Pontine atrophy precedes cerebellar degeneration in spinocerebellar ataxia 7: MRI-based volumetric analysis

O Y Bang, P H Lee, S Y Kim, H J Kim, K Huh

Background and objective: Spinocerebellar ataxia 7 (SCA7) is characterised by cerebellar ataxia and visual loss. The aim of the present study was to elucidate the magnetic resonance imaging (MRI) findings characteristic of patients with SCA7.

Methods: Twenty patients with SCA (eight SCA3, three SCA6, and nine SCA7) and 20 control subjects underwent an MRI-based volumetric analysis.

Results: The pontine volume in patients with SCA7 was decreased by a greater amount than in patients with other types of SCA (p<0.01), whereas the cerebellar volume was not different from that in other types of SCA (p>0.05). Pontine atrophy was a consistent finding in all patients with SCA7 regardless of the degree of cerebellar atrophy or the severity or duration of illness. In contrast, cerebellar atrophy was not found in those with a short duration of illness or mild ataxia, but became prominent as the severity and duration of illness progressed.

Conclusions: Our study suggests that neurodegeneration is ongoing during the life of individuals with SCA7, and that the primary pathology in these individuals involves the brainstem rather than the cerebellum. In addition, pontine atrophy is a prominent, consistent finding in SCA7, and may help in establishing the clinical diagnosis of SCA7.

Spinocerebellar ataxia type 7 (SCA7) is a neurodegenerative disorder caused by a CAG/polyglutamine repeat expansion mutation in the gene encoding the ataxin 7 protein. This type of mutation is known to cause nine inherited neurodegenerative disorders, Huntington’s disease (HD), dentatorubral pallidoluysian atrophy (DRPLA), and SCA 1, 2, 3, 4, 5, 6, and 7.1

SCAs form a heterogeneous group of dominantly inherited disorders characterised by progressive ataxia that results from degeneration of the cerebellum and its afferent and efferent connections. Although cerebellar atrophy is a consistent feature in most symptomatic SCA patients, the involvement of extracerebellar structures varies with the type of SCA. Multiregional brain hypometabolism has been observed in SCA, even in SCA6,2 in which selective cerebellar atrophy is consistently observed,3 suggesting that the brain dysfunction associated with SCAs is not limited to the cerebellum. However, the initial site of involvement in each type of SCA remains unclear.

With the availability of magnetic resonance imaging (MRI), it has become possible to study the brain morphology in SCA in vivo. Previous MRI studies revealed significant differences in the pattern and extent of the morphological alterations with different SCA mutations. There is more severe cerebellar and brainstem atrophy in SCA2 than in SCA1 and SCA3,4,5 and there is relatively selective involvement of the cerebellum in SCA6.6 MRI-based volumetric analysis appears to be of particular importance because the neuropathological abnormalities observed in postmortem examinations may only reflect far advanced pathological changes. To the best of our knowledge, MRI-based volumetric analysis of patients with SCA7 has not been carried out previously.

This study elucidates the characteristic MRI findings of SCA7 compared with other SCA types. We hypothesised that a morphometric analysis of patients with SCA7 could reveal the disease course in the early stage of cerebellar ataxia. Therefore, we conducted a volumetric analysis of nine genetically confirmed SCA7 patients, and compared the findings with those of other SCA patients and normal control subjects.

METHODS

We studied 20 patients manifesting progressive ataxia as the main clinical finding: nine patients with SCA7 from six families and 11 patients with other types of SCA (eight SCA3 and three SCA6). Informed consent was obtained from all enrolled patients.

For the molecular genetic studies, previously published primer sequences and conditions for the polymerase chain reaction were used to quantify the trinucleotide repeats of SCA 1, 2, 3, 6, 7, and DRPLA.7,8 We also screened the patients who lacked an expanded pathological allele and had a maternal inheritance pattern for known mutations associated with mitochondrial encephalopathy with ragged red fibre (MERRF), as described previously.9,10 We excluded patients with a clinical diagnosis of possible or probable multisystem atrophy following the consensus statement published by Gilman et al.11 Those with MERRF gene mutations. Twenty age and sex matched control subjects with no evidence of organic brain disease, such as migraine or tension headache, were selected for determination of reference values for morphometric analysis.

The neurological examination carried out had a specific focus on certain clinical features of brainstem involvement (pyramidal and extrapyramidal symptoms, voluntary and involuntary slow saccades, and dysphagia), and severity of ataxia. The results were graded as follows: I, walks without help; II, walks with some help; III, needs help to walk; IV, needs help to stand; V, bed-ridden.

The subjects were examined using 1.5-T MRI. MRI-based volumetric analysis was performed according to previously

Abbreviations: DRPLA, dentatorubral pallidoluysian atrophy; HD, Huntington’s disease; MRI, magnetic resonance imaging; SCA, spinocerebellar ataxia
published methods. The axial and sagittal T1-weighted magnetic data (repetition time, TR = 500 ms; echo time, TE = 8 ms; slice thickness, 4 mm; gap, 1 mm) were processed using a commercially available computer workstation (Scion Image Beta 4.02; Scion Corp., Frederick, MD). Brain segmentation was performed manually on all controls and patients with SCA by a neuroradiologist who was blinded to the clinical data. Thepons were segmented first. The pontine volume was calculated by summation and linear interpolation of the segmented axial slices. All slices between the inferior limit of segmentation, set at the lowest point of thepons, and the superior point of the pons were measured. Thepontes and cerebellum were separated by transecting thecerebellar peduncles along the plane of their entrance intothepons, namely at the shortest segment between theanterior recess of the fourth ventricle and the junctionbetwenthelateral border of the peduncles and the cerebellar cortex. Using this technique, the peduncles were largelyexcluded from the pontine volume. The cerebellar volume wascalculated by summation and linear interpolation of thesegmented sagittal slices. The pontine and cerebellum volumeswere computed by multiplying the measured area per slice bythe section thickness. Both volumes were normalised to thetotal intracranial volume, measured in cross-section, toreduce interindividual variation and are expressed as thepercentage of the respective total intracranial volume. Otherareas of the brain were not measured.

The differences between the groups were analysed usingthe Kruskal–Wallis H-test with the Mann–Whitney U-test asapost hoc analysis. The relationships between the variousclinical parameters and the pontine or cerebellar volume andbetween the CAG repeat length and the pontine or cerebellarvolumewere evaluated using a linear regression analysis forthe SCA7 patients. Probability values less than 0.05 wereaccepted as significant.

RESULTS

Volumetric analysis was performed in nine SCA7 patients,eight SCA3 patients, three SCA6 patients, and 20 controlsubjects. There were no significant differences in the clinicalfeatures (age, duration of illness, age at onset, and severity ofataxia) of patients with SCA7 and those with other types ofSCA (p > 0.05).

The clinical and volumetric data for the nine patients withSCA7 are shown in Table 1. All the patients showed thetypical pattern of autosomal dominant cerebellar ataxia andexhibited visual loss with pigmentary retinopathy andophthalmoscopy. Extracerebellar symptoms, such as pyramidal and extrapyramidal symptoms, voluntary and involuntaryslow saccades, and dysphagia, were found more frequently inpatients with severe pontine atrophy (r = 0.722, p < 0.05). Ofthe extracerebellar symptoms, slowing of saccades was mostfrequently observed (Table 1). However, an increased numberof CAG repeats did not significantly influence the volume ofthe cerebellum (r = 0.256, p > 0.05) or pons (r = 0.024,p > 0.05).

Figure 1A shows the similarity in the degree of pontine atrophyin patients with different severity of illness. The degree of pontine atrophy in a patient (case 1, fig 1A, left) with disease of 22 years duration and severe cerebellar symptoms (wheelchair bound) was similar to that of a patient (case 4, fig 1A, right) with disease of six years duration and mild cerebellar symptoms (walks without help) (pons volume/total intracranial volume, 0.38% vs 0.33%).

Figure 1(B, C) show the correlation between pontine orcerebellar atrophy and the duration of illness or severity ofataxia in the patients with SCA7. The degree of cerebellar atrophy was significantly correlated with both the duration of illness (r = 0.664, p < 0.05, fig 1B) and the severity of ataxia (r = 0.673, p = 0.05, fig 1C). However, there was no significant correlation between pontine atrophy and any clinical parameters measured—that is, duration of illness, age of onset, or severity of ataxia (p > 0.05 in all cases). Pontine atrophy was consistently observed in all the patients with SCA7, including those with minimal ataxia and illness of very short duration. Conversely, cerebellar atrophy was not found in either of the two patients with illness of short duration (<4 years) and in two of the three patients with mild ataxia (walks without help).

Figure 2 summarises the MRI findings of the 20 patientswith SCA and the 20 control subjects. The volumes of boththe cerebellum and pons differed between the patients withSCA7 and control subjects (p < 0.001 in both cases; 95%confidence interval (CI) of the difference, 1.822 to 3.54 and0.348 to 0.493, respectively) (Fig 2A). Although the degreeof pontine atrophy correlated with the cerebellar atrophy(r = 0.884, p = 0.004), pontine atrophy was the mostconsistent MRI finding in SCA7, regardless of the presence orabsence of cerebellar atrophy (Fig 2A).

The cerebellar volume did not differ between the patients withSCA7 and those with other types of SCA (p = 0.239) (Fig 2B). In contrast, compared with the patients with other SCATypes, the patients with SCA7 had significant pontine atrophy(SCA3 vs SCA7, p = 0.002; SCA6 vs SCA7, p = 0.009).

DISCUSSION

Clinical implications of our findings

SCA7 is characterised by cerebellar ataxia and visual loss, andsome characteristic clinical features of molecularly confirmedSCA7 have been reported previously. However, the diagnosisof SCA7 based on clinical assessment has limited accuracy because there is marked variation in the age of onset, initial symptoms, and associated signs. It has been reported that decreased visual acuity and pigmentary macular degeneration are not necessarily found in patients with SCA7 and may be observed in other SCAs.

In this respect, MRI may be helpful in revealing significantdifferences in the pattern and extent of the morphologicalalteration in SCA7 and other SCAs. In this study, we observedsevere pontine atrophy in the patients with SCA7; this wasmuch more prominent than in other types of SCA (SCA3 andSCA6) and was consistently found in patients with varyingdegrees of cerebellar atrophy and severity of illness. Pontineatrophy has been reported in other SCAs, even in SCA6, although it is quite unexpected for such patients to have pontine atrophy with their cerebellum spared, which wefound in our patients with SCA7. All patients with SCA7 maynot have the neuroradiological characteristics observed inthis study, yet pontine atrophy was a prominent finding inour patients with SCA7. Our results suggest that assessmentof pontine involvement on MRI substantiates the clinicaldiagnosis of SCA7. The difference between the ages of the patients with SCA7, (mean 40.7 (SD 12.8) years), those with other SCAs (37.9 (9.1) years), and normal control subjects (40.4 (11.2) years) did not affect the baseline volumetric data. The same was true for sex: SCA7 (male, 67%), other SCAs (male, 45%), and normal control subjects (male, 50%).

In this study, both the pontine and cerebellar volumeswere normalised to the total intracranial volume, rather thanmeasuring each volume directly, because firstly, in degenerative diseases in which the whole brain is subject to atrophy, the total intracranial volume may provide the best available estimate of the premorbid brain volume, and secondly, measuring the total intracranial volume allows the whole brain and regional volumetric measures to be normalised for head size. The pontine volumes of the female control subjects included in this study were significantly lower than those of the male control subjects (p = 0.038), but
when we used this method of volumetric measurement, neither the pontine nor the cerebellar volumes differed as regards epidemiological factors such as age and sex.

Recently, Martin et al. suggested that the term “mildly affected patient” should be reserved for those who show a definite degree of cerebellar atrophy without pontine involvement on MRI. However, they used visual inspection rather than volumetric analysis. In our volumetric analysis, pontine atrophy was a consistent finding, and we did not find a significant correlation between pontine atrophy and any of the clinical parameters measured or the CAG repeat length. Further studies with more subjects are needed to confirm possible relationships between the clinical parameters or CAG repeat length and the degree of pontine or cerebellar atrophy.

Table 1  Clinical and neuroimaging findings of nine patients with spinocerebellar ataxia 7

<table>
<thead>
<tr>
<th>Case</th>
<th>No. of expanded CAG repeats</th>
<th>Sex/age</th>
<th>Age at the onset of symptoms</th>
<th>Duration of disease in years (age at walking aid)</th>
<th>Ataxia scale</th>
<th>Extracerebellar symptoms</th>
<th>Volume of the posterior fossa structures/total intracranial volume</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pons (%)</td>
</tr>
<tr>
<td>1</td>
<td>45/10</td>
<td>F/59</td>
<td>37</td>
<td>22 (40)</td>
<td>5</td>
<td>Bulbar, EOM, PS</td>
<td>0.38</td>
</tr>
<tr>
<td>2</td>
<td>47/10</td>
<td>M/37</td>
<td>32</td>
<td>4 (self ambulatory)</td>
<td>1</td>
<td>EOM</td>
<td>0.63</td>
</tr>
<tr>
<td>3</td>
<td>43/10</td>
<td>F/52</td>
<td>39</td>
<td>13 (self ambulatory)</td>
<td>1</td>
<td>EOM, PS</td>
<td>0.35</td>
</tr>
<tr>
<td>4</td>
<td>47/10</td>
<td>M/40</td>
<td>34</td>
<td>6 (37)</td>
<td>2</td>
<td>Bulbar, EOM, PS</td>
<td>0.33</td>
</tr>
<tr>
<td>5</td>
<td>50/8</td>
<td>M/29</td>
<td>22</td>
<td>7 (self ambulatory)</td>
<td>1</td>
<td>EPS</td>
<td>0.38</td>
</tr>
<tr>
<td>6</td>
<td>46/10</td>
<td>M/33</td>
<td>29</td>
<td>4 (self ambulatory)</td>
<td>1</td>
<td>EOM, PS</td>
<td>0.61</td>
</tr>
<tr>
<td>7</td>
<td>44/12</td>
<td>M/59</td>
<td>45</td>
<td>14 (56)</td>
<td>3</td>
<td>Bulbar, EOM, PS, EPS</td>
<td>0.34</td>
</tr>
<tr>
<td>8</td>
<td>51/10</td>
<td>F/29</td>
<td>15</td>
<td>13 (22)</td>
<td>4</td>
<td>Bulbar, EOM, PS, EPS</td>
<td>0.31</td>
</tr>
<tr>
<td>9</td>
<td>NC</td>
<td>M/28</td>
<td>19</td>
<td>9 (24)</td>
<td>5</td>
<td>EOM, PS</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Bulbar, bulbar symptoms; EOM, extraocular movement disturbance; PS, pyramidal symptoms; EPS, extrapyramidal symptoms; NC, not checked

Figure 1  Correlation of clinical parameters with pontine and cerebellar volumes in nine patients with spinocerebellar ataxia 7. (A) Similar degree of pontine atrophy (0.38% v 0.33%) in patients with different severity of illness: (left) patient with long duration of disease and severe cerebellar symptoms and (right) patient with short duration of disease and mild cerebellar symptoms. Correlation of pontine and cerebellar volumes with (B) the duration and (C) severity of illness. *Inverse correlation of cerebellar volume and the duration of illness. /Inverse correlation of cerebellar volume and the severity of illness. The grey area indicates the range of 2 SD values of normal controls: cerebellum, mean 11.14 (range of 2 SD 9.58–12.70); pons, mean 0.84, (range of 2 SD 0.70–0.98).
Neuropathological changes in patients with SCA7
The degenerative pattern may be specific enough to allow the diagnosis of SCA on neuropathological grounds. Our volumetric data are in good agreement with the neuropathological data of Martin et al., who found pontine atrophy to be a prominent feature in patients with SCA7. A neuropathological study of patients with SCA7, including a nearly asymptomatic patient, showed involvement of the pyramidal pathways and motor neurones of the brainstem and spinal cord, in addition to cerebellar atrophy affecting both the spinocerebellar and olivocerebellar tracts and the cerebellar cortex and efferent cerebellar pathways.

Using an ataxin 7 immunoreactivity test, Lindenberg et al. recently reported that the intensity of staining differed from region to region; staining was relatively strong in the inferior olive, dentate nucleus, and pontine nuclei, whereas the cerebellum, which was also affected, stained faintly. Moreover, Holmberg et al. found very few nuclear inclusions in the cerebellum, a severely affected site in SCA7; ubiquitinated nuclear inclusions, a common characteristic in polyglutamine disorders, were frequently observed in the brainstem (14–24%), but not in the cerebellum (<1%). Our findings are in good agreement with this study in that pontine involvement rather than cerebellar atrophy was a consistent finding in SCA7. However, despite myriad studies of ataxin 7 distribution in the brain and non-central nervous system tissues of normal and SCA7 individuals, the distribution of ataxin 7 and the relation between ataxin 7 and nuclear inclusions remain controversial.

Distinct neuropathological pattern in SCA7
SCA2 also shows pontine atrophy that is complete quite early during the course of SCA2; however, SCA2 differs from SCA7 in that it shows particularly widespread degeneration of neuronal populations, including regions thought to be typically affected in HD.

Unlike SCA7 and SCA2, SCA6 displays predominant Purkinje cell degeneration as the characteristic pathological feature, and shows neuronal degeneration confined to the cerebellar Purkinje cells and, to a lesser degree, the granular cells, with no structural involvement of other parts of the central nervous system. In the more common SCA3, the neuropathological findings of autopsied brains include neuronal cell loss in the dentate nucleus of the cerebellum, pontine nuclei, substantia nigra, and inner segment of the globus pallidus, and the preservation of the inferior olivary nucleus and Purkinje cells of the cerebellar cortex. In a case report, SCA3 showed a pattern consistently different from SCA7, in that spinopontine involvement predominated over cerebellar involvement, no olivary involvement was seen, and the globus pallidus was clearly affected.

Early involvement of the brainstem in patients with SCA7
While SCA is diagnosed primarily from motor signs, especially ataxia, a recent study suggests that other signs, such as the slowing of saccades, precede motor disturbance as cognitive deficits in HD. The slowing of saccades has been reported to occur quite early in patients with SCA7 and SCA2, suggesting that the brainstem regions that mediate the generation of saccadic eye movements are a site of early neurodegeneration in both SCA7 and SCA2. Patients with SCA7 or SCA2 have been reported to show pontine atrophy. In our study, the slowing of voluntary and involuntary saccades was observed in eight of the nine patients with SCA7, independent of the duration or severity of illness.

Limitations of the study
This study has some limitations. First, we focused mainly on the changes in the pons and cerebellum and did not measure other intracranial structures. It should be mentioned that the atrophy of other structures of the central nervous system, such as the striatum, is reported to be a consistent neuropathological feature in the early stages of SCA2 and SCA3, but not in SCA7. Secondly, and most importantly, we did not perform an MRI morphometric analysis of asymptomatic gene carriers of SCA7. Until sufficient data from
presymptomatic patients are accumulated, it will remain unresolved whether the disease progresses linearly from birth or develops as a multistage process with a long latent period followed by rapid progression of the dysfunctional stage. Lastly, we did not compare SCA7 with other types of SCA in which brainstem atrophy is reported to be a consistent feature, such as SCA2.\(^4\)

**CONCLUSIONS**

In summary, our results suggest that neurodegeneration progresses continuously during the life of individuals with SCA7 and that the primary pathology may involve the brainstem, rather than the cerebellum. Although not all patients with SCA7 may have the neuroradiological characteristics observed in this study, pontine atrophy is a prominent finding in SCA7 and validates the clinical diagnosis of SCA7.

**ACKNOWLEDGEMENT**

We thank Professor Woon Ki Paik at Hanyang University for his advice and assistance in preparing the manuscript.

**Authors’ affiliations**

O Y Bang, P H Lee, K Huh, Department of Neurology, School of Medicine, Ajou University, Korea

S Y Kim, Department of Neuroradiology, School of Medicine, Ajou University, Korea

H J Kim, Department of Medical Genetics, School of Medicine, Ajou University, Korea

Competing interests: none declared

**REFERENCES**


