Hereditary spastic ataxia simulating disseminated sclerosis

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In 1929 Ferguson and Critchley published a detailed clinical study of a family, many members of which suffered from a disease resembling disseminated sclerosis. As far as Ferguson and Critchley could discover the syndrome described had not been recorded previously.

The average age of onset was 35 to 45 years and the initial symptoms were weakness and unsteadiness of the legs, followed by dysarthria, visual disturbances, dysesthesiae of the arms and legs, and bladder disorders. The syndrome progressed steadily without remissions. The duration of the disease in fatal cases was from five to 10 years and, in those still living at the time, up to 16 years. There were alterations in the emotional sphere with marked euphoria and instability of mood. Optic atrophy was present in some and in a few Argyll Robertson pupils were noted; one patient had a positive Wassermann reaction. A marked feature in a majority of patients was a defect of upward movement of the eyes. Pyramidal signs were present in most of them and the cerebellar type of incoordination in several. Speech defect was noted in almost every case, mainly due to cerebellar dysfunction. Extrapyramidal signs formed a prominent feature in many of the patients. Sensory disturbances were present in the majority, diminution to light touch and pin prick being more marked than postural and vibratory sensibility. Gait was markedly abnormal in every patient and in the final stages they were unable even to stand. Frequency and precipitancy of micturition, leading to occasional incontinence, were observed in some patients.

An Iranian family is now described with a large number of members suffering from a syndrome with marked similarities to the one described by Ferguson and Critchley. Four affected members were seen personally and information obtained about others.

CASE 1 A 38-year-old widow from Teheran was admitted to the Nemazee Hospital in April 1961 with the chief complaints of difficulty in walking for six years and dysarthria for four years. She had been quite well up to the age of 32 when she first noticed difficulty in running and jumping which gradually deteriorated until, at the time of admission, she could hardly walk unaided. Later there was involvement of the upper limbs making ordinary movements hard to carry out. The speech was affected later still and, although comprehensible after four years, was markedly abnormal. There was no history of any visual disturbances in the past and she had never had any pain or paraesthesiae. The sphincters had always been under full control.

Examination revealed an intelligent, cooperative and pleasant woman of average stature. She had an ataxic, scanning speech with a nasal twang. The optic discs, although on the pale side, were considered to be within normal limits. Visual acuity was 20/40 in each eye and could be corrected to normal with minus one (−1.00) lenses. The fields showed slight peripheral contraction but no scotoma was detected. Upward and lateral conjugate movements of the eyes were defective but there was no nystagmus. There was an economy of facial expression and the muscles were thought to show some weakness. The jaw jerk was brisk. No other cranial nerve deficit could be detected.

In the upper limbs, the tone of muscles was normal and the power quite good. There was moderate cerebellar ataxia of both sides. The arm jerks were brisk and equal. No sensory loss of any modality was noted.

In the lower limbs there was considerable global increase in tone but only slight weakness of dorsiflexion and toe movements bilaterally. Severe and widespread incoordination was a marked feature. The tendon jerks were very brisk and equal but there was no clonus. Both plantar responses were extensor. The abdominal reflexes were present and equal. Vibration sense was lost at and below the left knee and much reduced on the right side. Otherwise there was no sensory deficit and position sense was intact. She was unsteady when standing with the feet together and this did not change on shutting the eyes. The gait was extremely slow, on a wide base and markedly ataxic. She was unable to jump off the ground.

Investigations including radiographs of the chest, a full blood count, urine and stool analysis, the blood sugar and urea, and an electrocardiogram, were all within normal limits. However, serological examination for syphilis on the first occasion showed a positive venereal diseases research laboratory test at a titre of 1 in 32 and a Kahn titre of 1 in 4. A second examination four days later proved them both to be negative. Apparently a similar result had been obtained elsewhere and she had been given penicillin which had to be stopped after two
days because of skin sensitivity. The possibility of syphilis in the husband had been raised but there was no proof of it; he had died of alleged cerebral vascular disease before the age of 40 years.

Because a similarly afflicted relative had had a lumbar puncture in Paris 20 years previously and this was said to have made him much worse, she refused to have the cerebrospinal fluid examined. Apparently a very distinguished Parisian neurologist had warned against lumbar puncture in any of the affected members.

Figure 1 shows the pedigree. The case just described is IV, 23. Another affected member, IV, 11, the only living step sister of case 1, was seen in her own home.

**Case 2** A 52-year-old woman from Teheran had been well up to the age of about 32 when she developed difficulty in walking and a year or two later had become dysartric. At about the same time movement of the hands had become awkward. She had gradually deteriorated until at the time of examination she was unable to walk at all.

Examination revealed a thin woman who looked older than her age. Although fully orientated and fairly cooperative, she showed some resentment at being examined and was rather suspicious. The speech was markedly ataxic and only on listening carefully was it comprehensible.

The optic discs were pathologically pale but there was no demonstrable defect of visual acuity. The external ocular movements were full and there was no nystagmus.

In the upper limbs, the tone and power of muscles appeared normal but there was gross cerebellar ataxia. All the tendon reflexes were very brisk. There was no sensory deficit except for slight diminution of vibration sense at and below the elbows.

In the lower limbs, there was some increase of tone in muscles below the knees but the power appeared normal. There was severe ataxia and she was unable to walk at all and found standing difficult. The reflexes were all extremely brisk and unsustained ankle clonus was obtained on both sides. The plantar responses were sharply extensor. On full sensory testing only reduction in vibration sense of equal sensory distribution was noticed throughout the limbs.

**Case 3** A 38-year-old man (V, 7) was seen at a later date with the chief complaints of difficulty in walking and unsteadiness of gait for about two years. There had been steady deterioration until at the time of examination he was unable to run.

Examination revealed a man of average intelligence who tended to minimize his disability. In fact he had not sought medical advice voluntarily but had been persuaded by a kind friend of the family to come to the clinic. He insisted that he did not suffer from the family disease but a minor separate illness.

His speech appeared to be normal. Visual acuity, as judged by reading newspaper print, was quite good and fundoscopy revealed no abnormality. There was a defect of upward conjugate movement of the eyes but otherwise the cranial nerves were intact.

In the upper limbs the tone and power of muscles were normal and there was only slight inco-ordination. The reflexes were brisk and equal and there was no sensory deficit.

In the lower limbs there was marked global spasticity with unsustained ankle clonus but no loss of power. Coordination was moderately defective and all the tendon jerks were markedly exaggerated and equal. The left plantar response was extensor and the right flexor. The abdominal reflexes were absent. Once again the only sensory deficit was diminution of vibration sense below the knees. His gait was spastic and he had difficulty in jumping off the ground.

Of the other living affected members only V, 9 was seen. He was a man of about 30 who had started with similar symptoms at about the age of 28, but he minimized his disabilities and did not care to see
Hereditary spastic ataxia simulating disseminated sclerosis

513

a doctor. From his walking and the few words of
greeting he uttered on arrival, there was no doubt
about the staggering and spastic gait and the dysar-
thric speech.

A so far unaffected member, V, 5, the elder
daughter of case 2, was a very intelligent and reliable
girl who helped in compiling the information about
the whole family. She showed understandable
concern and was naturally worried about her
younger sister who, against all advice, still planned
to marry a first cousin, V, 8. She had observed her
mother and other affected relatives closely and the
summary of her findings, as a lay person, is as follows:

Almost all of them started to show symptoms at
or about the age of 30 years. In her mother and aunt
(cases 1 and 2) symptoms, on the whole, appeared
late. In some of them the first symptom was a little
difficulty in swallowing fluids when they would
cough but without regurgitation through the nose.
This was not seen in the three patients examined.
The involvement of the lower limbs was an early
sign, first noticed on jumping over gutters and
walking in a straight line. A year or two later
dysarthria would become evident and the upper
limbs would show ataxia. The picture would then
progress to the full syndrome as in the cases de-
dscribed.

According to the informant, there were undoubted
mental changes. They tended to minimize their dis-
abilities and their morale usually remained high.
They showed nervousness and paranoid tendencies
but never became confused or disoriented. Death
usually occurred about the age of 40 and case 2 held
the record in longevity. The actual cause of death
could not be surmised.

DISCUSSION

It is clear that in isolation any of the patients
personally examined might well have been suffering
from disseminated sclerosis. It is now generally
accepted that there is a familial incidence of this
disease in at least 10% of all examples but it has
not yet been suggested, and still less proved, that
there is any genetic basis for this disorder.

Perusal of the pedigree, and assuming it to be
valid, seems to make it quite certain that this is a
progressive, fatal and degenerative disease of the
central nervous system. Again if the information be
valid this syndrome seems to be determined by a
single autosomal dominant gene, probably of great
rarity. The disorder described seems to approximate
only to that previously observed by Ferguson and
Critchley (1929), and the differences are small.

Such differences are frequent in hereditary disorders
of the nervous system when, not infrequently, the
disorder may run true to type in any one family
though no two families present an identical picture.
Both Ferguson and Critchley (1961) are of the
opinion that nothing similar to the syndrome they
first described has been recorded since.

The gene concerned is obviously not sex-linked
and is dominant. Patient III, 6, had married twice,
the first wife being a first cousin (III, 5). That
marriage produced 10 children of whom five died
in infancy or early childhood (ages 1 to 4 years).
There were no known miscarriages and all except
one (case 2) died before the age of 41 years. It is
probable that the ones who died in childhood had
received a double dose of the gene but it should not
be forgotten that the infant mortality rate is high in
Iran and was undoubtedly higher in those days.
Therefore, a dominant gene represented by A (for
example Aa x Aa in the cousin marriage) easily
fits the whole picture except for the second filial
generation (marriage of II, 1 and II, 2). All their
children appear to have been affected and, on the
basis of probability, the chances of that happening
is no higher than 4%. In the absence of more data
no explanation is offered.

Regarding the last generation, attention must be
drawn to the fact that the syndrome starts at about
30 years of age and some of them may well develop
it in the years to come.

Unfortunately first cousin marriages are extremely
common in Iran and, as I hope to show in future
articles, a phenomenal number of cases of hereditary
neurological disease of all varieties are encountered
in ordinary practice. The impending marriage of
cousins V, 8 and V, 6 will no doubt produce results
worthy of a paper in the next century.

SUMMARY

A very rare hereditary syndrome of spastic ataxia,
closely resembling disseminated sclerosis, is de-
scribed in an Iranian family. The pedigree shows
that it is determined by a single autosomal dominant
gene.

I am much indebted to Dr. Hugh Garland, who first
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scribed, for his constant encouragement and helpful
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REFERENCES

—- (1961). Personal communication.
Hereditary spastic ataxia simulating disseminated sclerosis
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