Teaching Video NeuroImage: Unilateral Myorhythmia in a Patient With a Midbrain-Diencephalic Junction Cavernous Malformation

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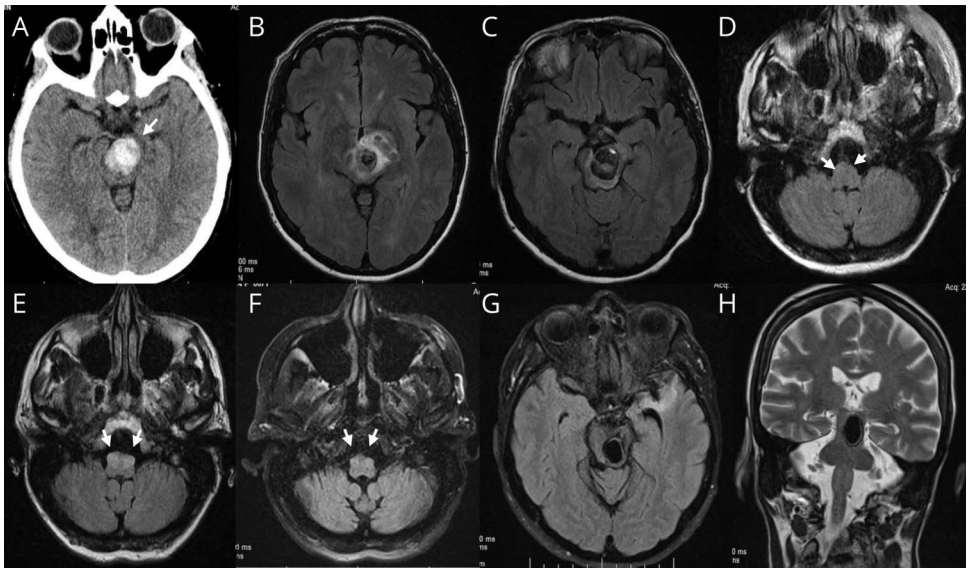
Figure Neuroimaging



CT of the brain shows midbrain-diencephalic junction hemorrhage (A), axial MRI T2/FLAIR sequences show left midbrain-diencephalic junction hematoma in the location of the cavernous malformation (B,C), inferior olives at the time of the hemorrhage (D), olivary pseudohypertrophy (arrowheads) 1 year (E) and 7 years (F) post-hemorrhage, and cavernous malformation 7 years posthemorrhage (G). Coronal T2-weighted MRI also shows the cavernous malformation 7 years posthemorrhage.

A 60-year-old woman with a cavernous malformation at the left midbrain-diencephalic junction presented 9 months after hemorrhage and resection. She developed a palatal tremor and rhythmic, 2–3 Hz movements of her right leg (myorhythmia) 3 months earlier. Trihexyphenidyl and amantadine provided benefit (Video 1). MRI of the brain demonstrated bilateral olivary pseudohypertrophy (Figure).

A lesion in the upper 2 arms of the Guillain-Mollaret triangle leads to central tegmental tract damage, deafferentation of the olivary nuclei, and pseudohypertrophy (OH).[1] Although the connection with palatal tremor is well-recognized, myorhythmia is rarely reported. Unilateral myorhythmia with bilateral OH was described in one case.[1] Isolated myorhythmia has also been reported and should be considered as part of the spectrum (brainstem insult/lesion).[2]

MORE ONLINE

Video

Teaching slides
links.lww.com/WNL/B814

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Anthony E. Lang, MD, FRCPC	The Edmond J. Safra Program in Parkinson's Disease and Morton and Gloria Shulman Movement Disorders Clinic, Toronto Western Hospital, University of Toronto, Canada	Drafting/revision of the manuscript for content, including medical writing for content, major role in the acquisition of data, and study concept or design

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