Long duration asymmetrical postural tremor is likely to predict development of Parkinson’s disease and not essential tremor: clinical follow up study of 13 cases

K Ray Chaudhuri, M Buxton-Thomas, V Dhawan, R Peng, C Meilak, D J Brooks

METHODS
From a clinical database of patients with tremor attending our regional movement disorders clinic, we identified 13 patients with a history of postural tremor with asymmetry >10 years and no rest tremor who had an initial diagnosis of probable ET but a final diagnosis of tremor dominant or mixed pattern PD satisfying the UK PD brain bank criteria. The database is continually updated and currently holds records of 480 patients with a diagnosis of PD. Patients with a history of neuroleptic or vestibular sedative use were excluded.

All 13 patients were examined by KRC and A Forbes (PD nurse specialist) and followed up in PD clinics. As our movement disorders clinic also offers surgical therapy with deep brain stimulation and has an active interest in the treatment of disorders with tremor, most patients with ET are not discharged but followed up at intervals of 6–12 months. Assessments at the time of original referral were ascertained retrospectively by examining case records and patient/caregiver interviews. Five of the 13 patients had striatal dopamine transporter (DAT) binding measured using β-CIT single photon emission computed tomography (SPECT), and all had trials of levodopa/dopamine agonists. Five patients underwent a levodopa challenge test using a standard protocol.

RESULTS
A total of 13 patients (10 men, three women; mean age at diagnosis of PD 69.8 years, range 51–87) presenting with asymmetrical postural tremor and subsequent development of rest tremor and parkinsonism with a tremor duration of 19.2 years (range 10–50) were included in the study. The duration of tremor could have been skewed by the tremor duration of 50 years in one patient. When this patient was excluded, the mean duration of tremor to final diagnosis was 15.9 years (range 10–26). Mean age at the time of original presentation with asymmetrical postural tremor was 50.6 years (range 36–69). Historical interviews suggested that the tremor pattern had changed from an asymmetrical postural tremor to express additional rest tremor and other signs of parkinsonism for a mean period of 2.5 years (range 1–5) before final presentation to our clinic (fig 1). All patients now had an 8–10 Hz postural tremor and a slower 3–5 Hz rest tremor in addition to bradykinesia and cogwheeling. The patients responded to dopaminergic treatment with levodopa and/or levodopa and dopamine agonist (n = 7), dopamine agonists (n = 5) and benzhexol (n = 1). Patients 9 and 13 were given a trial of dopamine agonists in spite of strongly positive levodopa challenge (table 1) because of their

Abbreviations: β-CIT SPECT, 2-(4-[(123I)b-carbomethoxy-3-(4-iodophenyl)]tropane single photon emission computed tomography; ET, essential tremor; PD, Parkinson’s disease
These conclusions are supported by the fact that the patients reported in this study presented with an asymmetrical postural tremor without rest tremor and were initially diagnosed as having ET, and all subsequently developed tremulous PD after a variable period averaging 15.9 years after exclusion of one case with a latent period of 50 years. The mean period of change in tremor characteristics and distribution prior to the final diagnosis of PD was 2.5 years and included the development of rest tremor in the arm affected by postural tremor and other signs of parkinsonism. Development of PD was supported by additional β-CIT changes in some patients, positive levodopa challenge test in others, and sustained response to dopaminergic treatment in all.

It may be argued that these patients represent coincidental development of PD in cases of ET, the so-called ETPD phenotype as has been suggested by Jankovic, or the condition of ET with isolated rest tremor as suggested by Louis and Jurewicz. However, the latter is unlikely in our patients as all expressed global signs of parkinsonism and not just rest tremor. Furthermore, development of PD with rest tremor occurring in arms affected by postural tremor is also unlikely to be wholly coincidental in 13 cases from a database sample of 480, although there is the inevitable bias in the ascertainment of these cases from a specialist movement disorders clinic database. We also acknowledge the fact that it is not possible to predict from this study what percentage of people with asymmetrical postural tremor will develop PD in the long term as we did not study a similar group of people with asymmetrical postural tremor who did not develop PD.

An overlap of parkinsonism and ET has been suggested previously by many workers and, more recently, electrophysiological means such as H-reflex recovery curves have been put forward as means to distinguish between ET, tremulous PD, and ET with PD although the pathophysiological basis of ET remains unclear. Overlap of ET and PD is also supported by the findings that occasionally parkinsonian tremors may respond to β blockers, may be attenuated by alcohol intake (as evident in several of our patients) and a recent description of the PARK4 locus in chromosome 4p in an autosomal dominant family (the Iowa kindred) with parkinsonism and postural tremor suggestive of ET with a good levodopa response. Overlap of ET and PD is also supported by the findings that occasionally parkinsonian tremors may respond to β blockers, may be attenuated by alcohol intake (as evident in several of our patients) and a recent description of the PARK4 locus in chromosome 4p in an autosomal dominant family (the Iowa kindred) with parkinsonism and postural tremor suggestive of ET with a good levodopa response.  

### Discussion

This clinical observational study has highlighted the following facts:

- **Late onset isolated unilateral or asymmetrical postural tremor may be a predictor of future expression of tremulous PD.**
- **There may be a long and variable latent period (up to 50 years in our series) before there is a phenotypic alteration suggesting the development of PD.**
- **Alcohol sensitivity and family history, thought to be useful as a diagnostic aid to ET, may also be present in patients with PD presenting initially with postural tremor.**

### Table 1 Clinical details of the 13 patients included in the study

<table>
<thead>
<tr>
<th>Patient</th>
<th>Postural tremor</th>
<th>Resting tremor</th>
<th>Final diagnosis</th>
<th>Asymmetry</th>
<th>Family history</th>
<th>Alcohol responsive</th>
<th>l-dopa % +ve</th>
<th>β-CIT</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>R-L</td>
<td>R-L</td>
<td>TPD</td>
<td>R</td>
<td>Sister TPD</td>
<td>No</td>
<td>l-dopa</td>
<td>DA</td>
<td>DA</td>
</tr>
<tr>
<td>2</td>
<td>R-L</td>
<td>R</td>
<td>TPD</td>
<td>R</td>
<td>Son T</td>
<td>No</td>
<td>l-dopa</td>
<td>DA</td>
<td>DA</td>
</tr>
<tr>
<td>3</td>
<td>L</td>
<td>L</td>
<td>TPD</td>
<td>L</td>
<td>Mother T</td>
<td>Yes</td>
<td>l-dopa</td>
<td>DA</td>
<td>DA</td>
</tr>
<tr>
<td>4</td>
<td>L</td>
<td>L→R</td>
<td>Mixed</td>
<td>L</td>
<td>–</td>
<td>No</td>
<td>20% Y</td>
<td>l-dopa</td>
<td>DA</td>
</tr>
<tr>
<td>5</td>
<td>R</td>
<td>R</td>
<td>Mixed</td>
<td>R</td>
<td>–</td>
<td>No</td>
<td>30% Y</td>
<td>l-dopa</td>
<td>DA</td>
</tr>
<tr>
<td>6</td>
<td>L&lt;R</td>
<td>L</td>
<td>Mixed</td>
<td>L</td>
<td>Mother/Uncle T</td>
<td>Yes</td>
<td>l-dopa</td>
<td>DA</td>
<td>DA</td>
</tr>
<tr>
<td>7</td>
<td>L</td>
<td>L→R</td>
<td>Mixed</td>
<td>L</td>
<td>Aunt T</td>
<td>Yes</td>
<td>35% Y</td>
<td>l-dopa</td>
<td>DA</td>
</tr>
<tr>
<td>8</td>
<td>R</td>
<td>R</td>
<td>Mixed</td>
<td>R</td>
<td>–</td>
<td>Yes</td>
<td>l-dopa</td>
<td>DA</td>
<td>DA</td>
</tr>
<tr>
<td>9</td>
<td>R</td>
<td>R</td>
<td>Mixed</td>
<td>R</td>
<td>–</td>
<td>No</td>
<td>50% Y</td>
<td>l-dopa</td>
<td>DA</td>
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<tr>
<td>10</td>
<td>L</td>
<td>L→R</td>
<td>TPD</td>
<td>L</td>
<td>Mother/GM T</td>
<td>No</td>
<td>Y</td>
<td>DA</td>
<td>DA</td>
</tr>
<tr>
<td>11</td>
<td>L</td>
<td>R-L</td>
<td>TPD</td>
<td>R</td>
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<td>Y</td>
<td>Anti-cholinergics</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>R</td>
<td>R</td>
<td>TPD</td>
<td>R</td>
<td>–</td>
<td>No</td>
<td>l-dopa</td>
<td>DA</td>
<td>DA</td>
</tr>
<tr>
<td>13</td>
<td>R</td>
<td>R</td>
<td>TPD</td>
<td>L</td>
<td>Father T</td>
<td>Yes</td>
<td>60% Y</td>
<td>l-dopa</td>
<td>DA</td>
</tr>
</tbody>
</table>

→ denotes progression to other side.
β-CIT: 2-[123I]carbomethoxy-3-(4-[125I]iodophenyl)tropane SPECT scan performed.
l-dopa %: levodopa challenge test (% positive)

DA, dopamine; GM, grandmother; mixed, tremor-kinetic pattern PD; T, tremor; TPD, tremor dominant PD; Y, impaired CIT uptake.

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with PD. In the present study, 61.5% of patients had a family history of tremor/parkinsonism and thus the genetic basis of this problem needs further exploration.

In conclusion, we have presented a clinical case series of 13 patients, all presenting with an asymmetrical postural tremor with or without a family history of tremor/parkinsonism and who after an initial diagnosis of ET and a variable period averaging 19.2 years developed signs of tremulous PD. The final diagnosis of PD was supported by a positive levodopa challenge test/successful dopaminergic treatment in all and supportive β-CIT SPECT in some cases. We suggest that caution regarding a diagnosis of ET should be exercised in patients presenting with late onset asymmetrical postural tremor even if there is no rest tremor. Alcohol sensitivity of tremor, family history of tremor or responsiveness to β blockers may not be helpful in such cases while dopamine transporter or fluorodopa imaging with SPECT or positron emission tomography may be useful in predicting which patients will develop PD although prospective studies are required to validate this observation. Our clinical study would suggest such cases develop PD after a variable and often a long latent period. Whether this phenotype represents an overlap of ET and PD or whether isolated postural tremor is a marker for tremulous PD remains unclear.

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Authors’ affiliations
K Ray Chaudhuri, V Dhawan, R Peng, Regional Movement Disorders Unit, King’s College Hospital, London, UK
K Ray Chaudhuri, V Dhawan, University Hospital Lewisham, Lewisham, UK
K Ray Chaudhuri, M Buxton-Thomas, C Meilak, Guy’s, King’s and St Thomas’ School of Biomedical Medicine, King’s College, London, UK
M Buxton-Thomas, Department of Nuclear Medicine, King’s College Hospital, London, UK
D J Brooks, MRC Clinical Sciences Centre, Faculty of Medicine, Hammersmith Hospital, London, UK

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