Abnormal movement related potentials in patients with lesions of basal ganglia and anterior thalamus

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Abstract

Movement-related cortical potentials (MRCPs) were recorded from scalp electrodes during wrist flexion in 15 dystonic patients with bilateral (nine) or unilateral (six) circumscribed lesions in the striatum (eight), pallidum (six), or anterior thalamus (one). The results were compared with those of 10 age-matched healthy volunteers. The early (BP) and late (NS') MRCP components were assessed in terms of their gradients and distribution on the scalp in Cz, C3', and C4'. The gradients of both BP and NS' components were significantly flatter in the patients with bilateral lesions than in the control subjects. Also, the BP gradient was maximum at Cz, and the NS' component was contralaterally predominant in the control subjects but not in the patients. In patients with unilateral lesions, the gradients were flatter (p < 0.05) during movement of the dystonic wrist than during movement of the normal wrist. This difference was significant for BP and NS', regardless of the location of the electrodes. Also, the normal topographic predominance of BP at Cz and of contralateral NS' disappeared. The BP and NS' components of the MRCPs are thought to reflect preparatory activity in the supplementary motor area and the primary motor cortex before movement. Reduced BP and NS' gradients in patients with both bilateral and unilateral lesions of the basal ganglia, where projective the supplementary motor area, are consistent with this hypothesis. The bilateral nature of these reductions suggests that both the ipsilateral and the contralateral motor cortex are involved in the genesis of the MRCPs and that the dystonia in these patients is associated with impaired motor preparation.

The negative slow potentials recorded from the human scalp before and after initiation of voluntary movements are referred to as movement-related cortical potentials (MRCPs).1,2 Shibasaki et al.1 have termed the two main premotor components of MRCPs BP and NS'. It has been suggested that BP and NS' arise from motor cortical structures, particularly the supplementary motor area and primary motor cortex.3,4 Anatomical studies have shown that the pallidal output is directed from the thalamus to the supplementary motor area and, possibly, to the premotor cortex.5 Conversely, the supplementary motor area provides an input into the pallidum via the striatum, thus forming an anatomical loop between motor cortical areas and basal ganglia.6 MRCPs might thus reflect the activity of this motor loop. Abnormal MRCPs have effectively been described in Parkinson's disease,6 and we found restoration of their amplitude during chronic treatment with levodopa.7 Here, we recorded MRCPs in nine dystonic patients with bilateral lesions and six patients with a unilateral lesion of basal ganglia or anterior thalamus.

Subjects and methods

PATIENTS

Fifteen patients with lesions in the basal ganglia and thalamus were studied after obtaining their informed consent. There were six women and nine men aged between 21 and 51 (mean 30.7 (SD 9.02)) years and they were all right handed. Table 1 shows their main characteristics at the time of the electrophysiological test. All the patients had a dystonia (generalised or hemidystonia) and were free of treatment at the time of examination.
Abnormal movement related potentials and lesions of basal ganglia and arterial thalamus

Well circumscribed lesions of the basal ganglia were confirmed by MRI. There were nine patients with bilateral lesions and six with unilateral lesions (table 1). The bilateral lesions were pallidal in four patients, striatal in four, and in the anterior thalamus in one. All the unilateral lesions were located in the right hemisphere—four in the striatum and two in the pallidum.

CONTROLS

Ten age-matched right-handed healthy volunteers were chosen from the hospital personnel (six women and four men aged from 23 to 47 (mean 31·3 (SD 7·4)) years. Neurological examination and a CT scan of the head were normal.

RECORDING

During the recording session the subjects lay comfortably on a bed with their study forearm maintained in a wedge. They were asked to make self-paced, brisk, phasic movements of the wrist, roughly every 5 seconds. The subjects were instructed to fix a point on a screen in front of them, to avoid blinking, and not to count during the interval between movements. Two hundred movements were recorded during each session. The most strongly impaired hand was tested in the patients with bilateral lesions, and both hands were tested in the patients with unilateral lesions. The recording of the healthy volunteers was done during movement of the right wrist.

The surface electromyogram (EMG) was recorded from the flexor carpi ulnaris and amplified within frequencies of 100–3000 Hz. The onset of the EMG burst triggered data collection by a computer assisted system similar to that described by Barrett et al. EEG potentials preceding self-paced wrist flexions were averaged on line by an evoked potential apparatus (Basis signal averager, OTE) from three scalp electrode positions (Cz, C3', and C4'–1 cm anterior to C3 and C4 of the 10/20 system). The filter band pass was 0·03 Hz–1·6 kHz. Scalp muscle activity and blink artefacts were excluded by a rejection system that automatically discounts potentials greater than ±0·1 mV. The EEG was averaged from 2·5 seconds before to 2·5 seconds after the upstroke of the EMG.

To measure the amplitude and velocity of the movement, a wedge hinge was placed coaxial to the wrist joint. The hinge contained a potentiometer that allowed the wrist angle to be measured. Angular velocity was measured with an electronic differentiator.

MEASUREMENTS

The measurements were done by two different investigators who were not informed of the clinical state of the subjects. Baseline was determined by averaging the recording from 2·5 seconds to 2·0 seconds before EMG onset in each channel. The gradients of the two premovement MRCP components (figure) were obtained by fitting a linear regression line between selected points. Onset of BP and peak negativity before EMG onset (N1) were first determined visually. The gradient of the early component was fitted by points on the shift between BP onset and 500 ms later, whereas that of the late component was fitted with points located on the shift between N1 and 500 ms earlier. Onset of NS' was determined on the shift as the intersection of the two regression lines. The figure gives examples.
STATISTICAL ANALYSIS

The significance of differences between the control subjects and the patients was determined by Student’s t test. Differences between recordings over the electrodes of the ipsilateral and contralateral sides were compared by two-way analysis of variance. This was also done for recordings during right or left wrist flexions in the patients with unilateral lesions. Correlations between the movement kinematics and the gradients of the MRCP components were sought by linear regression analysis.

Results

Patients with bilateral lesions of the basal ganglia

The figure (A) shows an example of MRCPs recorded in a control subject (C-T2), a patient with bilateral lesions of the pallidum (B2), and a patient with lesions of the putamen (B6).

The latencies of the two main premotor components (BP and NS') did not differ between the patients and the control subjects. By contrast, the gradient of BP was flatter on both sides in the patients (mean: 1.32 (SD 0.94) μV/s at C2) than in the control subjects (mean: -3.2 (SD 1.3) μV/s at C2) (p < 0.01). The gradient of NS' was also flatter (-3.4 (SD 1.5) μV/s at the contralateral hand motor area) in the patients than in the control subjects (-8.4 (SD 1.8) μV/s) (p < 0.001) (table 2).

Changes were also noted in the MRCP topography over the scalp. In the control subjects the BP gradient was significantly greater at C2 (p < 0.01) and showed a bilateral symmetrical distribution at C3' and C4'. NS' was maximal at C3 for a movement of the right wrist. Its mean gradient (-8.44 (SD 1.81) μV/s) was significantly steeper (p < 0.001) than at C4' (-5.16 (SD 1.51) μV/s). In the patients with unilateral lesions, the BP gradient at C2 was not significantly different from that at other electrode positions. The NS' gradient at the contralateral hand motor area was not steeper than in the ipsilateral side.

Concerning the movement kinematics (table 2), the velocity of wrist movement in the patients with unilateral lesions was not reduced by more than 74% (range 90 to 220 degrees/s) relative to the control values. There was no correlation, in either patients or controls, between the velocity and gradients of the MRCPs, either for BP or for NS'.

Patients with unilateral lesions of the basal ganglia

The figure (B) shows an example of the MRCPs for a movement of the left (dystonic) side in a patient with a limited lesion of the right putamen: scalp recordings of the BP and NS' gradients over the scalp were significantly flatter than during a movement of the unaffected side (BP p < 0.01, NS' p < 0.05). The gradients were also flatter (p < 0.05 for both BP and NS') relative to those in the control subjects (table 2). During the movement of the dystonic wrist, the gradient was flatter in both ipsilateral and contralateral recordings.

The normal topographic predominance of BP and NS' disappeared during movement of the normal or dystonic wrist. BP was therefore no longer predominant at Cz, and NS' was no longer predominant on the side contralateral to the movement. BP was not maximal at Cz for either right or left wrist movement. During movement of the right (normal) wrist, BP was predominant at C3' (contralateral normal hemisphere) by comparison with Cz and C4' (ipsilateral damaged hemisphere) (F 13.47, df 2/10, p < 0.001). There was no effect of electrode position on the BP gradient before left (dystonic) wrist flexion.

NS' distribution

Comparison of NS' amplitudes in C3', Cz, and C4' by ANOVA showed no significant differences between these electrode locations, whatever the side of the movement.

Parameters of movement

The amplitude of wrist flexions did not differ between the right (dystonic) or a left (normal) sides of movement (table 2). The velocity was, however, significantly lower during movement of the affected side (200-8 (SD 29-7) degrees/s) than the normal side (323-3 (SD 38-8) degrees/s) (p < 0.01). No correlation was found between the velocity of movement and the gradient of BP or NS', whatever the side of the movement.

Table 2 Kinematic parameters and MRCPs

<table>
<thead>
<tr>
<th>Patients</th>
<th>Kinematic</th>
<th>BP at Cz</th>
<th>NS' at CHM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Angulation (degrees)</td>
<td>Velocity (degrees/s)</td>
<td>Onset (deg)</td>
</tr>
<tr>
<td>Bilateral dystonia (mean SD)</td>
<td>35 (1-6)</td>
<td>165 (50)</td>
<td>1546 (320)</td>
</tr>
<tr>
<td>Controls (mean SD)</td>
<td>104 (11-09)</td>
<td>346 (33)</td>
<td>1562 (198)</td>
</tr>
<tr>
<td>Bilateral dystonia, p &lt; 0.05</td>
<td>0-01</td>
<td>0-001</td>
<td>NS</td>
</tr>
<tr>
<td>Unilateral dystonia, damaged</td>
<td>100 (8-32)</td>
<td>196 (28-7)</td>
<td>1309 (168)</td>
</tr>
<tr>
<td>Unilateral dystonia, normal</td>
<td>105 (5-47)</td>
<td>355 (17-6)</td>
<td>1150 (202)</td>
</tr>
<tr>
<td>Normal dystonia, p &lt; 0.05</td>
<td>NS</td>
<td>0-001</td>
<td>NS</td>
</tr>
</tbody>
</table>

CHM = contralateral hand motor area.
Abnormal movement related potentials and lesions of basal ganglia and arterial thalams

Discussion
Relative to the healthy control values, both the BP and NS' gradients were flatter on both sides in the patients with bilateral lesions of the basal ganglia, and before movement of the impaired side in patients with unilateral lesions. All these patients had circumscribed ischaemic lesions of the pallidum, putamen, caudate nucleus, or anterior thalamus. These features are consistent with the involvement of basal ganglia and anterior thalamus in principal neuronal motor circuits, the "complex loop" (prefrontal cortex, caudate nucleus, pallidum and substantia nigra, ventral anterior thalamus, prefrontal cortex), and the "motor" loop (premotor and sensory-motor cortex, putamen, pallidum, and substantia nigra, ventrolateral thalamus, premotor and sensory-cortex). As MRCPs are thought to originate from both the primary motor cortex and the supplementary motor area,11 their decrease could reflect lower activity of motor cortical structures due to lesions in the basal ganglia. Failure of cortical activation of patients with Parkinson's disease and those with lesions of subcortical structures, particularly of the basal ganglia, has already been reported.14-16 These reports are in agreement with the decrease in MRCPs found here.

As well as the flattening of the gradients relative to those in the healthy control subjects, a change of the topographic distribution and a bilateral decrease in the MRCPs was noted during movement of the impaired side in the patients with unilateral lesions. As surface recording of the MRCPs probably reflects activities of both the right and the left motor cortex before voluntary movement,17 a large unilateral decrease in the activity of one hemisphere could produce a decrease in both right and left MRCPs recorded on the scalp. The activity of motor cortex structures could also be bilaterally reduced, however, in patients with unilateral lesions of the basal ganglia. Indeed, both bilateral supplementary motor areas are activated before unilateral, spontaneous, purposeful movement, as shown by subdural MRCP recordings12 17 and cerebral blood flow.18

As MRCPs probably reflect motor preparation before ballistic self-paced movements,19 our results could be due to an impairment of motor preparation after lesions of the basal ganglia. Various motor disorders have been described after such lesions.20 Parkinson's disease is another condition in which there are elective lesions of these structures. Although an earlier study of MRCPs in Parkinson's disease gave conflicting results, Dick et al20 21 showed that the earlier component of MRCPs was clearly reduced in patients with Parkinson's disease. In the early stages of Parkinson's disease, changes in MRCPs were limited to the BP component but in later stages the two premotor components were altered.22 Furthermore, there was a relation between amplitude of MRCPs and the Parkinsonian score.23 The patients we studied are dystonic and, as bradykinesia is seen in Parkinson's disease, the pathophysiology of dystonic movement remains unclear. Although the movement of our patients were slower than in control subjects, the velocity was never less than 26% of normal and this was not sufficient to affect the MRCP gradients, which have been noted to be affected for a reduction of more than 90% of the velocity of movement.21 Also, there was no positive linear correlation between velocity and MRCP gradients. This suggests that the impaired motor control in dystonic subjects does not affect the velocity directly, but rather other parameters of motor programming, as has been suggested by peripheral recordings.23 One of the involved parameters could be the increasing amplitude of muscular potentials at the onset of the muscular burst. Thus Hallett and Khoshbin24 hypothesised that the basal ganglia are concerned with the grading of movement amplitudes by inappropriately energising of muscles.

Our results suggest that movement movements may be associated with a decrease in motor cortex activity due to a disruption of the striato-pallido-thalamo-cortical loop by a vascular lesion. Although MRCP flattening after lesions of the basal ganglia raises the problem of cortical or subcortical origin of its components, this study provides new insights concerning the relation between lesions of the basal ganglia and genesis of dystonia.

We thank Miss Clara Bazzinotti for typing and Mr David Young for reading the text.

6 Schelt GR, Strick PL. The origin of thalamus inputs to the arcuate premotor and supplementary motor areas. J Neurosci 1984;4:559-60.


