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## Cerebellar ischaemia

*Part of "Chapter 18.24 - Dizziness"*

Dizziness is common in patients with cerebrovascular disease. This is often due to dysautoregulation of the intracranial blood vessels so that they fail to respond to changes in arterial pressure. This can be defined by transcranial Doppler sonography, but the technique requires a high level of patient co-operation, and is not yet ready for routine clinical use in most centres (Rubin et al. 1994). A cerebellar infarction sometimes has a dramatic onset with vomiting, ataxia, vertigo, and headache associated with truncal ataxia, ipsilateral gaze palsy, and a lower motor neurone facial palsy. Around 80 per cent of cases, however, present with a vague history of dizziness or vertigo, and around a quarter have no focal cerebellar signs. Lesions of the cerebellar vermis, in particular, produce an atypical picture, with vertigo, downbeat nystagmus, and truncal ataxia, but no signs of past pointing, intentional tremor, or dysdiadokokinesia.

Variants of cerebellar ischaemia associated with similar symptoms and signs are labyrinthine infarction, associated with unilateral deafness; lateral medullary infarction, associated with facial numbness, diplopia, dysphagia, and dysphonia; and lateral pontomedullary infarction, associated with deafness and facial weakness.

CT is useful in identifying a haemorrhage or an infarct of 7 to 10 days duration, but usually misses one of recent onset. MRI provides much better definition of small cerebellar lesions, and is successful in detecting infarcts within the first 24 h.