Teaching NeuroImages: Villaret syndrome

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Figure 1 CT

CT of the neck with contrast showing an irregular hypo-dense lesion with some rim enhancement (arrow), most consistent with infiltration. The diameter of the left carotid artery (asterisk) is smaller than the right, presumably due to external compression. No contrast is visible within the left jugular vein due to thrombosis.

A 3-year-old boy presented with fever and painful swelling of the left side of the neck due to retropharyngeal bacterial infection (figure 1). Neurologic examination showed left-sided ptosis, miosis, paresis of the sternocleidomastoid and trapezius muscle, difficulty swallowing, hoarseness, and left tongue deviation (figure 2). Laryngoscopy showed left vocal cord paralysis.

Unilateral lesion affecting nIX to nXII, Collet-Sicard syndrome, in combination with ipsilateral Horner syndrome is called Villaret syndrome,¹ anatomically located outside the skull, in the posterior parapharyngeal space, where these cranial nerves and the sympathetic trunk lie in proximity.^{1,2} Six months after surgical exploration and antibiotics, no neurologic improvement had occurred.

Figure 2 Photographs

Photographs of the patient taken 1 month after presentation show a lowered left shoulder due to weakness of the trapezius muscle demonstrating nXI involvement, a left-sided ptosis and miosis as part of Horner syndrome, and an atrophic and left-deviated left side of the tongue consistent with ipsilateral hypoglossal nerve lesion.

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