Mirror movements in parkinsonism: evaluation of a new clinical sign

A J Espay, J-Y Li, L Johnston, R Chen, A E Lang

Background: Mirror movements (MM) are not widely appreciated in parkinsonism and no report has evaluated this clinical sign in detail.

Objectives: To define the parkinsonian clinical features associated with MM in patients with early, asymmetric parkinsonism.

Methods: Twenty seven patients with early Parkinson’s disease were evaluated using a standardised videotaping protocol. MM were scored from blinded video assessment using a clinical scale that rates the amplitude, distribution, and proportion of mirroring in the less affected limb. Parkinsonian features were combined into axial and lateralised scores using related items of the Unified Parkinson’s Disease Rating Scale.

Results: MM were present in 24 of 27 patients. There was a significant linear correlation between the degree of asymmetry of motor deficits and MM on the less affected side. The effect of asymmetry was greater when the proportional rather than the absolute motor difference between sides was largest. Asymmetry in leg rigidity was the most important examination feature in the prediction of contralateral foot mirroring.

Conclusions: MM are a clinical feature of the unaffected or less affected side in mild asymmetric parkinsonism. Their presence may be a useful clinical finding in early parkinsonism.

Materials and Methods

Subjects

Patients with suspected MM and recent onset, asymmetric parkinsonism consistent with idiopathic PD who were seen at the movement disorders centre, Toronto Western Hospital, Canada, between September 2001 and January 2003 were recruited. The university health network research ethics board approved our study and all patients signed informed consent. Exclusion criteria included evidence of associated lower motor neurone (atrophy, fasciculations, weakness, and hyporeflexia) or upper motor signs, previous neurosurgical procedures, severe resting tremor on the less affected side, which could preclude observation and scoring of mirroring, or clinical features that suggested a diagnosis other than PD including, but not restricted to, oculomotor disturbances, cognitive impairment, apraxia, and early falls. Although treatment with low doses of dopamine agonist monotherapy was permitted, patients treated with levodopa were generally excluded because of the potential for drug induced dyskinesias to be confused with MM. Only one patient who had been on a low dose of levodopa (200 mg/day) was included because confounding dyskinesias were not felt to be a concern.

Clinical evaluation

The initial assessment included ascertainment of handedness, duration of symptoms, side of first symptoms, and nature of earliest deficit. Patients underwent motor evaluation according to the motor subscale (part III) of the Unified Parkinson’s Disease Rating Scale (UPDRS). Four tasks performed using the most affected limbs were videotaped: tapping of thumb against index finger (finger tapping, UPDRS item 23), rapid hand opening and closing (hand.
To evaluate the regional components of parkinsonism, we used selected items of the UPDRS to determine axial and lateralised deficits. The axial UPDRS sub score was derived from the sum of subjective items 5, 7, 12, 13, 14, and 15 from part II and motor exam items 18, 19, 22 (neck only), 27, 28, 29, and 30 from part III. The lateralised UPDRS score indicates greater difference of disease burden between sides and, therefore, more asymmetry. In addition, we calculated a composite rigidity–bradykinesia score for each limb. For the upper extremities, the scores for the more affected (MAA) and less affected (LAA) arm were obtained as follows: 

\[
MAA = (\text{UPDRS item } 22) + ((\text{UPDRS items } 23 + 24 + 25)/3)
\]

for more affected arm.

\[
LAA = (\text{UPDRS item } 22) + ((\text{UPDRS items } 23 + 24 + 25)/3)
\]

for less affected arm.

Similarly, for the lower extremities, the scores for the more affected (MAL) and less affected (LAL) leg were calculated as follows:

\[
MAL = (\text{UPDRS item } 22 + \text{UPDRS item } 26) \text{ for more affected leg.}
\]

\[
LAL = (\text{UPDRS item } 22 + \text{UPDRS item } 26) \text{ for less affected leg.}
\]

An investigator, unaware of the clinical variables collected separately, determined the severity of the mirroring. This entailed blinded videotape assessment using a scale that rated amplitude, distribution, and proportion of mirroring activity in the less affected limbs (table 1; for representative mirroring subjects see video available at http://www.jnnp.com-supplemental).

The three item scale included a measure of amplitude (defined as the range of excursion of the fingers and wrist (for hand MM) and ankle (for foot MM)), distribution (the extent to which these movements matched those of the joints and muscles of the task performing limb), and proportion (the approximate fraction of time during which the mirroring occurred during task performance). When in doubt about the degree of mirroring, the lower most appropriate rate for the movement was used. Because there were three tasks in the potentially mirroring hand (UPDRS items 23–25) and one in the ipsilateral foot (UPDRS item 26), the total possible score was 40. Our cohort exhibited a range of 0–31.

### Table 1: Scale used to assess severity of mirror movements in the resting less affected or unaffected hand and foot

<table>
<thead>
<tr>
<th>Features</th>
<th>Characteristics of mirroring</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amplitude of mirroring</td>
<td>No movement</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Barely discernible but repetitive movement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Clear movement with excursion of finger, wrist and ankle of less than 2 cm. Movement is either slight but sustained or stronger but briefer Excursion of finger, wrist, or ankle greater than 2 cm and movement readily distinguished as mirroring (strong and sustained movement) Pronounced mirroring, with amplitude approaching or matching the requested task in the opposite limb</td>
<td>2</td>
</tr>
<tr>
<td>Distribution of mirroring</td>
<td>Less than mirrored task (fewer fingers for instance)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mirroring that involves the same areas as intended task</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Mirroring spreads beyond the intended task areas</td>
<td>3</td>
</tr>
<tr>
<td>Proportion of mirroring</td>
<td>Mirroring occurs in less than 1/3 of the task intended cycles</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mirroring occurs in between 1/3 and 2/3 of the task cycles</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Mirroring occurs for most of the task cycles (&gt;2/3 of the task cycles)</td>
<td>3</td>
</tr>
<tr>
<td>Maximum possible scoring:</td>
<td>40 (10 points/task)</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: Characteristics of enrolled patients

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD; range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at enrolment</td>
<td>59.0 (9.9; 39–82)</td>
</tr>
<tr>
<td>Age at disease onset</td>
<td>56.7 (7.6; 36–78)</td>
</tr>
<tr>
<td>Disease duration (month)</td>
<td>27.8 (14.7; 6–64)</td>
</tr>
<tr>
<td>Motor UPDRS</td>
<td>18.9 (7.7; 10–36.5)</td>
</tr>
<tr>
<td>Axial UPDRS</td>
<td>5.8 (3.3; 0–14.95)</td>
</tr>
<tr>
<td>Lateralised UPDRS</td>
<td>7.7 (3.7; 1–14)</td>
</tr>
</tbody>
</table>

UPDRS, Unified Parkinson’s Disease Rating Scale.

### Table 3: Clinical aspects of enrolled patients

<table>
<thead>
<tr>
<th>Clinical aspects</th>
<th>Patient number (percentage of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side of first symptoms</td>
<td>Left, 13 (48%); right, 13 (48%); bilateral, 1 (4%)</td>
</tr>
<tr>
<td>Nature of first symptom</td>
<td>Tremors, 19 (70%); bradykinesia, 5 (19%); micrographia, 2 (7%)</td>
</tr>
<tr>
<td>Drug treatment</td>
<td>Pramipexole, 2 (7%); ropinirole, 2 (7%); levodopa, 1 (4%); no treatment, 22 (81%)</td>
</tr>
</tbody>
</table>
Data analysis
Simple and multiple linear regressions were used to test the effects of UPDRS total motor, axial, limb composites, and lateralised scores on MM. Pearson correlation coefficients were obtained between the mirroring score and the lat-eralised UPDRS. Analysis of covariance (ANCOVA) was applied to determine the predictive effect of age, sex, nature of initial symptom, side of initial symptom, dopaminergic treatment, and duration of disease on the degree of mirroring. The Mann-Whitney U test was used to determine differences of baseline parkinsonian deficits based on sex and nature and side of initial symptom. SAS statistical software version 8.2 and StatView version 5.01 (SAS Institute Inc, Cary, North Carolina, USA) were used for analyses and graphics.

RESULTS
Baseline characteristics
Tables 2 and 3 list the demographic features of the 27 patients. The side of the first symptom, the nature of their first symptom, age, and sex had no influence on MM score, disease duration, or UPDRS score.

General features of mirroring
MM were easily discernible in the less affected limb in 24 of the 27 early asymmetric patients with PD. No MM were noted in the most affected limb while the patient performed activities in the less affected limb. Mirroring was present only in the hand in 10 of 24 and in the foot in two of 24. Half of our mirroring subjects (12 of 24) had both hand and foot MM. Of these, mirroring was more predominant in the less affected hand in seven of 12 and in the less affected foot in five of 12. Hand mirroring was slightly more common during finger tapping (mean score, 5.23; maximum possible, 10) than during hand movements (mean, 4.04) or forearm pronation–supination (mean, 4.91). The mean (SD) total MM score was 14.8 (9.3) and was higher in those whose presenting deficit was tremor (mean, 15.5; SD, 10.1) than bradykinesia (mean, 8.3; SD, 3.7). Mirroring in the resting limb could be conspicuous during one task (for example, finger tapping) but absent during another (for example, pronation–supination of the forearm).

Relation between mirroring and parkinsonian features
The lateralised UPDRS score predicted the severity of mirroring in the less affected or unaffected side in a linear fashion (R = 0.56; p = 0.005; fig 1A), and this finding remained significant even when the three subjects without mirroring were included (R = 0.39; p = 0.046). When using an index of asymmetry by determining the ratio between absolute differences of motor deficits between sides and the total motor impairment, a significant direct correlation between this index and the MM scores was found (R = 0.728; p < 0.001; fig 1B), indicating that the higher the absolute difference between sides in relation to the total impairment (higher ratio), the more prominent the mirroring observed. Conversely, patients with a greater burden of motor impairment and more symmetry of bilateral deficits (lower ratio) exhibited little or no mirroring. In other words, given two individuals with similar absolute motor differences between sides, greater mirroring was present in the individual who exhibited a greater proportional difference, as is the case at the milder end of the motor impairment spectrum (for example, approaching the state of pure hemiparkinsonism). Although there was a trend for an inverse correlation between the total UPDRS and MM, no correlation was found between MM and the modified axial UPDRS or the duration of disease.

To determine regional predictors of mirroring, we first evaluated the influence of the combined rigidity–bradykinesia composite on MAA, MAL, LAA, and LAL scores. Foot mirroring, but not hand mirroring, was predicted when both leg composites were considered together in a multiple regression analysis (R = 0.55; MAL, β = 3.60, p = 0.02; and LAL, β = −5.92, p = 0.004). This suggested that the more severe the core motor deficits (rigidity and bradykinesia) in the more affected leg, the greater the correlation with foot mirroring in the less affected leg, particularly if this limb exhibited minimal motor deficits. When differences in bradykinesia and rigidity between sides were considered in separate linear regression models, a significant direct correlation was found only between lateralised rigidity in the legs and foot MM (R = 0.66; p<0.001). Differences in rigidity or bradykinesia between arms failed to predict hand mirroring.

DISCUSSION
We have found that MM are a feature of asymmetric parkinsonism, particularly when overall motor impairment is relatively minor. Hand and foot mirroring were predicted by the difference in motor deficits between sides. Differential rigidity in the legs was significantly associated with foot mirroring. Because no relation was found between MM and the total motor UPDRS score, a modified axial score, or the duration of disease, the
syndrome, or other structural abnormalities.

movements, Klippel-Feil syndrome, X linked Kallmann’s

hemisphere has been correlated with MM in the unaffected

unaffected motor cortex with preserved activation in the stroke

and H2

interhemispheric pathways involved in limb motor control. In

were subsequently confirmed to have an adequate response to levodopa or dopamine agonists. However, sufficiently long-

term follow up would have been required to exclude other

causes of parkinsonism. It is our impression that MM correlate with clinical asymmetry and not with diagnosis because we have also seen MM in patients with asymmetric parkinsonism caused by multiple system atrophy.

In summary, MM of the unaffected or less affected hand and foot are a feature of relatively mild asymmetrical parkinsonism, especially dominated by rigidity. Further studies may shed light on the potential value of MM in categorising and staging patients with early parkinsonism.

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Competing interests: none declared

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A 67-year-old alcoholised woman stumbled over an unevenness, lost her balance, and fell into an ordinary butterknife while preparing cat food. Initially, the woman was awake with a Glasgow coma scale (GCS) of 9. On hospital admission, she was intubated, sedated, the pupils were equal and reactive to light, the eyeballs were both intact, and there was no neurological deficit. The handle of the knife was protruding from the right orbit. There was a leakage of bloody cerebrospinal fluid (CSF) out of the inner right canthus.

X-ray and computed tomography (CT) demonstrated the blade penetrating the medial part of the right orbit—gyrus rectus extending to the anterior horn of the right lateral ventricle (fig 1). Beside there was an old infarction area due to the right medial cerebral artery. After exclusion of a space occupying intracerebral haemorrhage the knife was pulled out in the operating theatre. After removing the knife a control CT was performed revealing only a minimal traumatic subarachnoid haemorrhage (tSAH) (fig 2). Thereafter, the right canthus was microsurgically sutured.

Postoperative contrast-enhanced, T1 and T2 weighted magnetic resonance images revealed minimal tSAH and a slight defect zone in the right gyrus rectus (fig 3). Hypothalamus, pituitary gland, and optic nerve were completely unaffected. Initially, CSF analysis indicated massive erythrocytes (due to the tSAH), a disturbed blood-brain-barrier function, and a total cell count of 38/mm³. Hormonal testing was inconspicuous including prolactin, follicle-stimulating hormone, luteinizing hormone, growth hormone, thyrotropin, and corticotropin. Electrolytes were normal and the patient did not develop a syndrome of inappropriate secretion of antidiuretic hormone (SIADH). Neuroophtalmologic investigation revealed no loss of visual acuity and full ocular motility.

She received a prophylactic antibiotic therapy including amoxicillin/clavulanate (3×2.2 g), ciprofloxacin (2×0.5 g), and metronidazole (2×0.4 g). Through the clinical course the patient showed no signs of infection. As an independent complication she developed a crural thrombosis and was discharged on day 37 after initial trauma.

Penetrating orbital trauma should alert the clinician because of potentially devastating consequences. Even an intact orbital globe does not exclude intracranial trauma. The high mortality rate associated with cranial penetration injuries is mainly a result of intracranial suppuration. Therefore, an appropriate, broad spectrum antimicrobial therapy is inevitable. Considering the serious injury the patient’s course was remarkably inconspicuous.

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