

Teaching Video NeuroImages: Delayed hemibody myorhythmia and palatal myoclonus after vertebrobasilar stroke

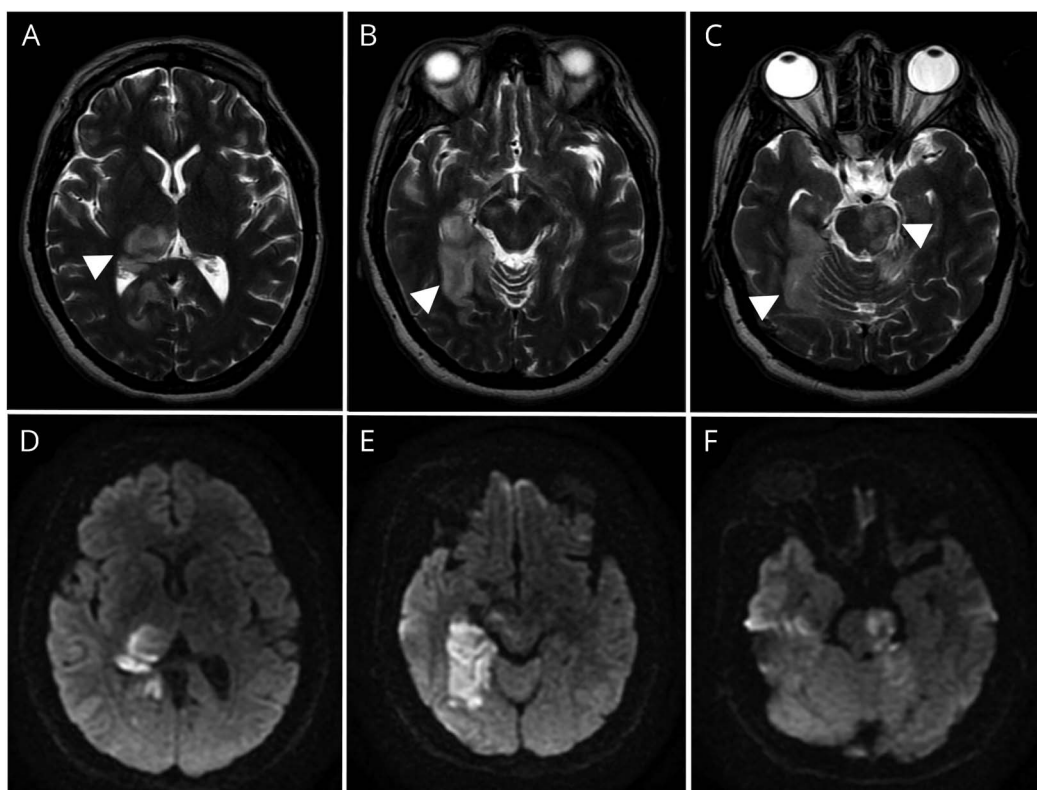
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Figure 1 Brain MRI shows acute vertebrobasilar stroke



Axial T2-weighted brain MRI obtained upon first admission reveals hyperintense lesions in right occipital lobe, thalamus (A) and midbrain (B), and left pons (C), indicated by arrowheads. These areas correspond to a high signal on the diffusion-weighted imaging (D-F) and a low signal in apparent diffusion coefficient map (not showed), confirming an acute infarction in vertebrobasilar territory.

A 40-year-old woman with well-controlled HIV infection had a vertebrobasilar stroke secondary to endocarditis by *Coxiella burnetii* (figure 1), with left hemiparesis remaining.

Five months later, the patient visited the emergency department complaining of a subacute onset of involuntary movements on her left hemibody. An examination revealed quasirhythmic slow movements at 2–3 Hz affecting the inferior facial musculature, the soft palate, and the left

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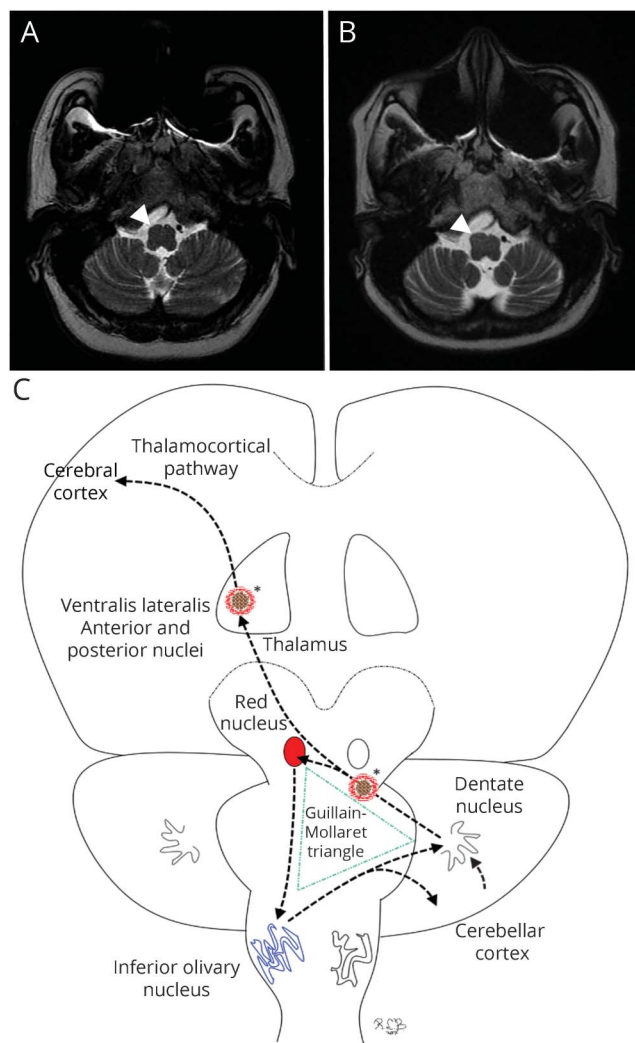
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Figure 2 Inferior olivary nucleus hypertrophy and illustration of the Guillain-Mollaret triangle



An axial T2-weighted MRI at the level of the medulla oblongata was unremarkable at first admission (arrowhead in A). One year later, T2-weighted MRI reveals a right inferior olivary nucleus hypertrophy (arrowhead in B). (C) Illustration of anatomic pathways implicated in the pathogenesis of myorhythmia and palatal myoclonus in our patient. Dashed arrows indicate the dentato-rubro-olivary and dentato-thalamo-cortical tracts. Asterisks indicate the insults in our patient affecting the right thalamus and the dentato-rubro pathway at the level of the left upper pons. The inferior olivary nucleus, colored blue, represents right hypertrophic olivary degeneration.

limbs. These movements were present at rest and worsened with voluntary activity (video, <http://links.lww.com/WNL/A115>).

EEG and CSF tests were normal, including PCR for *Tropheryma whipplei*, since it is a treatable cause of involuntary rhythmic slow movements. A brain MRI showed hypertrophic olivary degeneration (figure 2), excluding new lesions.

These findings are suggestive of hemimyorhythmia with palatal myoclonus.¹ Trials with adequate doses of tetrabenazine, clonazepam, and trihexyphenidyl were unsuccessful.

Author contributions

Luisa Panadés-de Oliveira: acquisition of data, drafting of the original manuscript. Antonio Méndez-Guerrero: study concept and design, drafting of the manuscript, critical revision of the manuscript. Roberto López-Blanco: acquisition of data, drafting of the manuscript, drawing the cartoon, critical revision of the manuscript. Elena Salvador Álvarez: preparation of image, neuroradiology interpretation. Juan Ruiz Morales: history and examination of patient, critical revision of the manuscript. Jesús González de la Aleja: analysis and interpretation of EEG, critical revision of the manuscript for important intellectual content.

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Disclosure

The authors report no disclosures relevant to the manuscript. Go to Neurology.org/N for full disclosures.

Reference

1. Baizabal-Carvallo JF, Cardoso F, Jankovic J. Myorhythmia: phenomenology, etiology, and treatment. *Mov Disord* 2015;30:171–179.

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