CASE 1992-2

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CLINICAL ABSTRACT:

A 77 year old male was admitted with a 5 year history of gradually progressive confusion. Family noted memory loss, disorientation, wandering and paranoia. He had a one week history of incontinence and inability to ambulate. There was no history of syphilis, trauma or toxic exposure. Family history was significant for senile dementia in three first degree relatives. There was no history of consanguinity.

Physical examination on admission showed moderate loss of subcutaneous tissue and generalized decrease in muscle mass. On neurologic examination he was alert, withdrawn and exhibited paranoid ideation. He was oriented to person but disoriented to place and time. Short term memory was poor with no recall of three objects at 2 minutes. Calculations were poor. Reading was intact. Speech showed mild dysnomia. Motor impersistence was present. Cranial nerves were intact except for mild flattening of the left nasiolabial fold. Strength was diffusely decreased in all muscle groups, but most prominently in the right lower extremity. Deep tendon reflexes were normoactive and symmetric in the upper extremities. Lower extremity reflexes were absent except for a brisk right knee jerk. Plantar reflexes were bilaterally extensor. Snout and bilateral grasp reflexes were elicitable. Sensory examination showed normal responses to painful stimuli. Patient was unable to stand unassisted.

LABORATORY STUDIES:

White blood cell count, urinalysis, routine serum enzymes and electrolytes, arterial blood gases, vitamin B12 and folate, thyroid functions, rheumatoid factor, ANA, and VDRL were normal on admission. Hematocrit was 37.5 and sedimentation rate was 55. Lumbar puncture was traumatic and revealed bloody, nonxanthochromic CSF. CSF glucose was 65, total protein was 87 and cell count showed 1447 RBC's and 2 WBC's (1L, 1S). CSF gram stains, AFB, and cultures were negative. CT scans demonstrated generalized atrophy and ventriculomegaly.

Hospital course was complicated by the development of sacral decubitii and poor oral intake requiring nasogastric feedings. He developed a pneumonia and expired.

NECROPSY FINDINGS:

Bronchopneumonia with abscess, bilateral, moderate atherosclerosis of coronary arteries, atherosclerotic aneurysm with thrombosis and tubulo-interstitial nephritis.

Brain 1100 grams in weight with hydrocephalus exvacuole.

MATERIAL SUBMITTED: H & E slide of medulla.

POINTS FOR DISCUSSION: Diagnosis/Nature of Lesion.