Teaching Video NeuroImages: An endoscopic view of symptomatic palatal tremor

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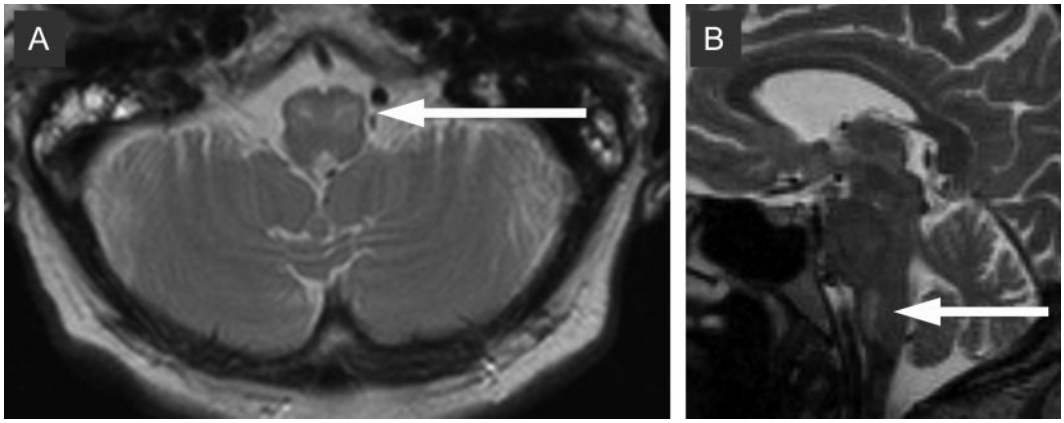
Figure T2-weighted (A) axial and (B) sagittal MRI showing enlarged and hyperintense inferior olivary nuclei bilaterally (arrow)



A 76-year-old woman presented with symptomatic palatal tremor (SPT) characterized by rhythmic contractions of the levator veli palatini muscle (video on the *Neurology*® Web site at www.neurology.org). She did not complain of ear clicks. Physical examination revealed bilateral saccadic pursuit, bilateral impaired suppression of the vestibulo-ocular reflex, and autonomic dysfunction. One year later, she developed left Horner syndrome. MRI showed bilateral olivary hypertrophy (figure). Further studies including routine blood tests, serologic tests, paraneoplastic antibodies, CSF, PET-CT, and ^{123}I-Iodobenzamide-SPECT were negative.

SPT is differentiated from essential palatal tremor (EPT) by 1) the presence of neurologic signs other than palatal tremor, 2) the absence of ear clicks, 3) olivary hypertrophy, and 4) contractions of the levator veli palatini.[1,2] Etiologies of SPT include cerebrovascular disease, trauma, multiple sclerosis, tumors, neurodegenerative diseases, and other causes. In contrast to SPT, EPT is caused by contractions of the tensor veli palatini. Patients frequently complain about ear clicks. There is no identifiable etiology, no additional neurologic deficit, and the MRI is unremarkable. Clinical and laboratory findings in our patient indicated SPT and suggested an underlying neurodegenerative disease.[3]

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Supplemental data at www.neurology.org

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