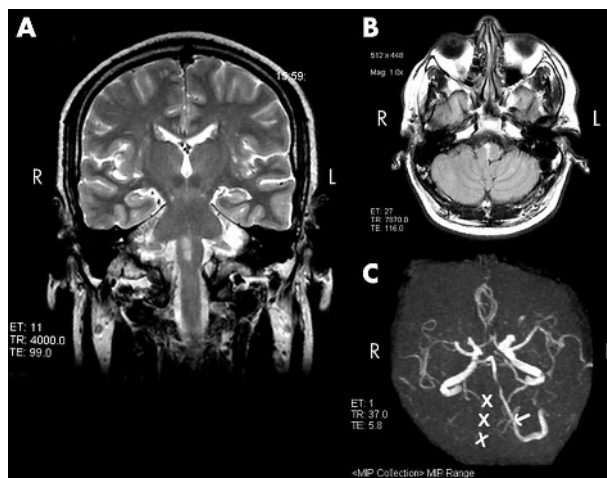


Figure 2 (A) Right medial medullary infarction seen on the T2 weighted coronal magnetic resonance imaging; (B) The same lesion in transaxial fluid attenuated inversion recovery sequence; (C) Magnetic resonance angiogram showing normal flow in the left vertebral artery (arrow). Note the absence of flow in the right vertebral artery (cross).