A previously healthy 30-year-old man presented with gradually worsening oscillopsia 2 weeks after an unusual headache; there was ocular flutter on examination (video on the Neurology® Web site at www.neurology.org) without other findings. Brain MRI was unremarkable. CSF showed mild pleocytosis (11 cells/mm3), but no evidence of active viral infections (herpes simplex virus, cytomegalovirus, varicella-zoster virus, Epstein-Barr virus, human herpesvirus 6, and measles). Serum antiganglioside antibodies (including anti-GQ1b antibody) were negative. The symptom resolved without treatment within 4 weeks. Ocular flutter is rare and may be isolated, although it is usually accompanied by generalized myoclonus or truncal ataxia.1,2 Brainstem (omnypause neurons in the paramedian pontine reticular formation3) or cerebellar dysfunction may contribute, as may abnormal pause cell control over saccadic burst neurons.

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