An 84-year-old man presented with acute dysphagia. He had a past history of cerebral infarction causing slight right hemiparesis. There was no facial palsy. His tongue was not deviated or atrophied. The soft palate elevation was good bilaterally. His speech was slightly dysarthric but easy to hear. There was no hemi- or monoparesis. He could walk without support. Diffusion-weighted MRI revealed a fresh infarction at the middle portion of the right posterior limb of the internal capsule (PLIC) (Picture A). T2-weighted MRI showed the old lacunar infarction at the left corona radiata (Picture B). His symptom was considered to be pseudobulbar palsy resulting from disturbance of the bilateral corticobulbar tracts (1). There is reported to be somatotopic organization in the PLIC (2). Even with diffusion-tensor MR tractography, the corticobulbar tract is thought to be difficult to be visualized because of its curved course. Although the corticobulbar tract has been considered to be localized in the genu of the internal capsule, this case suggests that it is localized more posterior in PLIC than previously considered.

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References