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## Pure sensory stroke from cortical infarction

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A 52-year-old man developed sudden numbness and paresthesias of the left face, ear, arm, leg, and trunk, but not the tongue or genitals, equally involving all affected areas. All elementary modalities of pain/temperature, light touch, and proprioception were impaired. He also had mild left-sided heaviness. On examination, he had normal visual fields, normal strength, and no neglect or visuospatial deficits. MRI showed infarction in the right postcentral gyrus (figure). The etiology of the stroke was cryptogenic. Over the next few months the symptoms in his leg improved, but he gradually developed chronic left arm dysesthesia, similar to the Roussy–Déjérine syndrome associated with thalamic strokes. He later developed tactile hallucinations in his left hand.

The anatomic localization of sensory loss in stroke generally is reliably determined by evaluation of the distribution of the deficit and the sensory modalities involved, but this can be misleading in the acute setting. The putative dictum is that in the absence of neuropsychological dysfunction, a pure sensory stroke involving face, arm, leg, and trunk usually localizes to the thalamus,<sup>1</sup> or rarely to the brainstem. Involvement of two or more regions of the body has high positive predictive value (95%) for a small vessel ischemic event.<sup>2</sup> Rarely, parietal cortical infarction may cause a pseudo-thalamic syndrome, particularly in

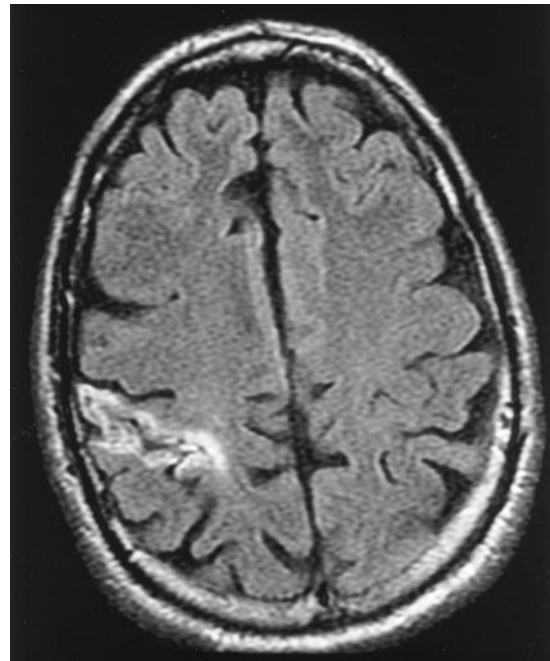


Figure. MRI FLAIR sequences revealed increased signal intensity isolated to the postcentral gyrus. The infarction was limited to the gray matter and was extended approximately 2 cm above and below this representative slice.

the acute setting. Over time the clinical manifestations may become more suggestive of cortical localization.

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