

Vernet syndrome and varicella-zoster virus infection (Maurice Vernet, French Neurologist-ORL, 1887-1974)

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Introduction

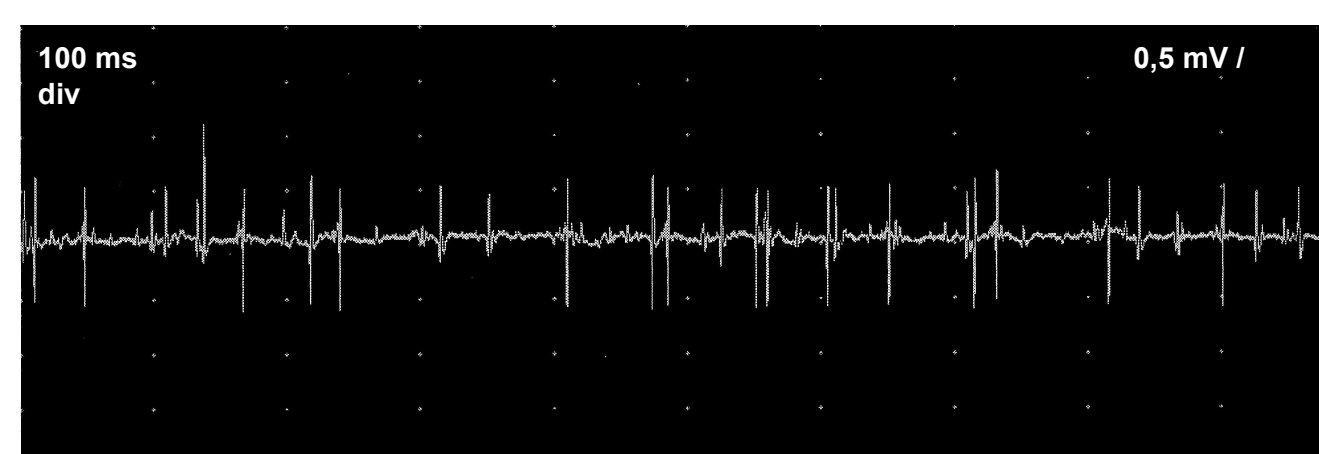
Cranial nerve involvement has been subdivided into several syndromes: they represent challenging issues in neurology, overall when MRI investigation could not provide information concerning aetiology.

Objective

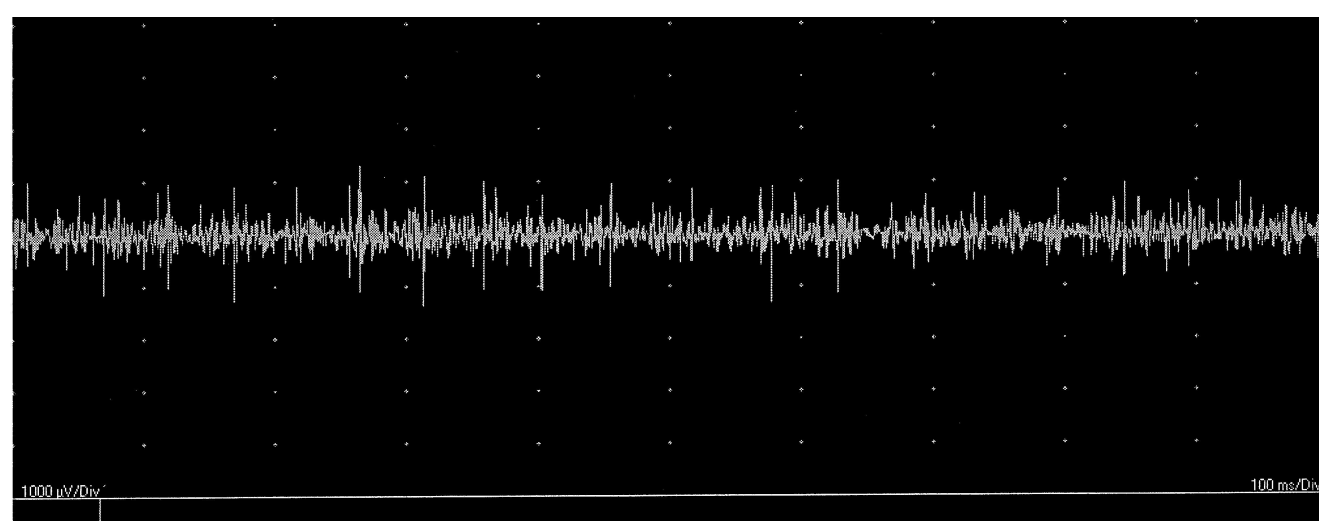
Vernet syndrome refers to paralysis of the IX, X and XI cranial nerves traversing the jugular foramen mostly produced by tumors, vascular lesions, infection and trauma. The following outlines a patient with Vernet syndrome and VZ virus infection

Conclusion

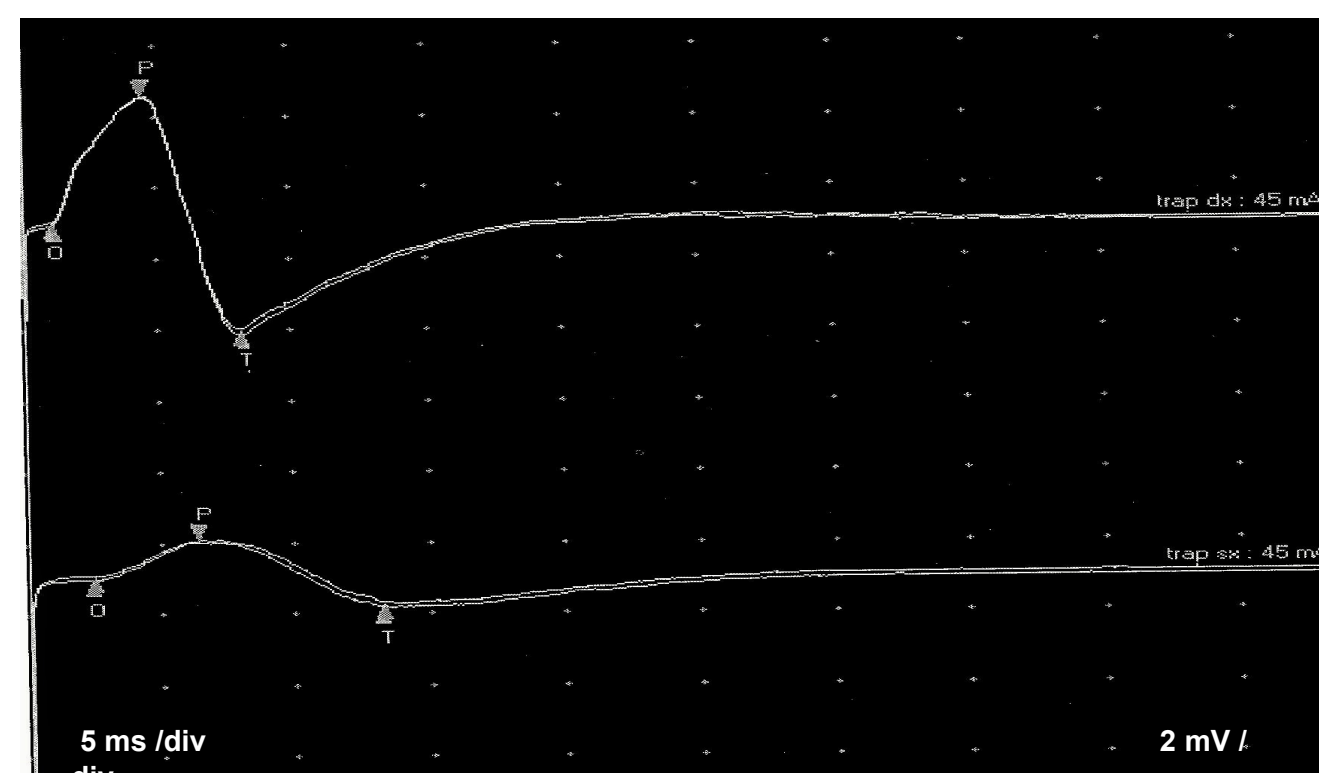
An unusual clinical variant of cranial polyneuritis characterised by pharyngeal-cervical weakness is herein described: clinical findings confined to involvement of lower cranial nerves are very rare. Clinical picture and electrophysiological findings suggested a demyelinating disorder.



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Case report

•A 76-year-old woman with no history of neurological disease presented with a period of generalised weariness. She rapidly experienced unpleasant sensations affecting oral cavity and hoarseness. After a sudden rise in temperature, which settled by antibiotics, earache, lasting for two days and paroxysmal pain in her left latero-cervical territory. The overlying skin was normal. Two weeks later, she began to complain with difficulty in swallowing and her speech became dysphonic. Symptoms worsened enough to produce a weight loss of 12 Kg. Almost concomitantly, she felt weakness involving left shoulder and a marked impairment of the arm abduction and elevation.

• Neurological examination She showed impaired gag reflex on the left side and deviation of the uvula to right side. Left trapezius muscle strength were severely reduced. Hypotrophy of the left shoulder was present; the left scapula at rest was displaced laterally and inferior edge was rotated internally. The tendon reflexes were present in all four limbs.

•Laryngoscopy showed that her left vocal cord was hypomobile with a palsy in adduction; a palsy of the left larynx was also found.

•NCV study showed a prolonged distal latency of CMAP from the trapezius muscle and mild bilateral abnormalities suggesting CTS. Electrophysiological findings in other nerves assessment were normal.

•Needle EMG showed increased insertional activity in the left SCM muscle; a discrete amount of abnormal spontaneous activity suggested mild denervation in trapezius muscle.

•Serological tests were performed to detect antibody to CMV, EBV, HSV and HZV: immunoglobulin G and M were positive against HZV. These findings were consistent with acute varicella-zoster infection.

•One month later, the patient gradually improved strength on left shoulder, speech and swallowing getting better.

Vernet syndrome by varicella-zoster virus

Ryun Yil Jo et al, Annals of rehabilitation Medicine 2013

Kavabe K et al, J Neurol Sci 2008

Maurice Vernet: Syndrome du trou déchire postérieur (paralysie des IX, X, XI). Rev Neurol 1918