Clinical Presentation

A 65-year-old woman, who underwent a gastric cancer gastrectomy 4/5 20 years ago, was admitted to the emergency department for confusion syndrome with speech disorder without any other associated signs. Brain MRI (Figure 1, 2) was performed showing hyperintensity on Flair and diffusion on both sides of the third ventricle that extends to the thalamis, periaqueductal, and mammillary bodies. The control MRI 3 months after treatment showed a disappearance of the lesions described on the initial MRI.

Discussion

Gayet Wernicke’s encephalopathy is a severe neurological disorder caused by vitamin B1 deficiency and remains a difficult diagnosis due to the variable clinical presentation, especially when the patient has no history of alcohol consumption. It is characterized by a clinical triad, often incomplete, that associates syndrome, ophthalmoplegia, and ataxia [1, 2]. Magnetic resonance imaging remains the gold standard for detection with a low sensitivity of 50% but a high specificity of 93% [2, 3]. However, patients with nonalcoholic Wernicke encephalopathy have highly variable neuroimaging results, making the diagnosis even more difficult. MRI shows a typical hypersignal on the T2, FLAIR and diffusion sequences, bilateral and symmetrical, on both sides of the third ventricle, of the medial part of the thalami, the periaqueductal, the mammary bodies, the tectal lamina, and the grey matter located in front of the fourth ventricle [3, 4]. These abnormalities reflect edema, necrosis, and the blood-brain barrier. The contrast enhancement in these same areas can be found after gadolinium injection. The prognosis is highly variable. It is favourable when the disease is diagnosed early and treatment is initiated promptly, there is complete remission of symptoms and the disappearance of signal abnormalities on MRI [3, 4].

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**References**


