Primary lateral sclerosis presenting parkinsonian symptoms without nigrostriatal involvement

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We encountered three patients with primary lateral sclerosis (PLS) showing bradykinesia, frozen gait, and severe postural instability, as well as slowly progressive spinobulbar spasticity. Cranial magnetic resonance (MR) imaging showed precentral gyrus atrophy. Central motor conduction was markedly prolonged or failed to evoke a response. Positron emission tomography (PET) showed significant reduction of [18F]fluoro-2-deoxy-D-glucose uptake in the area of the precentral gyrus extending to the prefrontal, medial frontal, and cingulate areas. No abnormalities were seen in the nigrostriatal system with PET using [18F]fluorodopa or [11C]raclopride or with proton MR spectroscopy. Thus, widespread prefrontal, medial, and cingulate frontal lobe involvement can be associated with the parkinsonian symptoms in PLS.

Methods
PET study
PET studies were performed using a ECAT EXACT HR47 (CTI/ Siemens, Knoxville, TN) and HEADTOME-IV (Shimadzu, Kyoto, Japan) for three patients with F-dopa, FDG, and two of the three patients with RACLO in three dimensional acquisition mode, which yielded 47 simultaneous planes, with an axial full width half maximum resolution of 4.8 mm and an inplane resolution of 3.9×3.9 mm. The protocol for F-dopa and FDG injection has been described previously.34 RACLO was injected at 494 MBq, and scanning consisted of 19 time frames for a total of 64 minutes. Photo data were presented with three dimensional stereotactic surface projection (3D-SSP) as normalised for the whole brain. 3D-SSP was performed as described by Minoshima et al.5 Data were normalised to global activities. The patients’ datasets were compared individually with the normal database by calculating a z score on a pixel-to-pixel basis, and were displayed in a 3D-SSP display for visual inspection.

1H-MRS study
1H-MRS was performed with a 3.0-T system (Bruker, Germany) using a standard head coil with circular polarisation. The spectroscopic volume of interest was placed in the putamen (1 cm3). 1H-MR spectra were acquired using a point-resolved spectroscopy sequence with chemical-shift selective water suppression. The metabolic ratios N-acetyl-aspartate (NAA)/creatine (Cr), and choline containing phospholipids (Cho)/Cr were determined as semiquantitative values. Data were compared with those of 18 age matched control subjects. The protocol was as previously described.6

Abbreviations: FDG, [18F]fluoro-2-deoxy-D-glucose; F-dopa, [18F]fluorodopa; PET, positron emission tomography; 1H-MRS, proton magnetic resonance spectroscopy; MND, motor neurone disease; PLS, primary lateral sclerosis; RACLO, [11C]raclopride
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RESULTS

The clinical features of the three patients are shown in Table 1. General physical examinations were normal in all patients. On neurologic examination, all three patients showed spastic dysarthria. Ocular movements were saccadic, but covered a full range. Muscle power was essentially normal (patient 1, all limbs normal; patient 2, Medical Research Council grade 4/5 in the arms; patient 3, 4/5 in the left biceps and iliopsoas muscles, but otherwise normal). Muscle tone was greatly increased in the limb flexor muscles but not in the extensors, this was appreciated best upon rapid movement. The jaw jerk reflex and deep tendon reflexes in the legs were brisk, and plantar responses were bilaterally extensor in all patients. No wasting, fasciculations, amyotrophy, sensory impairment, or cognitive dysfunction was seen in any patient.

With respect to parkinsonian symptoms, slowness and fatiguing of voluntary movement, poverty of movement, loss of facial expression, and reduction of blinking were observed in all patients. Finger tapping and foot tapping were performed slowly, with gradual reduction in amplitude. All patients showed a shuffling, short stepped gait with backward falling en bloc without corrective steps when equilibrium was momentarily upset. The posture of patient 1 was stooped. Patient 2 showed some emotional lability. Patients 1 and 2 showed freezing, particularly at initiation of gait, although ability to move otherwise was relatively preserved. Kinésie paradoxale was not observed. Levodopa was not effective in any patient.

Haematological and serum biochemistry tests gave normal results. Tests for human T lymphocytoparvovirus 1 and syphilis were negative in all patients. Cerebrospinal fluid test results were abnormal except in patient 2, who had slightly elevated protein (65 mg/dl). MR images of the cervical spine were normal except for non-specific degenerative changes without spinal cord compression. Cranial MR images showed generally mild cortical atrophy including the precentral gyrus in all patients. Nerve conduction studies were normal. Concentric needle electromyography (EMG) showed only focal neurogenic change in the right first dorsal interosseus muscle (patients 1 and 2), left gastrocnemius (patient 2), and right triceps (patient 1) without fulfilling revised El Escorial criteria. In all patients, motor evoked potentials showed markedly increased central motor conduction time or failed to evoke responses in the lower limbs.

FDG-PET showed significantly decreased glucose uptake in the area of the precentral gyrus (table 2, fig 1). The reduced glucose uptake extended to the medial frontal lobe including the prefrontal area (patients 1 and 2) and the anterior cingulate cortex (patients 2 and 3). In addition, patient 3 showed significantly low glucose uptake in the medial posterior parietal lobe. No significant reduction of glucose utilisation was observed in the basal ganglia in any patient. In addition, F-dopa and RACLO PET showed no significant reduction of uptake in the putamen and caudate nucleus compared with control subjects. NAA/Cr and Cho/Cr values in the putamen were also within the normal range.

DISCUSSION

We studied three patients with PLS who, in addition to the expected bulbospinal spasticity, presented poverty of movement, loss of facial expression with reduced blinking, frozen gait with initial hesitation, gradual reduction in finger and foot tapping rate and amplitude, and severe postural instability that mimicked parkinsonism. They also all showed symmetric spasticity, hyperreflexia, extensor plantar responses, and spastic dysarthria. No fasciculations, muscle tone changes, or atrophy were observed. Slight parkinsonian features were evident in all patients. The posterior parietal lobe showed a relative hypometabolism compared with the control group. FDG-PET studies showed a significant decrease of glucose utilisation in the cerebral cortex and basal ganglia. Despite the absence of any degenerative changes in the spinal cord, the precentral gyrus showed a significant reduction of glucose utilisation in all patients. This finding suggests the presence of a precentral corticobulbar tract dysfunction. The cognitive and motor dysfunction observed in all patients is consistent with a precentral corticobulbar tract dysfunction.
involvement. In addition, pathological examination of the three patients revealed widespread frontal lobe atrophy, or weakness were noted, and the sensory and other systems were uninvolved. No patient fulfilled the diagnostic criteria for amyotrophic lateral sclerosis, but all fulfilled the criteria for PLS proposed by Pringle et al. In the symptomatology of PLS, facial hypokinesia and lack of animation have been reported, but patients presenting not only generalised bradykinesia but also parkinsonian-like frozen gait with initial hesitation and severe postural instability have not been well described.

Several neurodegenerative diseases including multiple system atrophy, frontotemporal dementia, and progressive supranuclear palsy show pyramidal tract signs and parkinsonism. These signs have also been reported concomitant with amyotrophic lateral sclerosis and Parkinson’s disease. However, the present patients did not show symptoms clearly indicative of these diseases. Furthermore, characteristic signal abnormalities and morphologic changes were not observed on MR images. None of the three patients exhibited nigrostriatal system involvement on PET (FDG, F-dopa, and RACLO) and 1H-MRS images. In addition, there was no improvement with dopaminergic medication. Considering all observations, the parkinsonian symptoms in our three patients were unlikely to have been caused by nigrostriatal involvement.

Frozen gait and severe postural instability including falling backward en bloc without corrective steps are commonly reported in pathologically proved progressive supranuclear palsy, vascular parkinsonism, and advanced Parkinson’s disease. Although the pathophysiological background of such symptoms is unclear, several PET studies have emphasised the causal importance of medial frontal lobe involvement. In addition, pathological examination of patients showing frozen gait suggested that the frontal lobe as well as the basal ganglia would represent essential lesion sites. The most striking observation in the present study was that FDG-PET uptake showed significant reductions extending from the precentral gyrus to the medial frontal cortex in all patients, including the supplementary motor area and anterior cingulate cortex. In contrast, the basal ganglia of all three patients were well preserved according to PET and 1H-MRS. Considering these observations together, it would seem that not only generalised spasticity but also widespread frontal lobe impairment was responsible for the parkinsonian symptoms in our patients with PLS.

Recent MRI and PET studies have demonstrated widespread involvement of the precentral gyrus as well as ventrolateral, prefrontal, and anterior cingulate cortices in PLS. Although spasticity may mask the presence of other clinical features, precise radiological study is expected to shed further light on the pathophysiology and symptomatology of PLS. We believe that parkinsonian symptoms in PLS without nigrostriatal involvement can result from frontal lobe involvement.

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