Pattern of segmental motor involvement in syringomyelia: a single fibre EMG study

MARTIN S SCHWARTZ, ERIK STÅLBERG AND MICHAEL SWASH

From the Departments of Clinical Neurophysiology and Neurology, Atkinson Morley's Hospital, London, University Hospital, Uppsala, and The London Hospital, London

SUMMARY Single fibre EMG has been used to study the pattern of upper limb motor involvement in syringomyelia. Biceps brachii, extensor digitorum communis (EDC) and first dorsal interosseous muscles (1stDI) representing C5/6, C7/8 and C8/T1 segments, were studied. In the biceps the fibre density was slightly increased in most patients, in EDC it was about twice the normal and in the 1stDI it was about three times normal. The potentials were least stable and of longest duration in the 1stDI. These findings seem to indicate a relatively constant pattern of involvement of anterior horn cells in the brachial segments in syringomyelia.

The upper level of cavitation in syringomyelia is variable, but is more frequently cervical than at any other level. Indeed the disease usually begins with symptoms and signs of a lesion in the spinal cord at the cervico-thoracic junction. The location of the cavity asymmetrically within the spinal grey matter is such that neither sensory abnormalities nor weakness and atrophy always provide accurate information about the extent of the cord lesion. Nevertheless, the disease often begins with wasting of the small hand muscles, an observation suggesting that the pattern of motor involvement in the cervical segments might be relatively consistent from case to case.

Electromyographic studies in syringomyelia have shown a neurogenic abnormality in the arm muscles but, although Lenman and Ritchie noted that the EMG changes were usually localized to a few segments, their distribution has not been studied in detail. In this paper we describe our observations on the pattern of motor involvement in the cervical segments in syringomyelia in ten patients, using both conventional and single fibre EMG.

Patients and methods

Ten consecutive, and thus unselected, patients with established syringomyelia were studied (table 1). Six were studied in London, (cases 1 to 6) and four in Uppsala (cases 7 to 10). All showed the typical clinical and radiological features of syringomyelia and four also had signs of syringobulbia. Their ages ranged from 30 to 68 years and symptoms had been present for 4 to 45 years (mean 20 years). There had been no progression of symptoms or signs for two years or more in five patients (cases 1, 2, 3, 7 and 8), but cases 4, 5, 6, 9 and 10 had progressed slightly in this time (table 1). In all the patients, however, progression had been most rapid in the first two or three years of the illness. In most of the patients (cases 4, 5, 7, 8 and 9) the sensory disturbance indicated a lesion located in the lower cervical and upper thoracic cord. The motor deficit in the arms suggested, similarly, that the lesion was most advanced in the lower cervical segments (table 1). In case 1, in whom there were signs of bulbar involvement, the sensory disorder extended into the upper cervical segments. All the patients except case 7 had wasted small hand muscles and five (cases 1, 2, 6, 9 and 10) had claw-hand deformities. The deltoid and periscapular muscles were relatively spared.

In each patient, conventional EMG, using concentric needle electrodes, was carried out in proximal and distal muscles of the right arm. Single fibre EMG recordings were made, using a Medelec SF25 electrode, in the right biceps brachii, extensor digitorum communis and first dorsal interosseous muscles, representing C5/6, C7/8 and C8/T1 spinal segments respectively. Fibre density measurements were made in each of these muscles; the fibre density is the average number of single fibre action potentials...
Pattern of segmental motor involvement in syringomyelia: a single fibre EMG study

Table 1  Clinical Data

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (yr)</th>
<th>Sex</th>
<th>Duration of symptom (yr)</th>
<th>Course</th>
<th>Distribution of impaired pin prick in right arm</th>
<th>Distribution of weakness in right arm</th>
<th>Arm tendon reflexes</th>
<th>Clinical bulbar involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>64</td>
<td>F</td>
<td>4</td>
<td>stable for 2 years</td>
<td>C2-T2 dense loss T2-L5 hypoalgesia</td>
<td>clawed atrophic hands, severe weakness of wrist extensors, biceps slightly weak, deltoid normal</td>
<td>absent</td>
<td>present</td>
</tr>
<tr>
<td>2</td>
<td>60</td>
<td>F</td>
<td>40</td>
<td>stable for 10 years</td>
<td>C6-L2</td>
<td>clawed atrophic hands, moderate weakness of biceps, triceps and wrist extensors</td>
<td>absent</td>
<td>present</td>
</tr>
<tr>
<td>3</td>
<td>65</td>
<td>F</td>
<td>45</td>
<td>stable for 3 years</td>
<td>C5-T7</td>
<td>weak, wasted hands, biceps weak</td>
<td>absent</td>
<td>present</td>
</tr>
<tr>
<td>4</td>
<td>33</td>
<td>F</td>
<td>6</td>
<td>slowly progressive</td>
<td>C8-T1</td>
<td>weak, wasted hands, weakness of flexors and extensors of wrist, Biceps and triceps strong</td>
<td>absent</td>
<td>present (cerebellar ectopia) (on myelogram)</td>
</tr>
<tr>
<td>5</td>
<td>30</td>
<td>M</td>
<td>19</td>
<td>slowly progressive</td>
<td>C5-C8</td>
<td>weak deltoids, biceps and finger extensors, Wasted hand muscles</td>
<td>absent</td>
<td>absent (cerebellar ectopia) (on myelogram)</td>
</tr>
<tr>
<td>6</td>
<td>64</td>
<td>M</td>
<td>30</td>
<td>recent progression after long remission</td>
<td>C6-T1</td>
<td>weak biceps and forearm muscles, clawed, atrophic hand</td>
<td>absent</td>
<td>present</td>
</tr>
<tr>
<td>7</td>
<td>68</td>
<td>M</td>
<td>20</td>
<td>stable for 10 years</td>
<td>C6-C8</td>
<td>none</td>
<td>diminished</td>
<td>absent</td>
</tr>
<tr>
<td>8</td>
<td>55</td>
<td>M</td>
<td>6</td>
<td>stable for 2 years</td>
<td>C6-T1</td>
<td>slight weakness and atrophy of the hand</td>
<td>diminished</td>
<td>absent</td>
</tr>
<tr>
<td>9</td>
<td>37</td>
<td>M</td>
<td>17</td>
<td>slowly progressive</td>
<td>C2-T2</td>
<td>atrophic clawed hand</td>
<td>absent</td>
<td>diplopia</td>
</tr>
<tr>
<td>10</td>
<td>31</td>
<td>M</td>
<td>17</td>
<td>slowly progressive</td>
<td>C2-L5</td>
<td>atrophic clawed hand, Klippel-Feil anomaly</td>
<td>diminished</td>
<td>absent</td>
</tr>
</tbody>
</table>

potentials (potential amplitude > 200 μV; duration < 300 μs) recorded within the uptake area of the single fibre EMG electrode in 20 different motor units in a muscle activated during weak voluntary effort.7 Late potentials of lesser amplitude (150μV) were accepted. In wasted muscles, however, it was not always possible to record as many as 20 potentials. The upper limits of the fibre density in these muscles in normal subjects are biceps 1·7, extensor digitorum communis 1·8 and first dorsal interosseous 1·7.8 In addition, in each of these muscles the neuromuscular jitter was determined8 and the presence of impulse blocking was noted. Sensory and motor nerve conduction velocity measurements were made in the median and ulnar nerves in all the patients.

Results

Conventional EMG showed abnormalities in all the muscles examined. These abnormalities were most prominent in the first dorsal interosseous muscles and least in the biceps brachii. In cases 2, 4, 9 and 10, no voluntary motor unit action potentials could be recorded in the first dorsal interosseous muscles, and in case 9 no potentials could be recorded in biceps brachii. Sparse fibrillation potentials were found in the extensor digitorum communis and first dorsal interosseous muscles in all the patients, but fibrillation potentials were recorded in the biceps muscles only in cases 3 and 5. On volition, there were polyphasic motor unit action potentials of normal to moderately high amplitude, often of long duration,
Martin S Schwartz, Erik Stålberg, and Michael Swash

Table 2  EMG Data

<table>
<thead>
<tr>
<th>Case</th>
<th>Biceps</th>
<th>Extensor digitorum communis</th>
<th>First dorsal interosseous</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FD</td>
<td>Number of potentials with FD</td>
<td>Duration (ms)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>increased number</td>
<td>increased jitter</td>
</tr>
<tr>
<td>1</td>
<td>2.1</td>
<td>0/0/0</td>
<td>2/9</td>
</tr>
<tr>
<td>2</td>
<td>1.6</td>
<td>0/0/0</td>
<td>2/3</td>
</tr>
<tr>
<td>3</td>
<td>2.4</td>
<td>0/0/0</td>
<td>3/2</td>
</tr>
<tr>
<td>4</td>
<td>2.1</td>
<td>1/20/5</td>
<td>1/20/5</td>
</tr>
<tr>
<td>5</td>
<td>2.3</td>
<td>1/20/5</td>
<td>2/20/10</td>
</tr>
<tr>
<td>6</td>
<td>2.7</td>
<td>1/20/5</td>
<td>3/20/15</td>
</tr>
<tr>
<td>7</td>
<td>1.2</td>
<td>2/20/10</td>
<td>1/20/5</td>
</tr>
<tr>
<td>8</td>
<td>1.4</td>
<td>2/20/10</td>
<td>2/20/10</td>
</tr>
<tr>
<td>9</td>
<td>no potentials recorded</td>
<td>no potentials recorded</td>
<td>no potentials recorded</td>
</tr>
<tr>
<td>10</td>
<td>1.4</td>
<td>2/20/10</td>
<td>2/20/10</td>
</tr>
</tbody>
</table>

Mean FD 1.9 (SD 0.50)  3.6 (SD 0.83)  4.4 (SD 1.43)

FD = Fibre Density

The mean fibre densities in biceps and extensor digitorum communis are significantly different (p < 0.002)

Similar comparison of biceps and first dorsal interosseous muscles shows a less significant difference (p ~ 0.02)

In all the patients, particularly in the extensor digitorum communis and first dorsal interosseous muscles.

Single fibre EMG recordings revealed a similar distribution of abnormality in each patient. Abnormalities were most marked in the first dorsal interosseous and least in the biceps brachii muscles (table 2). In the biceps brachii and extensor digitorum communis muscles 16 to 28 motor unit action potentials were recorded in each patient. The mean fibre density in the biceps was slightly increased (1.9). The highest fibre density found in this muscle was 2.7 (case 6). In four patients the fibre density was normal in this muscle, and in one no potentials were recorded. In the extensor digitorum communis the mean fibre density (3.6) was nearly twice that found in the biceps. In the first dorsal interosseous the mean fibre density was 4.1 (table 2). The fibre density was increased in all those first dorsal interosseous muscles in which motor unit action potentials could be recorded. In the first dorsal interossei in cases 2, 4, 9 and 10 and in the biceps muscle in case 9, no motor unit action potentials could be recorded; in these muscles, therefore, the fibre density could not be determined. In three other patients (cases 1, 3 and 5) only 12 potentials could be recorded in the first dorsal interosseous muscle, but in these muscles the fibre densities were greatly increased (table 2).

Most of the motor unit action potentials recorded with single fibre EMG in the three muscles were stable. Increased neuromuscular jitter was noted in 1% of potentials in the biceps brachii muscles examined, in 16% of potentials in the extensor digitorum communis muscles, and in 21% of potentials in the first dorsal interosseous muscles (table 2). Impulse blocking was not observed in the biceps brachii in any of the patients; it was present in 7% of motor unit action potentials in the extensor digitorum communis and first dorsal interosseous muscles (table 2). Late potentials, occurring more than 8 ms after the triggering potential, were recorded in several patients (Fig 1). These showed increased jitter and blocking more.

Fig 1  Varying degrees of instability and complexity in four different recordings. A, B and C: first dorsal interosseous muscle. D: extensor digitorum communis muscle. In A a pair of single fibre action potentials is seen; the second increased jitter and blocking. In B a more complex potential, consists of 3 action potentials; the last component shows a slightly increased jitter. In D, a very complex long duration potential, with components showing a normal or slightly increased jitter, without impulse blocking. A may represent early reinnervation, and D long-standing, effective reinnervation.
often than earlier components of the motor unit action potentials. The mean duration of the recorded motor unit action potentials was most increased in the first dorsal interosseous muscles and least abnormal in the biceps brachii muscles. In the first dorsal interosseous and extensor digitorum communis muscles most patients were unable to maintain a steady innervation rate. In a number of the recordings double discharges were seen (fig 2). These discharges appeared 5 to 10 ms after the initial component. Their shape was usually different from the triggering motor unit action potential complex.

Sensory and motor nerve conduction velocities in the median and ulnar nerves were normal in all patients in whom measurement was possible. In cases 9 and 10 motor nerve conduction velocity could not be measured in the ulnar nerve, because no muscle action potential could be recorded in the abductor digiti minimi.

**Discussion**

In neurogenic disorders an increased fibre density indicates that reinnervation has occurred. Because the technique requires only slight activation of a muscle, and type 1 units are generally first activated,10 the motor unit action potentials recorded with single fibre EMG are predominantly type 1 motor units.11 Indeed, an increased fibre density has been shown to correlate with histochemical evidence of type 1 fibre grouping in muscle biopsies.12 The abnormalities found with single fibre EMG in our patients with syringomyelia, consisting of increased fibre density, and of some potentials with increased neuromuscular jitter and impulse blocking, are similar to those found in other disorders affecting anterior horn cells, particularly the slowly progressive form of motor neuron disease.13 The combination of complex but stable motor unit action potentials, with an increased fibre density, is evidence of a chronic disorder with effective reinnervation. Our single fibre EMG measurements provide quantifiable evidence of abnormality, particularly of increased fibre density, even in muscles such as the biceps brachii, in which conventional EMG was virtually normal. In slowly progressive disorders, however, a stage is eventually reached at which few motor units remain and severe neurogenic atrophy has occurred. At this stage it may be difficult or impossible to record functioning motor units, as in the first dorsal interosseous muscles in our cases 2, 4, 8 and 9.

In our patients the neuromuscular jitter was increased to a similar degree both in those in whom the disease had progressed in the previous two years, and in those in whom it had been stable during this period (table 3). However, in the group of patients with recent progression impulse blocking was more frequent (13% in the extensor digitorum communis) than in those with a stable course (3% in the extensor digitorum communis). Impulse blocking is due to failure of excitation of a muscle fibre either at the neuromuscular junction or in the terminal

---

**Fig 2** Two recordings from the same first dorsal interosseous muscle. Both potentials are complex. *A* is an unstable potential with prominent jitter and impulse blocking. *B* is stable; a double discharge is seen in two of the ten sweeps.
nerve branches. This functional abnormality probably occurs both in degenerating axons and in immature regenerating axons and neuromuscular junctions. Impulse blocking is therefore associated with weakness and fatiguability. The neuromuscular jitter was increased both in the clinically progressive, and in the stable groups of patients. This phenomenon, when it occurs without blocking, is not associated with weakness or fatiguability. The fibre density in the extensor digitorum communis muscle was greater (p < 0.002: table 3) in the group of patients (mean 4.1) with a progressive course than in the group with a stable course (mean 2.8). Similar trends were noted in the first dorsal interosseous muscles.

In a previous study of three patients with recently progressive syringomyelia, a similar increase both in fibre density and in impulse blocking was observed in the extensor digitorum communis muscle. The combination of an increased fibre density, and increased frequency of impulse blocking in the group of patients with a progressive course is consistent with a continuing loss of anterior horn cells, leading to marked peripheral axonal sprouting, as shown histologically in methylene blue studies of the terminal innervation pattern. In our patients these single fibre EMG abnormalities were not related to the duration of symptoms and it may therefore be inferred that a moderate increase in fibre density (> 3.5) with infrequent impulse blocking, indicates that the syringomyelia is in a stable phase.

In neurogenic disorders, including syringomyelia, increased motor unit action potential duration could be due to several factors, including dispersion of the motor end-plate zone, slowed propagation velocity in small or reinnervated muscle fibres, and slowed conduction in thin, sprouting axons. Low discharge rates and irregular firing patterns of motor units have been reported with upper motor neuron lesions, but in our patients it seems likely that the predominant disorder was lower motor neuron in type, from direct damage to anterior horn cells, although descending projections to these cells could have been interrupted locally by the syrinx.

In our patients the abnormalities found were most prominent in the first dorsal interosseous muscles (C8/T1 segments) and least in the biceps brachii muscles (C5/6 segments). This pattern of segmental involvement differs from that found in motor neuron disease, in which the abnormality is less constantly distributed and in which the motor unit action potentials are generally less stable than those we have recorded in syringomyelia. Although the pattern of segmental involvement in syringomyelia is consistent from case to case, this pattern of abnormality could also result from other disorders, such as cervical radiculopathy and cervical intramedullary neoplasms. In cervical radiculopathy other EMG investigations such as F response studies are usually abnormal. Further, sensory nerve conduction studies may be abnormal in radiculopathies but are normal in syringomyelia.

The constant pattern of motor involvement found in our patients, despite the varied duration and severity of their disease, suggests that the pattern of segmental damage to anterior horn cells in syringomyelia may be similar from case to case. Pathological studies of the distribution of anterior horn cell damage in syringomyelia are not available and most recent reports have been concerned
Pattern of segmental motor involvement in syringomyelia: a single fibre EMG study

with associated craniovertebral¹ or other anomalies.² Our EMG data suggests that detailed pathological study of the pattern of involvement of the ventral grey matter of the spinal cord, and of the distribution of cavitation in the cord, might be interesting.

References

18 Swash M. Selective involvement of lower brachial myotomes in motor neuron disease. (unpublished observations)
21 Taylor J, Greenfield JG, Martin JP. Two cases of syringomyelia and syringobulbia, observed clinically over many years, and examined pathologically. Brain 1922; 45:323–56.
Pattern of segmental motor involvement in syringomyelia: a single fibre EMG study.

M S Schwartz, E Stålberg and M Swash

*J Neurol Neurosurg Psychiatry* 1980 43: 150-155
doi: 10.1136/jnnp.43.2.150

Updated information and services can be found at: [http://jnnp.bmj.com/content/43/2/150](http://jnnp.bmj.com/content/43/2/150)

These include:

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to: [http://group.bmj.com/group/rights-licensing/permissions](http://group.bmj.com/group/rights-licensing/permissions)

To order reprints go to: [http://journals.bmj.com/cgi/reprintform](http://journals.bmj.com/cgi/reprintform)

To subscribe to BMJ go to: [http://group.bmj.com/subscribe/](http://group.bmj.com/subscribe/)