When is Onuf’s nucleus involved in multiple system atrophy? A sphincter electromyography study

T Yamamoto, R Sakakibara, T Uchiyama, Z Liu, T Ito, Y Awa, K Yamamoto, M Kinou, T Yamanishi, T Hattori

Background: External anal sphincter (EAS) electromyography (EMG) abnormalities can distinguish multiple system atrophy (MSA) from Parkinson’s disease in the first five years after disease onset. However, the prevalence of the abnormalities in the early stages of MSA is unknown.

Objectives: To present EAS-EMG data in the various stages of MSA.

Methods: 84 patients with ‘probable’ MSA were recruited (42 men, 42 women; mean age 62 years (range 47 to 78); mean disease duration 3.2 years (0.5 to 8.0; <1 year in 25%); 50 cerebellar form (MSA-C), 34 parkinsonian form (MSA-P)). EAS motor unit potential (MUP) analysis and EMG cystometry were carried out in all patients.

Results: The overall prevalence of neurogenic change of the EAS MUP was 62%—52% in the first year after disease onset, increasing to 83% by the fifth year (p<0.05); it also increased with severity of gait disturbance (p<0.05), storage and voiding disorders, and detrusor sphincter dyssynergy (NS). The neurogenic change was not correlated with sex, age, MSA-P/C, postural hypotension, constipation, erectile dysfunction in men, underactive or acontractile detrusor, or detrusor overactivity. In 17 incontinent patients without detrusor overactivity or low compliance, urinary incontinence was more severe in those with neurogenic change than in those without (p<0.05).

Conclusions: Involvement of Onuf’s nucleus in MSA is time dependent. Before the fifth year of illness, the prevalence of neurogenic change does not seem to be high, so a negative result cannot exclude the diagnosis of MSA.

Abbreviations: EAS, external anal sphincter; MSA, multiple system atrophy; MSA-C, cerebellar form of multiple system atrophy; MSA-P, parkinsonian form of multiple system atrophy; MUP, motor unit potential; PVR, post-void residual
PVR volume measured by transurethral catheterisation was experienced in 25, monthly in 14, weekly in 13, and daily in 32. Urinary incontinence (storage disorder) was never experienced (score of 0) in none, independent walking (score 1–3) in 23, walking with one stick (score 4–5) in 22, walking was absent (score of 0) in none, independent walking (score 1–3) in 23, walking with one stick (score 4–5) in 22, walking was absent (score of 0) in none, independent walking (score 1–3) in 23, walking with one stick (score 4–5) in 22, walking was absent (score of 0) in none, independent walking (score

All patients gave their informed consent before participating in the study. Statistics were analysed using the χ² test.

RESULTS

Patients’ functional ability and urinary disorders were as follows. Gait disorder (as measured by the international cooperative ataxia rating scale, walking capacities subscale) was absent (score of 0) in none, independent walking (score 1–3) in 23, walking with one stick (score 4–5) in 22, walking with aid (score 6–7) in 28, and wheelchair bound (score 8) in 11. All patients except for two had urinary symptoms. Urinary incontinence (storage disorder) was never experienced in 25, monthly in 14, weekly in 13, and daily in 32. The PVR volume measured by transurethral catheterisation was <100 ml in 35, 100–200 ml in 27, and >200 ml in 22.

The overall prevalence of neurogenic change was 62% in our patients—52% in the first year after disease onset, and 83% by the fifth year. Thus the prevalence of neurogenic change increased during the course of the illness (p<0.05) (fig 1). Changes in the percentage of MUPs with a duration of more than 10 ms, including patients undergoing repeated studies, are shown in fig 2. Many of the patients who underwent repeated studies had normal to mild abnormality at the initial assessment, and this became marked during the course of the illness, although in two cases the EAS EMG findings remained normal. The prevalence of neurogenic change was 47% in patients who walked independently, but 82% in those who were wheelchair bound (p<0.05) (table 1). Similar but non-significant changes were found for urinary incontinence (59% of patients without urinary incontinence had neurogenic change v 63% with incontinence); post-void residual (58% with PVR <200 ml v 73% in those with PVR >200 ml); and detrusor sphincter dyssynergy (60% in patients without detrusor sphincter dyssynergy v 73% in those with dyssynergy). The neurogenic sphincter EMG results were not clearly correlated with sex, age, MSA-P/C, postural hypotension, constipation, erectile dysfunction in men, underactive or acontractile detrusor, or detrusor overactivity.

Seventeen of the 56 incontinent patients (seven men, 10 women) lacked abnormal bladder contraction during the filling phase, although 12 of the 17 also had PVR (mean 135 ml (range 30 to 500)). In the 17 patients, urinary incontinence was more severe in those with neurogenic change (n = 8; monthly, 0; weekly, 1; daily, 7) than in those without (n = 9; monthly, 4; weekly, 2; daily, 3) (p<0.05).

DISCUSSION

Results of the EAS EMG in over 500 MSA patients have already been reported, with an abnormality rate of more than 70% in many studies. Compared with those findings, the overall prevalence rate of neurogenic change in the present study was slightly lower (62%). This is presumably because up to 25% of our patients had a disease duration of one year or less, as early referral to our department has increased recently, and patients are able to come to us without referral. Thus the diagnosis of MSA in such early cases should be made with extreme caution. In addition to the clinical diagnostic criteria, we added an imaging study to ensure the diagnosis in all patients, and we carried genetic analyses as far as possible. Although the EAS MUP abnormalities allow one to distinguish MSA from Parkinson’s disease in the first five years after disease onset, the prevalence of the abnormalities in the early stages of MSA (or, conversely, the false negative rate) has not been established up to now. We report here for the first time that in our patient cohort the prevalence of neurogenic change was 52% in the first year after disease onset, increasing to 83% by the fifth year (p<0.05). Among the patients who underwent repeated studies, many were normal or had only mild abnormality at the initial examination, but the abnormality became marked during the course of their illness. Therefore, as expected, the involvement of Onuf’s nucleus in MSA is time dependent. In the early stages of illness, the prevalence of neurogenic change in MSA does not seem to be high. In two patients who underwent repeated studies, the EAS EMG findings remained normal. We do not know whether there are some
MSA patients who never develop neurogenic change during the course of their illness. However, Wenning et al reported three patients with normal EAS EMG and necropsy confirmation of MSA.34 Thus the negative result cannot exclude the diagnosis of MSA.

The prevalence of neurogenic change also increased with the severity of gait disturbance (p<0.05) in the present study. However, it was not related to postural hypotension (reflecting adrenergic nerve dysfunction), erectile dysfunction in men (presumably reflecting cholinergic and nitrate oxidergic sphincter aetiology). Urinary incontinence was more severe overactivity or a low compliance detrusor, which might have noted urinary incontinence in 17 patients without detrusor incontinence in MSA is urge incontinence, which mostly causative relation. In the former, the most common urinary PVR. The latter may only reflect a parallel and not a storage disorder (incontinence) and voiding disorder (large volume; UD, underactive detrusor).

In conclusion, the results of the present study suggest that the involvement of Onuf’s nucleus in MSA is time dependent. In the early stages of the illness, the prevalence of neurogenic change does not seem to be high, so a negative result cannot exclude a diagnosis of MSA.

| Table 1 Neurogenic sphincter EMG and clinical variables other than duration of illness

<table>
<thead>
<tr>
<th>Patients with neurogenic sphincter EMG</th>
<th>Patients with neurogenic sphincter EMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>27/42</td>
</tr>
<tr>
<td>Age &lt; 60 years</td>
<td>22/39</td>
</tr>
<tr>
<td>MSA-C</td>
<td>29/30</td>
</tr>
<tr>
<td>Independent walking (1–3)</td>
<td>11/23</td>
</tr>
<tr>
<td>Postural hypotension –</td>
<td>30/48</td>
</tr>
<tr>
<td>Constipation –</td>
<td>40/66</td>
</tr>
<tr>
<td>Erectile dysfunction –</td>
<td>4/5</td>
</tr>
<tr>
<td>Continent</td>
<td>15/25</td>
</tr>
<tr>
<td>RU &lt; 200 ml</td>
<td>36/62</td>
</tr>
<tr>
<td>Detrusor overactivity –</td>
<td>14/26</td>
</tr>
<tr>
<td>UD/AD –</td>
<td>29/52</td>
</tr>
<tr>
<td>DSD –</td>
<td>44/73</td>
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</tbody>
</table>

*International cooperative ataxia rating scale, walking capacities subscale.
AD, achondroplastic detrusor; DSD, detrusor sphincter dyssynergy; MSA, multiple system atrophy; RU, residual urine volume; UD, underactive detrusor.

REFERENCES

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