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Clinical History: At the age of 74 in 1987, this right-handed woman was noted to be forgetful and to have changes in her personality. She no longer cared about having a tidy house, or her appearance. She denied any hallucinations and reported good sleep. Her walking had slowed. She had no tremor. Three years later she was still living by herself and her mood was described as at times depressed and at times hyperactive. Her speech was normal with no anoma. There was decreased arm swing bilaterally. A SPECT scan was normal. Around 1991 her memory difficulties were worse and she had begun misplacing items. She was aware of her deficits and frustrated by them. Naming, reading and writing were normal. She was repetitious in conversation and some constructional apraxia was noted. By late 1991 her daughter noted her speech to be circumloquacious. On examination her spontaneous speech was notable for tangential accounts without clear aphasia. She moved to a Nursing Home in 1993. At that time she had a paucity of speech and difficulty figuring out how to use a cup or napkin. At times she did not recognize her daughter. She had several falls. Gait was shuffling and unsteady with no arm swing and en bloc turning. Suck reflex and Myerson’s sign were present as were bilateral Babinskis. She died at the age of 87. Autopsy was limited to examination of the brain and eyes.

She had a diagnosis of depression at age of 63 and a small stroke at age 74.

Necropsy Findings: Brain weight: 1010 gm. The brain was symmetric with mild generalized atrophy of frontal, temporal and parietal lobes, mild hydrocephalus, mild to moderate pallor of the substantia nigra and old small infarcts in the basal ganglia.

Material Submitted: 1 H&E and 1 unstained slide of amygdala and entorhinal cortex.

Points for Discussion: 1. Diagnosis
2. Pathogenesis