

CASE 2

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This 42 year old male became acutely blind on the right and had episodes of numbness of the right half of the body lasting about five minutes. Over the succeeding two months his memory began to fail and he developed a slurring, faltering speech. He was frequently somnolent. He was then admitted to the hospital.

On hospital admission his blood pressure was 130/80 mm Hg and remained in this range for the rest of his life. Neurologic examination revealed dysphasia, dyscalculia, right-left disorientation, right central facial palsy, and mild weakness of the right arm and leg. The right eye was amaurotic due to "central retinal artery thrombosis." Proprioceptive and epicritical sensitivity were intact.

Laboratory studies: Blood counts were normal throughout the entire illness. Cerebrospinal fluid protein was consistently normal except for increase to 100 mgm % toward the end of his illness. Repeated pneumoencephalograms and bilateral carotid arteriograms were normal.

During the following three months his neurological signs became more pronounced and complicated by incoordination and intellectual deterioration. A biopsy from the right temporal lobe was obtained.

For the remaining sixteen months of his life he was confined to a wheelchair, because of weakness and incoordination. Serial EEGs showed evidence of progressive generalized cerebral dysfunction. He developed generalized seizures, headaches and many somatic complaints. He was comatose for several days prior to his death which occurred 20 months from first presentation.

At autopsy the adrenals appeared reddish and symmetrically enlarged to 4 cm in diameter. The brain weighed 1300 grams and displayed numerous minute foci of cortical and subcortical necrosis.