Structural and functional neuroimaging in Myoclonus-Dystonia
Beukers, R.J.

Citation for published version (APA):
Beukers, R. J. (2011). Structural and functional neuroimaging in Myoclonus-Dystonia
Deep Brain Stimulation of the Pallidum is effective and might stabilize striatal dopamine D2 receptor binding in Myoclonus-Dystonia

R.J. Beukers¹, M.F. Contarino¹, J.D. Speelman¹, P.R. Schuurman², J. Booij³, M.A.J. Tijssen¹

¹Academic Medical Centre, University of Amsterdam, department of Neurology
²Academic Medical Centre, University of Amsterdam, department of Neurosurgery
³Academic Medical Centre, University of Amsterdam, department of Nuclear Medicine

Submitted

Financial Disclosure
This study was supported by the following research grants: NWO-VIDI grant (project 016.056.333, to R.J.B. and M.A.J.T.), and the ONWA-meetfonds (ABIP).
Abstract

Purpose: To assess clinical efficacy of deep brain stimulation of the pallidum in Myoclonus-Dystonia patients, and to compare pre- and postoperative striatal dopamine D$_2$ receptor availability.

Methods: Clinical parameters were scored using validated rating scales for myoclonus and dystonia. Dopamine D$_2$ receptor binding of three patients was studied before surgery and approximately two years postoperatively using [123-I]iodobenzamide Single Photon Emission Computed Tomography. Two patients who did not undergo surgery served as controls.

Results: Clinically, the 3 Myoclonus-Dystonia patients improved 83%, 17% and 100%, respectively on the myoclonus rating scale and 78%, 23% and 65% on the dystonia rating scale after deep brain stimulation. Dopamine D2 receptor binding did not change after surgery. In the two control subjects, binding has lowered further.

Conclusions: These findings confirm that deep brain stimulation of the pallidum has beneficial effects on motor symptoms in Myoclonus-Dystonia and suggest this procedure might stabilize dopamine D2 receptor binding.
Effect of DBS on clinical features and D2R

Introduction

Myoclonus-Dystonia (M-D) is a movement disorder clinically characterized by myoclonic jerks and dystonic postures or movements of the upper body, often combined with psychiatric symptoms such as depressed mood or anxiety. M-D is autosomal dominantly inherited and is frequently caused by mutations in the epsilon-sarcoglycan gene (SGCE) on chromosome 7q21 (DYT-11).

Deep brain stimulation (DBS) of the globus pallidus internus (GPI) is currently the most promising technique for treatment of patients with severe medically refractory dystonia. Three randomized controlled trials investigated this procedure in primary generalized dystonia and found significant clinical improvement on the Burke-Fahn-Marsden Dystonia Rating Scale (BFMDRS) after 6 and 12 months, sustained after a three year follow up period. More specifically on M-D, a recent study of GPI-DBS in 5 M-D patients found striking beneficial effects on dystonia and particularly on myoclonus as did another study, comparing GPI-DBS and thalamic nucleus ventralis intermedius (VIM)-DBS in 10 M-D patients with either target. Additional case reports describe good response of motor symptoms after VIM-DBS or GPI-DBS in M-D patients. To summarize, GPI-DBS has been reported in only 19 M-D patients so far and positive results were reported, although no class I or II trial has been reported.

Neuronal models of dystonia have postulated hyperactivity of the direct putamino-pallidal pathway with reduced inhibitory output of the internal segment of the globus pallidus (GPI), with subsequently increased thalamic input to the (pre-) motor cortex, resulting in excessive motor cortex excitation. Previously, our group showed statistically significantly lower striatal dopamine D2 receptor (D2R) binding in M-D patients, possibly due to decreased D2R availability or increased levels of endogenous dopamine and consequently competitive D2R occupancy, consistent with a mouse model showing increased striatal dopamine and metabolites in SGCE knockout mice.

In Parkinson’s disease several studies regarding the effect of DBS on D2R have been published. Acute stimulation (stimulator on versus off) of the subthalamic nucleus (STN) did not induce sufficient endogenous dopamine to influence D2R binding significantly. Hesse and co-workers showed a statistically significant increase of IBZM binding to D2R after STN-DBS (pre- versus post-surgery; stimulator on versus off)
Structural and functional neuroimaging in Myoclonus-Dystonia

However, the opposite was found after GPi-DBS. To our knowledge, studies comparing D2R availability before and after DBS have never been performed in any type of dystonia. The first aim of this study is to report the clinical effects of GPi-DBS on M-D patients who had surgery in our centre. Moreover, as our previous study showed decreased striatal receptor binding in M-D patients, our second aim was to examine whether D2R may increase (reflecting normalization) after GPi-DBS.

Methods

Patients:

Three male M-D patients (ages 29, 48 and 48 yrs) at the time of the first Single Photon Emission Computed Tomography (SPECT) scan, in whom the DYT-11 mutation was genetically confirmed (1 basepair insertion: 885Tins, 304 C>T and 619-620 delAG, respectively), were studied using [123-I]IBZM SPECT before and approximately two years after bilateral simultaneous GPi DBS implant. Surgery was performed under local anesthesia, with the use of intraoperative microelectrode recordings and test stimulation. Post-operative CT-scans were co-registered with the frame-based pre-operative MRI to confirm positioning of the electrodes in the GPi. The pre-operative [123-I]IBZM SPECT scans of these three patients and of 12 other mutation-positive M-D patients were reported previously. From this same study population, two genetically confirmed M-D patients who had not received DBS agreed to be re-scanned after approximately three and a half years to serve as controls (both mutation 619-620 delAG, related to subject 3). None of the patients had a history of neuroleptic drug usage or any other dopamine receptor blocking agent. Dystonia and myoclonus were assessed at the time of the first and second scan using the Burke-Fahn-Marsden Dystonia Rating Scale (BFMDRS) and the Unified Myoclonus Rating Scale. Subject 2 was the only one who had received Botulinum toxin injection in cervical muscles approximately 9 weeks prior to the first scan; for this reason, in this subject the myoclonus and dystonia scores of his pre-operative assessment were used approximately 3 months after his last botulinum toxin injection. Patient characteristics and time-frames of scanning are summarized in Table 1. All subjects gave written informed consent and the study was approved by the local medical ethics committee.
Effect of DBS on clinical features and D2R

Data acquisition:

IBZM-SPECT methods, for data acquisition and processing were identical for all scans. Shortly, subjects received a potassium iodide solution to block thyroid uptake of free radioactive iodide. Approximately 100 MBq of \([123\text{-I}]\)IBZM was given intravenously as bolus, followed by continuous infusion of 25 MBq/h to achieve unchanging regional brain activity levels. Acquisition of the images was started 2 hours after the bolus injection.

SPECT studies were performed using a 12-detector single slice brain-dedicated scanner (Neurofocus 810, which is an upgrade of the Strichmann Medical Equipment).

Data processing:

Attenuation correction of all images was performed. Images were reconstructed in 3D mode (http://www.neurophysics.com). These 3D reconstructed images were then randomly numbered by an independent physician and analyzed blindly by one observer (RJB). For quantification, a region-of-interest (ROI) analysis was performed. For analysis of striatal \([123\text{-I}]\)IBZM binding, the ratio of specific striatal to occipital binding (representing non-specific binding) was calculated by averaging four transverse slices, representing the most intense striatal binding. Standard templates with fixed ROIs were manually placed on the striatum and occipital cortex, and then the ratio of striatal to occipital binding (SOR) was calculated as follows: (total striatal binding – occipital binding)/occipital binding. The analyses of the 3D reconstructed images was performed again the following week, variability and the intraclass correlation coefficient were then calculated to assess intra-observer reliability.

Data analysis:

Symmetry of the left and right SORs was calculated using a Wilcoxon signed ranks test in all patients, this analysis was performed using SPSS version 17. Because the number of patients is too small to perform meaningful statistics between groups, none were calculated. Instead, all data is presented in Tables 1 and 2. All videos used to assess the UMRS and BFMDRS were scored by a movement disorder specialist (JDS),
Structural and functional neuroimaging in Myoclonus-Dystonia

Results

Clinical characteristics

Patient characteristics are summarized in Table 1. The patients who underwent DBS all reported significant improvement of their symptoms at the time of the second [123-I]IBZM SPECT scan. When formally scored on video, Gpi-DBS patients had improved 78%, 23% and 65%, respectively on the BFMDRS and 83%, 17% and 100% on the UMRS. One patient not having undergone DBS improved on the BFMDRS (77%) and on the UMRS (17%), the other patient showed no change on the clinical rating scales.

Table 1: subject characteristics

<table>
<thead>
<tr>
<th></th>
<th>M/ F</th>
<th>Age</th>
<th>BFMDRS/ UMRS at first scan (before Gpi-DBS)</th>
<th>BFMDRS/ UMRS at second scan (after Gpi-DBS)</th>
<th>% change</th>
<th>Stimulation settings L/R</th>
<th>Time after Gpi DBS</th>
<th>Time between scans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M 29</td>
<td>18/46</td>
<td>4/8</td>
<td>-78/-83</td>
<td>3,5V 120us/130 Hz</td>
<td>2.8V 90us/130 Hz</td>
<td>27mo</td>
<td>30 mo</td>
</tr>
<tr>
<td>2</td>
<td>M 48</td>
<td>26/70</td>
<td>20/58</td>
<td>-23/-17</td>
<td>3,2V 60us/130Hz</td>
<td>3,0V 60us/130Hz</td>
<td>12mo</td>
<td>28 mo</td>
</tr>
<tr>
<td>3</td>
<td>M 48</td>
<td>20/100</td>
<td>7/0</td>
<td>-65/-100</td>
<td>3,0V 60us/130Hz</td>
<td>-</td>
<td>19mo</td>
<td>29 mo</td>
</tr>
<tr>
<td>4</td>
<td>M 53</td>
<td>4/4</td>
<td>4/4</td>
<td>0/0</td>
<td>-</td>
<td>No DBS</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>M 51</td>
<td>26/12</td>
<td>6/10</td>
<td>-77/-17</td>
<td>No DBS</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>


[123-I]IBZM SPECT

Variability between the two analyses performed with a one week interval was 3.7%, with an intra-class correlation coefficient of 93.5%. Results of second analysis are presented in Table 2. No asymmetry between left and right SORs was found, either at the first or at the second scan (first scan p=0.50; second scan p=0.69 respectively). No consistent differences between the measurement before and after DBS are discernable (SOR mean: one unchanged, one higher, one lower). Of both subjects who did not have DBS, the mean SOR was lower after surgery compared to before surgery.
Effect of DBS on clinical features and D2R

Table 2: SORs before and after GPI-DBS.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Before GPI-DBS</th>
<th>After GPI-DBS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SOR Left</td>
<td>SOR Right</td>
</tr>
<tr>
<td>1</td>
<td>0.90</td>
<td>0.85</td>
</tr>
<tr>
<td>2</td>
<td>1.06</td>
<td>0.90</td>
</tr>
<tr>
<td>3</td>
<td>1.04</td>
<td>1.06</td>
</tr>
<tr>
<td>No DBS, first scan</td>
<td>1.14</td>
<td>1.14</td>
</tr>
<tr>
<td>4</td>
<td>1.05</td>
<td>0.94</td>
</tr>
<tr>
<td>Table legend: GPI-DBS: globus pallidus internus deep brain stimulation, SOR: striatal to occipital ratio.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Discussion

GPI-DBS improved greatly myoclonus and, to a lesser extent dystonia, consistent with earlier studies.\(^8,9\) In our previous study, we found decreased D2R in 15 M-D patients, possibly reflecting an increase in endogenous striatal dopamine.\(^15\) In this study, no large effect of GPI-DBS on D2R binding potential in M-D patients was observed despite obvious clinical benefit on myoclonus and dystonia rating scales. This lack of change is consistent with studies regarding STN-DBS in Parkinson's disease, but not consistent with the GPI-DBS study describing normalization (decrease) of D2R binding potential in Parkinson's disease. A drawback of this study is the small number of patients. Interestingly, in both M-D patients who did not had surgery, a clear decrease of D2R binding was observed. The changes on the clinical rating scales in patient 5 might be attributed to symptom variability over time or variable effect of medication. Progression of M-D could be associated with a further decline of D2R, which may be mitigated by DBS of the GPI. Although in our previous study we did not find an association between disease severity and D2R across patients, this might be true for the individual patient. The decline of SORs in non-operated patients is faster than the 5% per decade previously reported in the literature in normal subjects\(^24\); for this reason it is unlikely that the slightly longer time interval between the first and second scan in this group is the cause of the lowered D2R binding. Future imaging studies on the effects of disease progression and the effects of DBS in M-D are needed to test this hypothesis.

In conclusion, this study confirms the clinical efficacy of GPI-DBS in M-D, that is not paralleled by any discernable changes on the dopaminergic pathways as measured with \([123-I]IBZM\) SPECT. In non-operated M-D patients D2R binding seems to have lowered even further, possibly reflecting a stabilizing effect of GPI-DBS on the dopaminergic pathways.
References

Effect of DBS on clinical features and D2R


