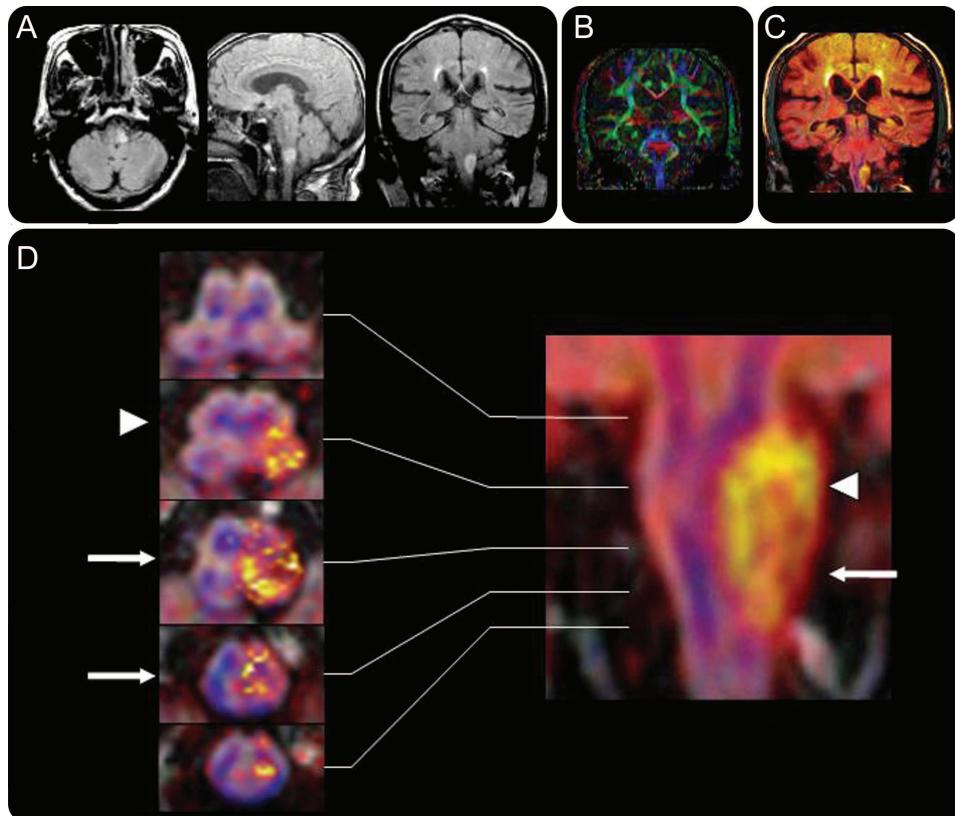


Opalski syndrome

Ipsilateral hemiplegia due to a lateral-medullary infarction

Figure Imaging features of Opalski syndrome



Fluid-attenuated inversion recovery MRI (A). Directionally encoded map with hues reflecting tensor orientation (B). Superimposed images (C, D): a yellow halo represents the infarct and blue lines represent the pyramidal tracts (coronal); the tracts fuse at the decussation (transverse). Caudal extension of the lesion involves the ipsilateral corticospinal tract (arrows) after the decussation (arrowheads).

A 66-year-old man developed left hemiparesis, left Horner sign, and sensory loss on his left face and right limbs, without contralateral hemiparesis or tongue weakness. MRI demonstrated a left lateral-medullary infarction (figure, A). A rare variant of lateral-medullary syndrome, Opalski syndrome,¹ manifests as ipsilateral hemiplegia; however, the anatomic basis is not established.² Therefore, we generated a directionally encoded color map (figure, B) using diffusion tensor imaging techniques and superimposed the images (figure, C and D). These suggest that involvement of the ipsilateral corticospinal tract after the pyramidal decussation, or compression of the decussation, could cause Opalski syndrome.

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1. Montaner J, Alvarez-Sabín J. Opalski's syndrome. *J Neurol Neurosurg Psychiatry* 1999;67:688–689.
2. Hermann DM, Jung HH, Bassetti CL. Lateral medullary infarct with alternating and dissociated sensorimotor deficits: Opalski's syndrome revisited. *Eur J Neurol* 2009;16:e72–e74.