An Unusual Stroke-like Clinical Presentation of Creutzfeldt-Jakob Disease

Acute Vestibular Syndrome

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Vertigo and dizziness are common neurological symptoms in general practice. Most patients have benign peripheral vestibular disorders, but some have dangerous central causes. Recent research has shown that bedside oculomotor examinations accurately discriminate central from peripheral lesions in those with new, acute, continuous vertigo/dizziness with nausea/vomiting, gait unsteadiness, and nystagmus, known as the acute vestibular syndrome.

Case Report: A 56-year-old man presented to the emergency department with acute vestibular syndrome for 1 week. The patient had no focal neurological symptoms or signs. The presence of direction-fixed, horizontal nystagmus suppressed by visual fixation without vertical ocular misalignment (skew deviation) was consistent with an acute peripheral vestibulopathy, but bilaterally normal vestibulococular reflexes, confirmed by quantitative horizontal head impulse testing, strongly indicated a central localization. Because of a long delay in care, the patient left the emergency department without treatment. He returned 1 week later with progressive gait disturbance, limb ataxia, myoclonus, and new cognitive deficits. His subsequent course included a rapid neurological decline culminating in home hospice placement and death within 1 month. Magnetic resonance imaging revealed restricted diffusion involving the basal ganglia and cerebral cortex. Spinal fluid 14-3-3 protein was elevated. The rapidly progressive clinical course with dementia, ataxia, and myoclonus plus corroborative neuroimaging and spinal fluid findings confirmed a clinicoradiographic diagnosis of Creutzfeldt-Jakob disease.

Conclusions: To our knowledge, this is the first report of an initial presentation of Creutzfeldt-Jacob disease closely mimicking vestibular neuritis, expanding the known clinical spectrum of prion disease presentations. Despite the initial absence of neurological signs, the central lesion location was differentiated from a benign peripheral vestibulopathy, strongly indicating a central localization. Because of a long delay in care, the patient left the emergency department without treatment. He returned 1 week later with progressive gait disturbance, limb ataxia, myoclonus, and new cognitive deficits. His subsequent course included a rapid neurological decline culminating in home hospice placement and death within 1 month. Magnetic resonance imaging revealed restricted diffusion involving the basal ganglia and cerebral cortex. Spinal fluid 14-3-3 protein was elevated. The rapidly progressive clinical course with dementia, ataxia, and myoclonus plus corroborative neuroimaging and spinal fluid findings confirmed a clinicoradiographic diagnosis of Creutzfeldt-Jakob disease.

Key Words: Creutzfeldt-Jakob syndrome, vertigo, dizziness, vestibular neuritis, neurological examination

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acute peripheral vestibulopathy, but the bilaterally normal horizontal vestibuloocular reflexes strongly indicated a central localization.3,7,8

A computed tomography scan of the head was normal. The patient left the emergency department before being fully evaluated because of a long delay. He returned 1 week later with a progressive deterioration of balance function. Review of systems then revealed 30-pound weight loss over 6 months (initially intentional by the patient, but apparently less so as the weight loss progressed) and a decline of cognitive function since the prior visit according to his wife. His second neurological examination revealed limb ataxia and occasional myoclonus in his right arm.

The combination of weight loss, cognitive decline, ataxia, and myoclonus suggested either a paraneoplastic (or other immune-mediated) encephalitis or Creutzfeldt-Jacob disease (CJD). A magnetic resonance imaging study with diffusion-weighted images revealed multiple regions of restricted diffusion involving the basal ganglia and cerebral cortex (Fig. 2), a radiographic pattern consistent with CJD. An electroencephalogram showed diffuse cerebral disturbances with periodic discharges, and a spinal fluid analysis revealed an elevated 14-3-3 protein level, both also consistent with a clinicoradiographic diagnosis of CJD. The patient progressed rapidly while an inpatient, was discharged to home hospice care, and died just 1 month after his dominantly vestibular presentation to the emergency department.

**DISCUSSION**

This case expands the known spectrum of CJD presentations, broadens the differential diagnosis of acute vestibular syndrome, and highlights the importance of bedside oculomotor examinations in discriminating central from peripheral causes of acute vertigo.

Sporadic CJD is a rare, untreatable, transmissible spongiform neurodegenerative disorder caused by infectious protein particles known as prions.12 Classic CJD is a rapidly progressive dementia with ataxia and myoclonus, although the spectrum of presenting symptoms is wide13 and focal variants can mimic stroke. Diagnostic delay for weeks or months is common with CJD, leading to confusion and frustration for patients, increasing risks of further disease transmission, and impeding scientific progress in studying early treatments.14 Vertigo and dizziness presentations are infrequent in CJD,13 and, to our knowledge, this is the first report of an initial presentation closely mimicking vestibular neuritis.

Perhaps more importantly, this case highlights the relevance of bedside vestibular physiology to clinical diagnosis in patients with acute vestibular syndrome. The central lesion location here was readily differentiated from a benign peripheral vestibulopathy at the first visit using simple bedside vestibular tests (normal vestibular reflexes in a patient with acute, continuous vertigo/dizziness, and nystagmus). Unfortunately, these well-established bedside techniques remain unexplored in patients with acute vestibular symptoms.
unfamiliar to most frontline clinicians and many neurologists. Dissemination using focused clinical skills training\(^\text{15}\) or device-based approaches\(^\text{11}\) may prove beneficial.

**REFERENCES**