LETTER

Sympathetic cardiac denervation in Parkinson's disease and pure autonomic failure but not in multiple system atrophy

Three neurodegenerative diseases causing primary autonomic failure are pure autonomic failure (PAF), Parkinson's disease (PD), and multiple system atrophy (MSA). Differential diagnoses among these diseases are often difficult especially in early disease stage. For example, it may be difficult to determine whether a patient with parkinsonism and autonomic failure has PD or MSA. Recently, a decrease in myocardial uptake of metaiodobenzylguanidine (MIBG), an analogue of norepinephrine, has been reported in PD but not in MSA using \(^{123}\)I-MIBG myocardial scintigraphy. This new imaging approach is thought to be of significance in the diagnosis and characterisation of akinetic rigid syndromes, especially PD. After that, we reported severe loss of cardiac sympathetic nerves in one patient with PD but not in one patient with MSA, which accounts for a difference in myocardial uptake of MIBG between PD and MSA. However, our observation was based on the study in only a single patient of each disease. In this study, we immunohistochemically examined the heart tissues from four patients with PD, three patients with MSA, and one patient with PAF, and showed the involvement of postganglionic cardiac sympathetic nerves in PD and PAF but not in MSA.

Pathologically verified patients with PD (n=4; 70, 78, 81, and 82 years of age, three men and one woman), MSA (n=3; 55, 59, and 59 years of age, one man and two women), PAF (n=1; 81 years of age, one man), and control subjects (n=5; 55, 57, 72, 76, and 91 years of age, four men and one woman) participated in this study, which did not include the previous patients. The clinical diagnosis of PAF was according to the criteria of The Consensus Committee of the American Autonomic Society and the American Academy of Neurology. The duration of the illness was 2, 4.6, 8, and 10 years in PD, 5, 8, and 10 years in MSA, and 2 years in PAF. Three of four patients with PD, all the patients with MSA and the PAF patient had orthostatic hypotension (OH). \(^{123}\)I-MIBG myocardial scintigraphy was examined for one patient with PD performed four years before the death and the patient with PAF performed one month before the death. Early phase of heart-mediastinum (H/M) ratio was 1.3 in PD and 1.38 in PAF (reference range: 1.94–2.57). Postmortem examination revealed marked loss of neurons with numerous Lewy bodies in the substantia nigra, locus ceruleus, and dorsal vagal nucleus in the patients with PD. In the patients with MSA, marked loss of neurons in the pontine nuclei, cerebellar cortex, putamen, substantia nigra, inferior olive and intermediolateral nucleus of the spinal cord with widespread occurrence of glial cytoplasmic inclusions. No Lewy bodies were present. The patient with PAF showed prominent neuronal loss and a moderate number of Lewy bodies in the substantia nigra and locus ceruleus. Neuronal loss with gliosis was observed in the intermediolateral nucleus but there were no Lewy bodies observed in the intermediolateral nucleus, Onuf's nucleus, or Auerbach's plexus.

The anterior wall of the left ventricle from each subject was fixed with formalin for three to four weeks, and embedded in paraffin wax. The sections were stained with haematoxylin and eosin (H&E), or immunostained with monoclonal antibody against tyrosine hydroxylase (TH) Sigma, St Louis, MO; diluted 1:1000) by the avidin/biotin/ peroxidase method with a Vectastain ABC kit (Vector, Burlingame, CA). On H&E staining, no abnormal findings were apparent in the nerve fibres both in the myocardium and epicardial space (fig 1 A, B, C, D) of each patient and control subjects. All the specimens from control subjects showed TH immunoreactive neuronal fibres both in the myocardium and epicardial space as well as those from all the patients with MSA. In contrast, TH immunoreactive fibres markedly decreased in number in the patients with PD and the patient with PAF (fig 1 G, H) compared with the MSA patients (fig 1 F) and the control subjects (fig 1 E).

Neuropathological, neuropharmacological, and neuroendocrine evidence has revealed that postganglionic sympathetic nerves were involved in PAF and PD but not in MSA. In the present study, TH immunoreactive nerve fibres markedly decreased in number in all the patients with PD, associated with or without OH, and the patient with PAF. In contrast, TH immunoreactive nerve fibres were well preserved in all the patients with MSA. These results confirm our previous observation that postganglionic cardiac sympathetic nerves are involved in PD but not in MSA, and show the involvement of cardiac sympathetic nerves in PAF. On the basis of these results and the previous report, we infer that the involvement of postganglionic sympathetic nerves including the cardiac sympathetic nerves predominates in PD and PAF, but not in MSA, which accounts for a difference in myocardial uptake of MIBG among PD, PAF, and MSA.

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Figure 1 The figure shows H&E and TH staining of the nerve fibres in the epicardial space from the control subject (A, E), the patient with MSA (B, F), PD (C, G), and PAF (D, H), respectively. On H&E staining, no abnormal findings were apparent in each patient (A, B, C, D). However, TH immunoreactive nerve fibres in the patient with PD and PAF are markedly decreased (G and H) compared with the patient with MSA (F) and the control subject (E). The bar indicates 100 μm.
An adult Japanese Sanfilippo A patient with novel compound heterozygous S347F and D444G mutations in the sulphamidase gene

Sanfilippo A is a neurodegenerative disease characterised by progressive dementia, sleep disturbance, developmental delay, hyperactivity, and aggressive behaviour. Sanfilippo A is inherited as an autosomal recessive disease caused by a defect of the lysosomal enzyme sulphamidase (N-sulphoglucosamine sulphohydrolase, SGSH, EC 3.10.1.1). Failure of the degradative effect of sulphamidase is thought to cause lysosomal accumulation of heparan sulphate, leading to neuronal dysfunction. Developmental abnormality is often noticed at 2 or 3 years of age and severe neurological deterioration occurs in most patients by 6 to 10 years of age. The average age at death is 13 years. The comparatively mild somatic manifestations often cause a delay in the diagnosis. The gene encoding Sanfilippo A has been cloned. We now report on a Japanese Sanfilippo A patient. A 26 year old patient had no recognisable developmental abnormality until the age of 4 years, when he had mild language disability without motor dysfunction. Mild ventricular enlargement and brain atrophy were found at the age of 12 years. Despite his language disability, motor function was well retained even in high school. Hyperactivity and irritability appeared at the age of 17 years, and mental deterioration ensued. Simple conversation was retained until the age of 24 years. The diagnosis was made then with the demonstration of increased excretion of heparan sulphate in urine and decreased sulphamidase activity in cultured fibroblasts (not detected; control 3.2-7.2 nmol/h/mg). His older brother had a mild language disability and died as a result of an accident at the age of 19 years. There was no family history of consanguinity. The patient was 164 cm in height, and weighed 50.4 kg. There was no recognisable pattern of malformation. His hair was stiff and coarse. No corneal opacities were found. Facial expression was poor, and affect was flattened. He had no meaningful expressive language. Visual pursuit was poor and frequently discontinued. Agitation could be induced by tactile or visual stimuli. Touching his limbs and trunk induced coordinated repetitive coarse movements such as holding up both arms and legs. There was no obvious weakness found, but ankle contractures render him wheelchair bound. Deep tendon reflexes were normal. A magnetic resonance imaging examination of the brain revealed thinning of the corpus callosum, ventricular enlargement and widening of the sulci. Gribiform changes (small cystic lesions) were found in the frontal lobe.

Genomic DNA was extracted from peripheral blood leukocytes using the Capture Column kit (Genta systems, MN). The sulphamidase gene consists of eight exons. The primer pairs used to amplify the exons by polymerase chain reaction (PCR) were described by Weber et al. Sequencing was done using an ABI 377 automated fluorescence sequencer (Perkin Elmer, Foster City, CA). Numbering of amino acids and nucleotides is according to Scott et al.

To determine the possibility of mutations in the sulphamidase gene, PCR was done on the genomic DNA of the patient. We sequenced all the coding regions and the sequence obtained showed two heterozygous nucleotide substitutions: a C to T at the position 1052 (S347F) and an A to G transition at the position 1343 (D444G), and one homozygous polymorphism: a G to A transition at the position 1367 (R456H). The patient’s mother had a single heterozygous nucleotide substitution: a C to T transition at the position 1052 (S347F), while his father had a heterozygous nucleotide substitution: an A to G transition at the position 1343 (D444G) (fig 1).

This is the first report of a genetically identified Japanese Sanfilippo A patient. The gene encoding sulphamidase spans about 11 kb,
includes 8 exons, and is localised to chromosome 17q25.3. We found two novel mutations (5347T, TCC to TTC and 6444G, GAC to GGC) in exon 8. The sulphamidase shares few common conserved sites toward the C terminus, and the conserved sites are relatively scarce in exon 7 and exon 8. The serine (S) residue at position 347 and the aspartic acid (D) residue at position 444 are located on sparsely distributed conserved sites among sulphatase families under the superimposition of the sequences of protein sulphatases. Polymorphisms were not reported at these two sites (1052C to T, and 1343A to G). These two mutational sites are conserved in the evolution process and obey the rule of Mendelian inheritance. Therefore, these mutations were predicted to cause disease.

The clinical course of the patient in this report was relatively slow. In reporting 73 patients with Sanfilippo syndrome, van de Kamp et al found that Sanfilippo B and C each average age of death of Sanfilippo A was 13 years (range 6–25) and the age range of the living patients was 5–26 years. Motor function of the patient in this report were well retained and language abilities remained until the age of 24 years. Significant clinical heterogeneity has been known in Sanfilippo syndrome (include Sanfilippo A). Patients with the clinically milder course may predominate in Japan. Further study is needed for evaluating mutational predominance and its clinical relevance in Japanese Sanfilippo A patients.

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References

Parkinson's disease: neurosurgery at an earlier stage?

Bilateral high frequency stimulation of the subthalamic nucleus in advanced Parkinson's disease. A 48 year old woman, single without children, had had PD for five years. She was on sick leave for two years, but had been on sick leave for two years.

Three findings suggest that bilateral high frequency stimulation of the STN, when performed sufficiently early in the evolution of PD, can prevent the motor handicap and adverse reactions of levodopa from interfering with socio-professional integration and family life. Although this is an open label observation of select PD patients reported in the absence of long term follow up, we wonder whether one should not give PD patients a chance for a normal life, when otherwise they are certain to lose their job and their autonomy, even with optimised antiparkinsonian medications. We propose that a controlled study should be performed to demonstrate the validity and the economical consequences of this proposition. Such a decision needs to be balanced by taking into consideration the long waiting lists in the centres performing such surgery and the risks associated with neurosurgery.

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