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Spontaneous resolution of frontotemporal brain sagging syndrome

Editor – Like Dr Kent and colleagues,¹ I have recently seen a patient with apparently spontaneous resolution of neuroradiological features of frontotemporal brain sagging syndrome (FTBSS), but with different clinical outcome.

A previously healthy 70-year-old man was referred from primary care with memory symptoms and headaches, the latter worse in the mornings. Family members reported forgetfulness over about 12 months, mixing up people's names and sometimes repeating himself. He had developed low mood, not helped with antidepressant medications.

On neurological examination, there was psychomotor retardation, and the head turning and applause signs were evident,² but no other features. On the Mini-Addenbrooke's Cognitive Examination he scored 10/30 (attention 2/4, memory 4/7, letter fluency 2/7, clock drawing 0/5, memory recall 2/7), and on Free-Cog 12/30 (cognitive function 8/25, executive function 4/5).

Magnetic resonance (MR) brain imaging, performed prior to neurology referral, showed normal brain parenchyma aside from minor small vessel ischaemic changes, but bilateral shallow subdural collections, slight inferior displacement of the brainstem, and uniform meningeal enhancement on contrast imaging, suggestive of low cerebrospinal fluid (CSF) pressure. A presumptive diagnosis of FTBSS was made. Subsequent MR spinal imaging revealed no CSF leak.

Blind blood patching was planned, but deferred when at 3-month follow-up both the patient and his family reported improvement in cognitive function. However, at 6-month follow-up the patient's clinical state had deteriorated, with reduced speech output and personality change with uncharacteristic outbursts of anger. Repeat MR imaging, 10 months after the initial study, showed complete resolution of both subdural collections and meningeal enhancement. There was evidence for right temporal lobe atrophy. A presumptive diagnosis of frontotemporal dementia was made.

The exact relationship of the neuroradiological signs of low pressure and the clinical features was uncertain in this patient. Resolution of the former with progression of the latter suggests that in this case they were incidental. Clinicians should keep an open mind on the cause of cognitive symptoms in the presence of neuroradiological signs of low CSF pressure. Based on experience of this case, I suggest continued follow-up of patients with spontaneous resolution of FTBSS is indicated. ■

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References

- 1 Kent L, Butterworth R, Butler C. Spontaneous resolution of frontotemporal brain sagging syndrome. *Clin Med* 2019;19:336–7.
- 2 Lerner AJ. Neurological signs of possible diagnostic value in the cognitive disorders clinic. *Pract Neurol* 2014;14:332–5.

Head injury in the elderly

Editor – We welcome the excellent review of head injury in the elderly¹ in a recent edition of your journal. The important point is made that head injury often occurs from a standing height in older adults, however so too does cervical spine fracture.² Indeed, the Canadian C-spine rules deem those at 'high risk' from a fracture to be those over the age of 65, those with extremity paraesthesia, or sustaining a dangerous mechanism of injury (fall from greater than three feet, axial load injury, road traffic accident, bicycle collision). According to this rule, the cervical spine cannot be clinically cleared if the patient fits any of the above criteria and imaging is recommended.³ Our local experience from a recent audit is that only 17% of patients over the age of 65 receiving a computed tomography head for a traumatic indication have their cervical spine imaged as well. A national audit of major trauma management in older people showed that current triage is not optimal for older people as they often get reviewed by more junior doctors than their younger counterparts.⁴ The advanced trauma life support (ATLS) guideline acknowledges that 'airway' always comes first but with the important adjunct of cervical spine protection.⁵ In our opinion, reference to the importance of cervical spine assessment in the management of head injury in older patients will lead to more appropriate and comprehensive imaging in a timely fashion thereby improving the outcome in these vulnerable patients. ■

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