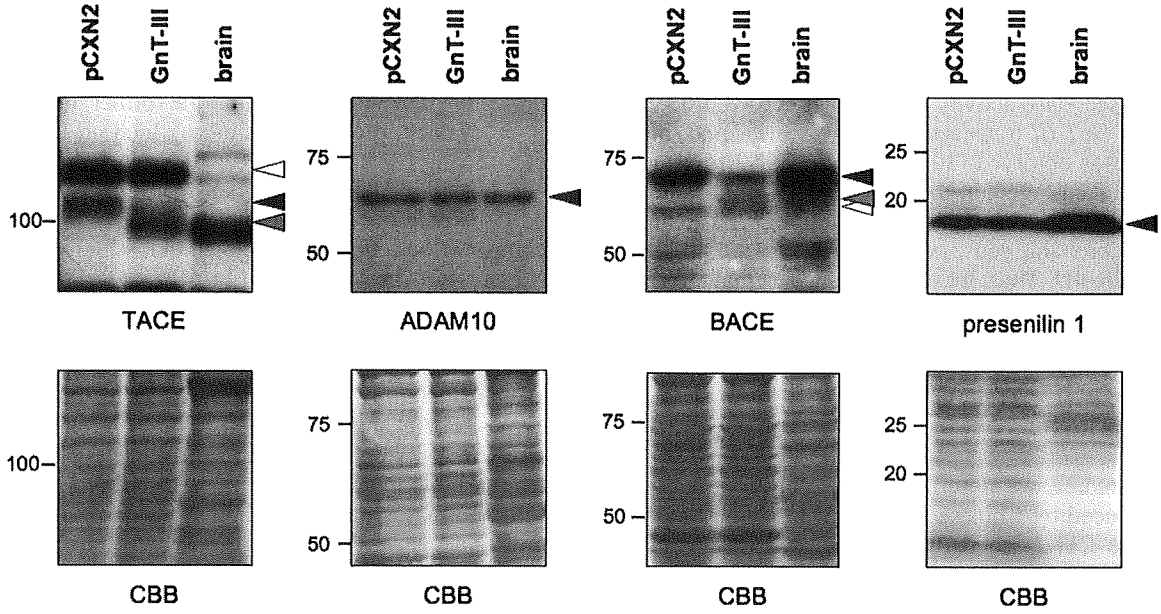

Fig. 5. Western blot analysis of various secretases (TACE, ADAM10, BACE, and presenilin) in *GnT-III*-transfected Neuro2a cells. For TACE and BACE, black and gray triangles indicate mature forms and white triangles indicate immature forms. For ADAM10 and presenilin 1, black triangles indicate the migration positions of ADAM10 and the C-terminal fragment of presenilin 1, respectively. Molecular weight standards are shown on the left. pCXN2: stable mock transfectant of Neuro2a cells; GnT-III: stable transfectant of Neuro2a cells expressing recombinant GnT-III; brain: mouse brain membrane fraction. Bottom figures indicate protein-staining patterns by CBB corresponding to each upper panel.

activity (Escrevente et al. 2008). BACE (β-site APP cleaving enzyme), which possesses β-secretase activity, has four potential *N*-glycosylation sites, three of them appear to be glycosylated (Charlwood et al. 2001). γ-Secretase is a protein complex consisting of presenilin, nicastrin, APH-1, and PEN-2. Nicastrin has 16 potential *N*-glycosylation sites, although inhibition of complex *N*-glycan processing does not affect γ-secretase activity (Herreman et al. 2003).

To clarify the mechanism(s) responsible for downregulating Aβ secretion, the expression levels of the secretases were measured. TACE is reported to change from an immature to a mature form (Milla et al. 1999; Schlondorff et al. 2000; Peiretti et al. 2003). Our Western blot analysis of TACE expressed by Neuro2a cells showed two major bands (Figure 5, left lane); results with proteins isolated from normal mouse brain are shown for comparison. The upper band (white triangle) corresponds to immature TACE bearing high-mannose *N*-glycans; the lower band corresponds to mature TACE (black triangle). Although two TACE bands were also observed in *GnT-III*-transfected Neuro2a cells (Figure 5, right lane), the mobility of mature TACE (gray triangle) from *GnT-III*-transfected cells was faster than that from the mock transfectant. As reported previously, this type of finding is a unique feature seen by introducing bisecting GlcNAc into glycoprotein *N*-glycans (Shigeta et al. 2006). In addition, the expression level of TACE in *GnT-III*-transfected cells was nearly the same as compared with mock transfectant. BACE is also reported to change from an immature form to a mature form (Benjannet et al. 2001; Schmechel et al. 2004). Our Western blot analysis of Neuro2a cells showed two BACE bands (Figure 5, left lane). The upper band corresponds to mature BACE (black triangle) and the lower to immature BACE (white triangle). An additional new band of intermediate mobility appeared in the *GnT-III*-transfected cells (Figure 5, gray triangle in the right lane). Interestingly, in the *GnT-III* transfectant, the

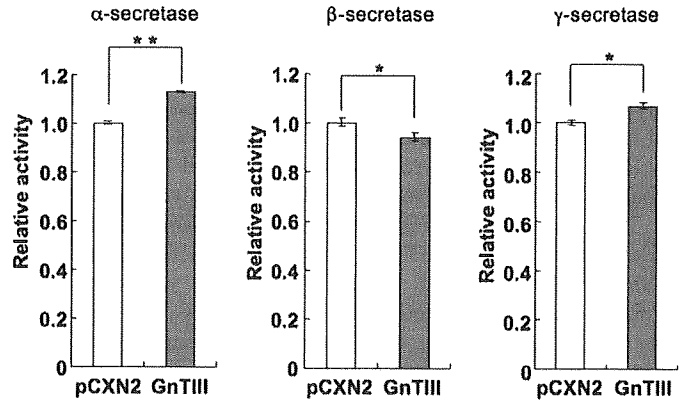

Fig. 6. Secretase activities in *GnT-III*-transfected Neuro2a cells. α-, β-, and γ-secretase activities (left, middle and right panels, respectively) were determined. For comparison, the fluorescence intensity of the pCXN2 transfectant was set to 1.0. The average percentages ± 1 SD of three independent experiments are shown. Asterisks indicate statistically significant differences (*$P < 0.01$, **$P = 0.0001$, Student's *t*-test).

molecular size and expression of BACE both decreased. In contrast, when comparing the mock transfectant with the *GnT-III* transfectant, no differences in the expression level or molecular size of ADAM 10 or the C-terminal fragment of presenilin 1 were seen (Thinakaran et al. 1996) (Figure 5). Taken together, these results suggest that changing the *N*-glycans of TACE and BACE may affect α- and β-secretase activities.

Secretase assays

To examine the effect of *N*-glycan changes of TACE and BACE on enzymatic activity, we measured α- and β-secretase activities in *GnT-III* transfectants of Neuro2a cells. As shown in Figure 6, in the *GnT-III* transfectant, α-secretase activity (113% of the

activity of the control pCXN2 transfectant, $P = 0.0001$) was slightly upregulated, but β-secretase activity (97% of the pCXN2 transfectant, $P = 0.042$) was modestly downregulated. Because changes in γ-secretase activity may also affect Aβ production, its activity in *GnT-III*-transfected cells was measured; modest upregulation was observed (107% of the pCXN2 transfectant, $P = 0.015$). Taken together, the increased α-secretase activity and decreased β-secretase activity in the *GnT-III* transfectant were the most probable cause of the reduction in Aβ production shown in Figure 4D. Thus, these results suggest that changes in *N*-glycan of TACE and BACE affect their enzymatic activities and lead to downregulation of Aβ production.

Discussion

In previous studies, we described the *N*-glycan structures of APP695 produced by Chinese hamster ovary cells (Sato et al. 1999) and the C17.2 mouse neural stem cell line (Akasaka-Manya et al. 2008). Recombinant APP695 in both cell lines had sialylated bi- and triantennary complex-type *N*-glycans with fucosylated and nonfucosylated trimannosyl cores. However, only APP695 produced by C17.2 cells had *N*-glycans containing bisecting GlcNAc. This may be due to cell-type-specific differences in *N*-glycan processing that can be found with various recombinant glycoproteins (Kagawa et al. 1988; Cumming 1991). To determine whether mutations in the *APP* gene alter the structures of processed *N*-glycans, we expressed two mutant recombinant APPs (i.e., the Swedish type and the London type) in transfected C17.2 cells. Structural analysis of these *N*-glycans revealed that the two mutant APPs had higher contents of bisecting GlcNAc and core-fucose residues as compared to wild-type APP. These results clearly showed that these slight changes in amino acid sequence affected *N*-glycan processing.

The glycosyltransferase responsible for adding the bisecting GlcNAc residue is GnT-III (Wilson et al. 1976; Narasimhan 1982; Nishikawa et al. 1992). To examine whether *GnT-III* mRNA levels are related to the pathogenesis of sporadic AD, we examined this issue by quantitative real-time RT-PCR using brains of normal individuals and AD patients. As shown in Figure 2, *GnT-III* mRNA levels were significantly increased in the brains of AD patients. This upregulation may affect AD pathogenesis because significant differences were found in patients with an advanced stage of AD. Interestingly, incubation of Neuro2a cells with Aβ42 increased *GnT-III* gene expression levels (Figure 3). In a recent report (Fiala et al. 2007), exposure of normal peripheral blood mononuclear cells to Aβ peptide upregulated transcription of *GnT-III* and led to increased Aβ clearance by phagocytosis; interestingly, mononuclear cells isolated from AD patients exhibited downregulated *GnT-III* gene expression and were defective in phagocytosis of Aβ. Since upregulation of GnT-III expression was associated with enhanced phagocytosis of Aβ, an increment of GnT-III levels in mononuclear cells may lead to improved Aβ clearance. In contrast, as reported here, increased expression of GnT-III in Neuro2a cells downregulated Aβ production (Figure 4D), and *GnT-III* mRNA levels were increased in AD brains (Figure 2). Taken together, these results suggest that upregulation of GnT-III in neuronal cells may diminish Aβ production in AD brains. In addition, expression of GnT-III in neurons and monocytes may modulate Aβ accumulation by different mechanisms. That is, upregulation of GnT-III expression in monocytes may enhance Aβ clearance, and increased GnT-III expression in neuronal cells may inhibit Aβ production. Taken together, both responses may be adaptive, protective responses that inhibit the further progression of AD.

To evaluate the mechanism by which an increased number of bisecting GlcNAc residues could reduce Aβ production, several possibilities should be considered. As reported here, the APP secreted by *GnT-III*-transfected Neuro2a cells has a higher content of bisecting GlcNAc than that secreted by control cells (Figure 4C). The addition of bisecting GlcNAc may affect the conformation of APP, thereby leading to a change in its susceptibility to α-, β-, and/or γ-secretases. Alteration of glycoprotein glycans is known to affect various properties of a given protein including its susceptibility to various modifying enzymes. For example, organ-specific differential glycosylation of low-density lipoprotein receptor-related protein 1 (LRP1) alters its proteolytic cleavage by γ-secretase (May et al. 2003). In addition, increased sialylation of APP enhanced Aβ secretion (Nakagawa et al. 2006). Bisecting GlcNAc residues are also known to affect the branching and elongation of various *N*-glycans antennae (Narasimhan 1982; Schachter et al. 1983; Schachter 1986). Therefore, it is possible that increasing bisecting GlcNAc expression on APP leads to changes in the APP *N*-glycan structure, including less sialylation, which may alter it susceptibility to cleavage by individual secretases (Fukuta et al. 2000; Koyota et al. 2001). Furthermore, because changing the *N*-glycan structure can alter intracellular glycoprotein localization, it is possible that bisecting GlcNAc affects APP trafficking and, thereby, its susceptibility to secretases. For example, in cells that overexpress GnT-III, cell surface turnover of E-cadherin is delayed (Yoshimura et al. 1996). In contrast, the cell surface expression of epidermal growth factor receptor is reduced in GnT-III overexpressing cells (Rebbaa et al. 1997). In addition, APP localization and trafficking vary according to its glycan modifications (McFarlane et al. 1999).

Another possibility is that increasing the bisecting GlcNAc content of the secretases affects their enzymatic activity. For example, glycosylation is known to play a critical role in maintaining the enzymatic activity of β-secretase (Charlwood et al. 2001). In that study, baculovirus-expressed β-secretase, which only has high-mannose-type *N*-glycans, exhibits only ~50% of the activity found when the enzyme is expressed by mammalian cells, when it has complex-type *N*-glycans (Charlwood et al. 2001). To investigate this issue, we measured secretase activities in *GnT-III*-transfected cells; α- and β-secretase activities were significantly increased and decreased, respectively (Figure 6). By Western blot analysis, the *N*-glycan structures of TACE and BACE are altered (Figure 5), perhaps explaining the changes in their enzymatic activities. In a previous study (Skovronsky et al. 2001), TACE-expressing neurons often colocalized with Aβ plaques. Our results showed that GnT-III expression was increased in AD brains (Figure 2) and that increases in GnT-III might decrease BACE expression (Figure 6). Taken together, it is likely that upregulation of GnT-III in AD brains induces changes in the APP processing enzymes, TACE and BACE, which may inhibit Aβ formation. Although the detailed mechanisms are not yet clear, this increased expression of GnT-III may homeostatically partially protect AD brains from further Aβ production.

Bisected *N*-glycans play important roles in neurological function in vitro and in vivo. For example, bisecting GlcNAc

regulated serum depletion-induced neuritogenesis (Shigeta et al. 2006). In addition, truncated, inactive GnT-III induced abnormal neurological phenotypes in mice (Bhattacharyya et al. 2002). As another example, changes in bisected *N*-glycans may be related to the pathogenesis of prion disease (Rudd et al. 1999). Therefore, further studies are required to understand the precise physiological and pathological roles of bisecting GlcNAc in brain development and function.

In summary, based on the current results, we propose that high expression of GnT-III in human AD brains reduces Aβ production and protects against further deterioration of neurological function during this disease process. Therefore, compounds that upregulate the expression of bisecting *N*-glycans may provide a novel therapeutic approach toward preventing or ameliorating AD.

Material and methods

Patients and controls

Human brain tissues were obtained from the Brain Bank for Aging Research (BBAR), which consists of consecutive autopsy cases from a general geriatric hospital with informed consent obtained from the relatives for each autopsy. The brains were handled using the BBAR protocol described previously (Fumimura et al. 2007). In brief, half of the brain was serially sections into 7 mm slices, snap-frozen using powdered dry ice, and stored at −80°C. To minimize RNA degradation, samples with the shortest postmortem intervals were selected for study. Two grams of frozen gray matter were sampled from the temporal pole of 10 cases each with AD, eAD, and age-matched normal controls. The diagnosis of AD was based on the BBAR criteria (Hughes et al. 1982; Murayama and Saito 2004), as follows: (1) clinical dementia rating (Hughes et al. 1982) $\geq$ 1; (2) Braak's senile plaque stage equal to C; and (3) the Braak's neurofibrillary tangle stage $\geq$ IV. The diagnosis of eAD was based on the following criteria: (1) clinical dementia rating, either 0 or 0.5; (2) Braak's senile plaque stage $\geq$ B; and (3) Braak's neurofibirillary tangle stage $\geq$ III. The criteria for designating brains as coming from normal controls included a clinical dementia rating of 0, Braak's senile plaque stage 0, and Braak's neurofibrillary tangle stage $\leq$ II. The age of the selected AD cases ranged from 79 to 98 years old (average of 88.2 years), and the postmortem interval from 1.8 to 17.7 h (average of 7.1 h). The age of the eAD cases ranged between 76 and 96 years (average of 90.3 years), and the postmortem interval between 1.2 and 39.9 h (average of 9.6 h). The age of the normal controls ranged from 68 to 86 years (average of 75.8 years), and the postmortem interval ranged from 1.5 to 29.1 h (average of 7.4 h). This study was approved by the Internal Review Board of Tokyo Metropolitan Institute of Gerontology and of Tokyo Metropolitan Geriatric Hospital.

Real-time RT-PCR analysis

Total RNA was isolated from a portion of each patient's brain using the guanidinium thiocyanate method with TRIzol (Invitrogen Corp., Carlsbad, CA), following the manufacturer's instructions. The integrity of the isolated total RNA was confirmed using an Agilent 2100 bioanalyzer (Agilent Technologies, Inc., Santa Clara, CA). Total RNA from Neuro2a cells was isolated using ISOGEN (Nippon Gene Co., Ltd, Tokyo, Japan), following the manufacturer's instructions. First-strand cDNAs were synthesized using 5 μg of total RNA, SuperScript II RNase H^- Reverse Transcriptase, and random primers (Invitrogen). The relative quantification of target mRNA was determined using a TaqMan real-time RT-PCR assay on a 7300 Fast Real-Time PCR System (Applied Biosystems, Foster City, CA), following the manufacturer's instructions using the TaqMan Universal PCR Master Mix and TaqMan Gene Expression Assays (i.e., a mixture of designed primers and TaqMan probes, Applied Biosystems): *GnT-III*, Hs02379589_s1; endogenous control, the TaqMan Ribosomal RNA Control Reagents VIC Probe. 18S rRNA was used as normalization control.

Cell culture and expression of GnT-III

Neuro2a mouse neuroblastoma cells were maintained in a mixture of Dulbecco's modified Eagle's medium and OptiMEM (1:1, v/v, Invitrogen) supplemented with 5% fetal bovine serum (Invitrogen), 2 mM L-glutamine, 100 units/mL penicillin, and 50 μg/mL streptomycin at 37°C in a 5% CO_2 atmosphere. The pCXN2-rat-*GnT-III* expression plasmid was described previously (Kitada et al. 2001). This plasmid was transfected into Neuro2a cells using Lipofectamine PLUS reagent (Invitrogen) according to the manufacturer's instructions. Stable transfectants were selected with G418 (Invitrogen) at 1 mg/mL. The culture supernatants of these transfectants were collected after 24 h incubation in Dulbecco's modified Eagle's medium:OptiMEM (1:1, v/v) supplemented with 0.2% fetal bovine serum. The cells were homogenized in 10 mM Tris-HCl, pH 7.4, 1 mM EDTA, 250 mM sucrose, 1 mM dithiothreitol, with protease inhibitor mixture (3 μg/mL pepstatin A, 1 μg/mL leupeptin, 1 mM benzamidine-HCl, 1 mM PMSF). After centrifugation at 900 × *g* for 10 min, the supernatant was centrifuged at 100,000 × *g* for 1 h; the pellet was used as the microsomal fraction. Protein concentration was determined by BCA assay (Thermo Fisher Scientific Inc., Waltham, MA).

Aβ treatment of Neuro2a cells was performed as follows: Aβ40 and Aβ42 were each purchased from PEPTIDE INSTITUTE, INC. (Osaka, Japan) and dissolved in H_2O. Aβ40 or Aβ42 were added to culture medium at a final concentration of 2 μg/mL. Cells were cultured for 48 h and harvested for RNA preparation followed by real-time RT-PCR.

Preparation of mouse brain membrane fraction

Brains were obtained from 4-week-old C57BL/6 mice, and homogenized with 9 volumes (weight/volume) of 10 mM Tris-HCl, pH 7.4, 1 mM EDTA, 250 mM sucrose. After centrifugation at 900 × *g* for 10 min, the supernatant was centrifuged at 100,000 × *g* for 1 h; the pellet was used as the microsomal membrane fraction. Protein concentration was determined by BCA assay. All experimental procedures using laboratory animals were approved by the Animal Care and Use Committee of Tokyo Metropolitan Institute of Gerontology.

Assay for GnT-III activity

GnT-III activity was measured using a modification of a previously reported method (Taniguchi et al. 1989). The enzyme assay mixture, containing 125 mM MES buffer (pH 6.25), 200 mM GlcNAc, 10 mM $MnCl_2$, 20 mM UDP-GlcNAc, 0.5% Triton X-100, 10 μM of 2-aminobenzamide-labeled [GlcNAcβ1-2Manα1-6 (GlcNAcβ1-2Manα1-3) Manβ1-4Glc

NAcβ1-4GlcNAc] (ProZyme, Leandro, CA), and cell homogenate were incubated at 37°C for 1 h. After boiling for 3 min to stop the reaction, the mixture was subjected to reversed-phase HPLC using a Cosmosil 5C18-AR column (Nacalai Tesque, Kyoto, Japan), which was equilibrated with the 100 mM ammonium acetate buffer, pH 4.0, and eluted with a gradient of 1-butanol (0.25–1% butanol) over 120 min at a flow rate of 1 mL/min at 55°C.

Immunoprecipitation

For APP immunoprecipitation, culture supernatants were mixed with an anti-APP monoclonal antibody (22C11, Millipore, Billerica, MA). After incubation at 4°C for 2 h, Protein G-coupled Sepharose-4B beads (GE Healthcare UK Ltd., Buckinghamshire, England) were added and the mixture rotated at 4°C for 2 h. The beads were washed three times with PBS and suspended in the sample buffer. Immunoprecipitated proteins were recovered by boiling for 3 min and then subjected to Western blot and lectin blot analyses.

Western blot analysis

Proteins were separated by SDS–PAGE (for TACE, a 5–10% gradient gel; for APP, BACE, and ADAM 10, a 7.5% gel; for presenilin 1, a 12.5% gel) and transferred to a PVDF membrane. The membrane, after blocking in PBS containing 5% skim milk and 0.05% Tween 20, was incubated with an anti-APP polyclonal antibody (Millipore, Billerica, MA) or an anti-APP monoclonal antibody (6E10, Signet laboratories, Dedham, MA). The membrane was then incubated with anti-rabbit IgG conjugated with horseradish peroxidase (GE Healthcare). Antibody-bound proteins were visualized using an ECL kit (GE Healthcare).

Secretases in the microsomal fractions were visualized after separation by SDS–PAGE using anti-TACE polyclonal antibody (Thermo Fisher Scientific), anti-ADAM10 antibody, anti-presenilin 1 antibody, and anti-BACE antibody (Abcam, Cambridge, England).

Lectin blot analysis

Immunoprecipitated proteins were separated by SDS–PAGE and transferred to a PVDF membrane. After blocking with 3% bovine serum albumin (BSA, Nacalai Tesque) in 10 mM Tris-HCl (pH 7.4) containing 140 mM NaCl, 1 mM $CaCl_2$, 1 mM $MgCl_2$, 1 mM $MnCl_2$, and 0.05% Tween 20 (TBS-T), the membrane was incubated with biotin-conjugated PHA-E_4 (Seikagaku Corporation, Tokyo, Japan) in TBS-T containing 1% BSA. After treating the membrane with the Vectastain ABC kit (Vector, Burlingame, CA), lectin-bound proteins were visualized with an ECL kit.

Quantification of soluble Aβ by sandwich ELISA

Culture supernatants were subjected to enzyme-linked immunosorbent assay (ELISA) using the Human/Rat β-Amyloid 40 ELISA kit II and the Human/Rat β-Amyloid 42 ELISA kit High Sensitive (Wako Pure Chemical Industries, Ltd., Osaka, Japan) according to manufacturer's instructions.

Secretase assays

Secretase enzymatic assays were performed using the α-secretase assay kit, β-secretase assay kit, and γ-secretase assay kit (R & D Systems, Inc., Minneapolis, MN), according to manufacturer's instructions. Briefly, cultured Neuro2a cells were harvested and cell numbers counted. Cells were lysed with the extraction buffer and used as an enzyme source for the assay. An APP peptide conjugated to fluorescent reporter and quencher was used as the substrate. The protein content of cell lysates was determined by BCA assay and secretase activities were normalized to protein concentration.

Funding

The Japan Society for the Promotion of Science (20390031).

Acknowledgements

We thank Ms. Harumi Yamamoto and Ms. Reiko Fujinawa for technical assistance.

Conflict of interest statement

None declared.

Abbreviations

Aβ, β-amyloid; AD, Alzheimer's disease; ADAM, a disintegrin and metalloprotease; APP, amyloid precursor protein; BACE, β-site APP-cleaving enzyme; eAD, early-stage AD; GnT, *N*-acetylglucosaminyltransferase; TACE, tumor necrosis factor-α-converting enzyme.

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Eur J Nucl Med Mol Imaging
DOI 10.1007/s00259-009-1202-1

ORIGINAL ARTICLE

Validation of cardiac ^{123}I-MIBG scintigraphy in patients with Parkinson's disease who were diagnosed with dopamine PET

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Received: 11 March 2009 / Accepted: 9 June 2009

Abstract
Purpose The aim of this study was to evaluate the diagnostic potential of cardiac ^{123}I-labelled metaiodobenzylguanidine (^{123}I-MIBG) scintigraphy in idiopathic Parkinson's disease (PD). The diagnosis was confirmed by positron emission tomography (PET) imaging with ^{11}C-labelled 2β-carbomethoxy-3β-(4-fluorophenyl)-tropane (^{11}C-CFT) and ^{11}C-raclopride (together designated as dopamine PET).
Methods Cardiac ^{123}I-MIBG scintigraphy and dopamine PET were performed for 39 parkinsonian patients. To estimate the cardiac ^{123}I-MIBG uptake, heart to mediastinum (H/M) ratios in early and delayed images were calculated. On the basis of established clinical criteria and our dopamine PET findings, 24 patients were classified into the PD group and 15 into the non-PD (NPD) group.
Results Both early and delayed images showed that the H/M ratios were significantly lower in the PD group than in the NPD group. When the optimal cut-off levels of the H/M ratio were set at 1.95 and 1.60 in the early and delayed images, respectively, by receiver-operating characteristic analysis, the sensitivity of cardiac ^{123}I-MIBG scintigraphy for the diagnosis of PD was 79.2 and 70.8% and the specificity was 93.3 and 93.3% in the early and delayed images, respectively. In the Hoehn and Yahr 1 and 2 PD patients, the sensitivity decreased by 69.2 and 53.8% in the early and delayed images, respectively.
Conclusion In early PD cases, cardiac ^{123}I-MIBG scintigraphy is of limited value in the diagnosis, because of its relatively lower sensitivity. However, because of its high specificity for the overall cases, cardiac ^{123}I-MIBG scintigraphy may assist in the diagnosis of PD in a complementary role with the dopaminergic neuroimaging.

Keywords ^{123}I-MIBG · ^{11}C-CFT · ^{11}C-Raclopride · Scintigraphy · Positron emission tomography · Parkinson's disease

Introduction

Cardiac ^{123}I-labelled metaiodobenzylguanidine (^{123}I-MIBG) scintigraphy has been suggested to be useful for the diagnosis of idiopathic Parkinson's disease (PD), because many recent studies have revealed that cardiac ^{123}I-MIBG uptake decreases with disease progression and that almost all

An Editorial Commentary on this paper is available at http://dx.doi.org/10.1007/s00259-009-1215-9.

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Published online: 22 July 2009

patients in the advanced stage of PD show decreased cardiac ^{123}I-MIBG uptake [1–5]. However, it is unclear whether cardiac ^{123}I-MIBG uptake is a good surrogate marker for the diagnosis of PD, especially in early and mild PD cases, which are the most difficult to diagnose in daily clinical practice, because the data on the reduction of cardiac ^{123}I-MIBG uptake in the early stage of PD vary greatly among different studies [1–8]. Therefore, we aimed to investigate the sensitivity and specificity of cardiac ^{123}I-MIBG scintigraphy in diagnosing PD, focusing on early and mild cases of PD in the Hoehn and Yahr (HY) stages 1 and 2.

While planning this study, we focused on dividing the patients into PD and non-PD (NPD) groups in the most appropriate manner in order to acquire precise results. Previous studies have shown that the usual clinical diagnostic accuracy of PD ranges from 70 to 90%, and the accuracy rate greatly decreases in early cases [9–12]. In vivo neurofunctional imaging of the basal ganglia, which provides images of both pre- and postsynaptic nigrostriatal dopaminergic functions, has been recognized as a standard marker for the diagnosis of PD in every clinical stage [13–25]. Therefore, in order to improve the accuracy of the diagnosis of PD, especially in early PD cases, and to classify the patients into the PD and NPD groups in a more appropriate manner, we performed positron emission tomography (PET) imaging with ^{11}C-labelled 2β-carbomethoxy-3β-(4-fluorophenyl)-tropane (^{11}C-CFT) and ^{11}C-raclopride. PET imaging with ^{11}C-CFT and ^{11}C-raclopride can assess the levels of presynaptic dopamine transporter (DAT) and postsynaptic dopamine D_2-like receptor (D_2R), respectively, in the striatum. The two types of PET imaging techniques were together designated as dopamine PET. Further, we proposed the definitions of PD and NPD patterns in dopamine PET findings on the basis of the results which had been confirmed by previous studies.

We also investigated the association between cardiac sympathetic function assessed by cardiac ^{123}I-MIBG uptake, presynaptic nigrostriatal dopaminergic function assessed by striatal ^{11}C-CFT uptake and disease stage determined according to the HY scale.

Materials and methods

Subjects

The present study was a retrospective study. The subjects comprised 39 patients who visited the neurological outpatient clinic at Tokyo Metropolitan Geriatric Hospital from November 2001 to October 2007. They chiefly complained of one or more parkinsonian symptoms, including resting tremor, rigidity, bradykinesia and postural instability. The patients were divided into PD and NPD groups (Fig. 1). Cardiac ^{123}I-MIBG scintigraphy, dopamine PET and magnetic resonance imaging (MRI) were performed for all patients. None of the patients had any concomitant hereditary disorder that could cause parkinsonian symptoms. None of the patients had an individual history of any heart disease. Further, none of the patients were on any medication that could cause parkinsonian symptoms.

For dopamine PET, eight healthy subjects (five men and three women) aged 55–74 years [mean±standard deviation (SD) = 62.3±6.9 years)]were considered as controls. They were deemed healthy based on their medical history, physical and neurological examinations and MRI of the brain. Further, none of them were on medication.

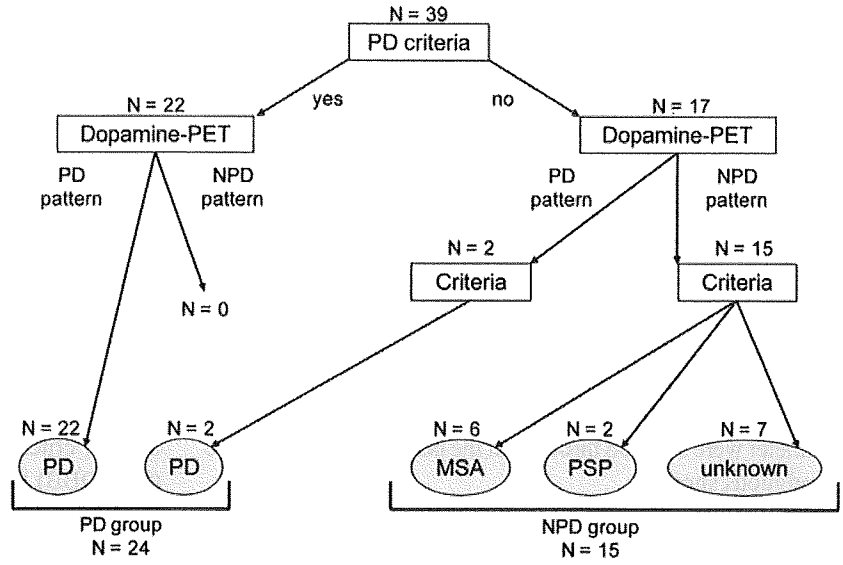

Fig. 1 Diagnostic flow chart and schematic representation of classification process. Patients were classified into PD and NPD groups on the basis of respective published clinical criteria and our dopamine PET findings

This study protocol was approved by the Ethics Committee of the Tokyo Metropolitan Institute of Gerontology. Written informed consent was obtained from all participants.

PET imaging

PET imaging was performed at the Positron Medical Center, Tokyo Metropolitan Institute of Gerontology by using a SET-2400 W scanner (Shimadzu, Kyoto, Japan) in the three-dimensional scanning mode [26], as described previously [27, 28]. The transmission data were acquired using a rotating $^{68}Ga/^{68}Ge$ rod source for attenuation correction. Images of 50 slices were obtained with a resolution of 2×2×3.125 mm voxels and a 128×128 matrix.

Dopamine PET imaging ^{11}C-CFT and ^{11}C-raclopride were prepared as described previously [29, 30]. The two types of PET imaging were performed for all of the subjects on the same day. The patients being treated with antiparkinsonian drugs underwent dopamine PET following at least 15 h deprivation of the medications. Each subject was administered an intravenous bolus injection of 341±62 (mean ± SD) MBq of ^{11}C-CFT, followed by that of 311±56 (mean ± SD) MBq of ^{11}C-raclopride after 2.5–3 h. To measure the uptake of the tracers, static scanning was performed for 75–90 and 40–55 min after the injection of ^{11}C-CFT and ^{11}C-raclopride, respectively. The specific activity of ^{11}C-CFT and ^{11}C-raclopride at the time of injection ranged from 5.9 to 134.2 GBq/μmol and from 10.2 to 201.7 GBq/μmol, respectively.

Analysis of dopamine PET images Image manipulations were performed using Dr. View version R2.0 (AJS, Tokyo, Japan) and SPM2 (Functional Imaging Laboratory, London, UK) implemented in MATLAB version 7.0.1 (The MathWorks, Natick, MA, USA).

The two PET images and one MRI image obtained for each subject were coregistered. The three coregistered images were resliced transaxially, parallel to the anteroposterior intercommissural (AC-PC) line. Circular regions of interest (ROIs) were selected with reference to the brain atlas and individually coregistered MRI images. In each of the three contiguous slices, one ROI with 8-mm diameter was selected on the caudate, two ROIs on the anterior putamen and two on the posterior putamen on both the left and right sides. In other words, the AC-PC plane and regions 3.1 and 6.2 mm above the AC-PC line were selected. A total of 50 ROIs with 10-mm diameter were selected throughout the cerebellar cortex in five contiguous slices.

To evaluate the uptake of ^{11}C-CFT and ^{11}C-raclopride, we calculated the uptake ratio index by the following formula [15, 31]: uptake ratio index = (activity in each region − activity in the cerebellum)/(activity in the cerebellum). We previously validated the method to estimate the binding potential of ^{11}C-raclopride and ^{11}C-CFT, adopting the uptake ratio index [27, 28]. For the further analyses, the uptake of each tracer in each subregion of the striatum (the caudate, anterior putamen and posterior putamen) was evaluated as the average value of the left and right sides. The uptake of each tracer in the whole striatum was evaluated as the average value of entire ROIs in the whole striatum.

Cardiac ^{123}I-MIBG scintigraphy

Scintigraphic studies were performed at Tokyo Metropolitan Geriatric Hospital by using a triple-headed gamma camera (PRISM-3000, Shimadzu, Kyoto, Japan). None of the patients were on any medication, i.e. they were not receiving any drugs such as antidepressants and monoamine oxidase inhibitors, which might influence cardiac ^{123}I-MIBG uptake. After a 30-min resting period, each patient was administered an intravenous bolus injection of 111 MBq of ^{123}I-MIBG (Fujifilm RI Pharma Co., Tokyo, Japan). Planar images of the chest in the anterior view were obtained twice for 5 min, starting at 20 min (early phase) and then at 180 min (delayed phase) after the injection of ^{123}I-MIBG. Relative organ uptake of ^{123}I-MIBG was determined by selecting the ROIs on the heart and mediastinum in the anterior planar image [32]. Average counts per pixel in the heart and mediastinum were used to calculate the heart to mediastinum (H/M) ratio.

MRI

MRI was performed at Tokyo Metropolitan Geriatric Hospital. By using a 1.5-T Signa EXCITE HD scanner (GE, Milwaukee, WI, USA), transaxial T1-weighted images [three-dimensional spoiled gradient-recalled (3D SPGR), repetition time (TR) = 9.2 ms, echo time (TE) = 2.0 ms, matrix size = 256 × 256 × 124, voxel size = 0.94 × 0.94 × 1.3mm] and transaxial T2-weighted images (first spin echo, TR= 3,000 ms, TE=100 ms, matrix size = 256 × 256 × 20, voxel size = 0.7 × 0.7 × 6.5mm) were obtained.

Clinical diagnosis

The diagnostic flow chart is shown in Fig. 1. First, the patients were divided into two groups (22 patients in one group and 17 patients in the other) on the basis of the clinical criteria of the UK Parkinson's Disease Brain Bank (UKPDBB) [10]. Each group was then further classified on the basis of dopamine PET findings. As shown in Fig. 2, the PD pattern in dopamine PET was defined as follows: (1)

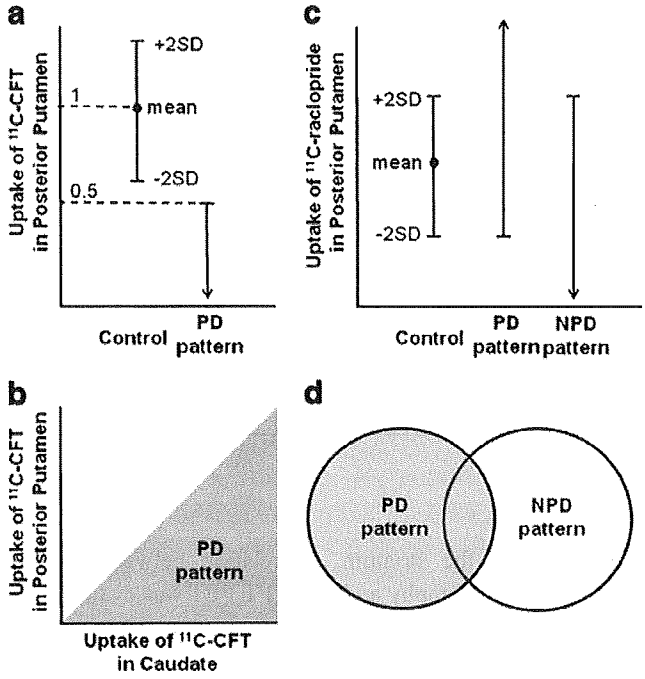

Fig. 2 PD and NPD patterns defined on the basis of dopamine PET findings. PD pattern: ^{11}C-CFT uptake in the posterior putamen of patients less than 50% of the mean uptake in the posterior putamen of normal controls (**a**) and less than that in the caudate of patients (**b**); ^{11}C-raclopride uptake in the posterior putamen of patients more than the mean – 2 SD of the uptake in the posterior putamen of normal controls (**c**). NPD pattern: ^{11}C-raclopride uptake in the posterior putamen of patients less than the mean + 2 SD of the uptake in the posterior putamen of normal controls (**c**). The patient was considered to be PD pattern when both PD and NPD were fulfilled (**d**). The uptake in each subregion of the striatum was evaluated as the average value of both sides

^{11}C-CFT uptake in the posterior putamen of the patients less than 50% of the mean uptake in the posterior putamen of normal controls (Fig. 2a) and less than that in the caudate of the patients (Fig. 2b) and (2) ^{11}C-raclopride uptake in the posterior putamen of the patients more than the mean – 2 SD of the uptake in the posterior putamen of normal controls (Fig. 2c). The NPD pattern was defined as follows: ^{11}C-raclopride uptake in the posterior putamen of the patients less than the mean + 2 SD of the uptake in the posterior putamen of normal controls (Fig. 2c). The patient was considered to be PD pattern when both PD and NPD were fulfilled (Fig. 2d).

Statistical analysis

Differences in the averages and variances were tested by Student's *t* test and one-way analysis of variance, respectively. Correlations between the two groups of patients were assessed by linear regression analysis with Pearson's correlation test; *p* values of <0.05 were considered statistically significant.

Results

Patients

Classification into PD and NPD groups All 22 patients who fulfilled the UKPDBB PD criteria at initial diagnosis [10] showed the PD pattern on dopamine PET (Fig. 1). They were classified into the PD group. The other 17 patients were further classified according to dopamine PET findings and respective published clinical criteria. Of the 17 patients, 2 showed the PD pattern on dopamine PET. In fact, the symptom manifested was only resting tremor at initial diagnosis; however, during the course of the study, they fulfilled the UKPDBB PD criteria [10] and were classified into the PD group.

Of the 17 patients, 15 showed the NPD pattern on dopamine PET and were classified into the NPD group (Fig. 1). These patients were then further divided into three subgroups. Six patients fulfilled the multiple system atrophy (MSA) criteria [33]. Two patients fulfilled the progressive supranuclear palsy (PSP) criteria [34]. For the remaining seven patients, no definitive diagnoses could be established despite follow-up for more than 1 year.

Finally, 24 patients (7 men and 17 women, age range: 60–85 years, mean age ± SD = 71.5±6.8 years) and 15 patients (8 men and 7 women, age range: 65–86 years, mean age ± SD: 76.0±5.5 years) were classified into the PD and NPD groups, respectively.

Demographic data Patient characteristics are summarized in Table 1. In the PD group, 11 patients were drug naive, 7 were being treated with L-dopa and 6 were being treated with L-dopa and dopamine agonists at the time of dopamine PET. The interval between cardiac ^{123}I-MIBG scintigraphy and dopamine PET was within 6 months for 16 patients, between 6 and 12 months for 1 patient and more than 1 year for 7 patients. However, the HY stage of each patient in the PD group remained the same between cardiac ^{123}I-MIBG scintigraphy and dopamine PET. In the NPD group, 11 patients were not administered any antiparkinsonian drug, and 4 were being treated with only L-dopa. The interval between the two examinations was within 6 months for 12 patients, between 6 and 12 months for 1 patient and more than 1 year for 2 patients.

Uptake of ^{123}I-MIBG

Both the early and delayed images showed significantly lower H/M ratios in the PD group than in the NPD group (Fig. 3). In both the early and delayed images, the H/M ratios tended to decrease with the progression of the HY stages; however, the decrease was not statistically significant.

Table 1 Clinical features of patients in Parkinson's disease and non-Parkinson's disease groups

Groups	Patients		Age (years)	Duration (years)	^{123}I-MIBG scintigraphy		^{11}C-CFT PET
	Number	M:F			Heart to mediastinum ratio		Uptake ratio index in the whole striatum
					Early	Delayed	
Parkinson's disease	24	7:17	71.5±6.8	3.5±3.2	1.66±0.45	1.46±0.41	0.98±0.34
Hoehn and Yahr 1	4	0:4	65.0±7.7	2.9±2.6	1.75±0.33	1.49±0.29	1.49±0.40
Hoehn and Yahr 2	9	2:7	73.9±5.6	2.4±1.0	1.81±0.54	1.60±0.45	1.00±0.20
Hoehn and Yahr 3	8	5:3	71.9±7.2	3.0±1.8	1.57±0.44	1.41±0.44	0.81±0.20
Hoehn and Yahr 4	3	0:3	72.3±5.0	9.0±6.1	1.36±0.05	1.12±0.08	0.69±0.07
Non-Parkinson's disease	15	8:7	76.0±5.5	2.8±1.9	2.35±0.46	2.18±0.51	1.65±0.68

Data are expressed as mean±SD

Table 2 shows the sensitivity and specificity of cardiac ^{123}I-MIBG scintigraphy in differentiating patients with PD from the other patients with chief complaints of parkinsonian symptoms. When the optimal cut-off levels of ^{123}I-MIBG were set at 1.95 and 1.60 by receiver-operating characteristic analysis, the sensitivity of cardiac ^{123}I-MIBG scintigraphy for the diagnosis of PD was 79.2 and 70.8% and the specificity was 93.3 and 93.3% in the early image and delayed images, respectively. In HY 1 and 2 PD patients the sensitivity was 69.2 and 53.9% and in HY 3 and 4 PD patients the sensitivity was 90.9 and 90.9% in the early image and delayed images, respectively

Uptake of ^{11}C-CFT

The uptake of ^{11}C-CFT in the whole striatum decreased with the progression of the HY stages (Fig. 4). Significant reduction in the ^{11}C-CFT uptake with the progression of the HY stages was also observed in each of the three subregions of the striatum. Correlation between cardiac ^{123}I-MIBG scintigraphy and ^{11}C-CFT PET was evaluated in the 16 patients who underwent the two examinations within 6 months. There was no significant correlation between the ^{11}C-CFT uptake in the whole striatum and the H/M ratios in both the early images (r=0.15, p=0.59) and delayed images (r=0.21, p=0.43) (Fig. 5). Further, no significant correlation was observed between the ^{11}C-CFT uptake in each of the three subregions of the striatum and the H/M ratio.

Discussion

In the present study, we investigated the sensitivity and specificity of cardiac ^{123}I-MIBG scintigraphy in diagnosing PD and differentiating the patients with PD from the others with chief complaints of parkinsonian symptoms. Further, we investigated the correlation between cardiac sympathetic function assessed by cardiac ^{123}I-MIBG uptake, nigrostriatal

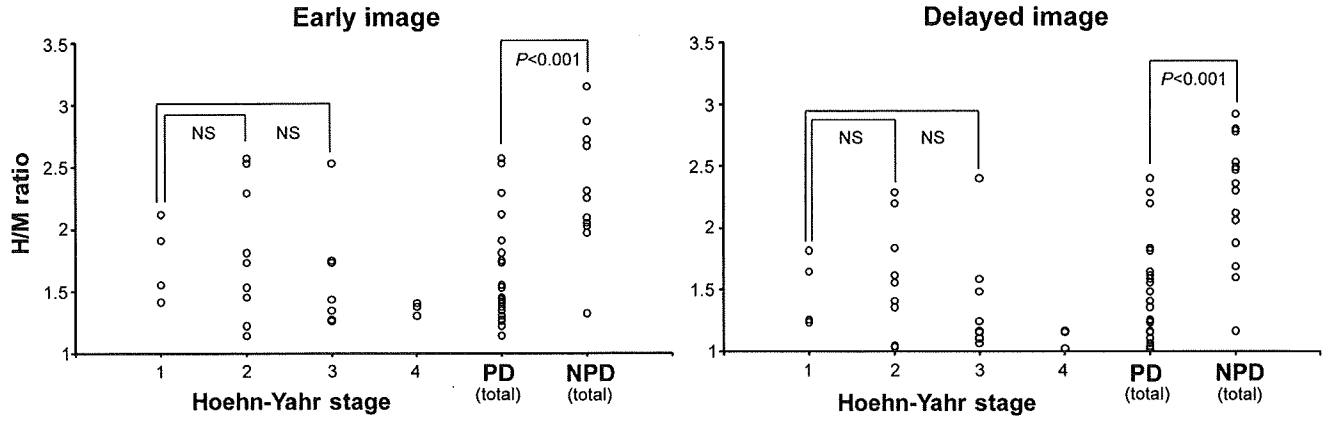

Fig. 3 H/M ratios in the PD and NPD groups in early and delayed images. Each graph represents the relation between the H/M ratio and Hoehn and Yahr stage of PD and a comparison of the H/M ratios of the total number of PD and NPD patients. Both images showed that the H/M ratios were significantly lower in the PD group than in the NPD group; however, the H/M ratios of patients in HY 1 of PD were not significantly higher than those of the patients in HY 2 and 3 of PD. *NS* not significant

Table 2 Sensitivity and specificity of cardiac ^{123}I-MIBG scintigraphy in differentiating Parkinson's disease from other parkinsonian syndromes

Total PD patients (n=24)												
	Early image						Delayed image					
Cut-off	1.80	1.85	1.90	1.95	2.00	2.05	1.60	1.65	1.70	1.75	1.80	1.85
Sensitivity	70.8%	75.0%	75.0%	79.2%	79.2%	79.2%	70.8%	75.0%	79.2%	79.2%	79.2%	87.5%
Specificity	93.3%	93.3%	93.3%	93.3%	86.7%	80.0%	93.3%	80.0%	73.3%	73.3%	73.3%	73.3%
Hoehn and Yahr 1 and 2 (n=15)												
	Early image						Delayed image					
Cut-off	1.80	1.85	1.90	1.95	2.00	2.05	1.60	1.65	1.70	1.75	1.80	1.85
Sensitivity	53.8%	61.5%	61.5%	69.2%	69.2%	69.2%	53.8%	61.5%	69.2%	69.2%	69.2%	84.6%

Cut-off levels, for which both the sensitivity and specificity were more than 70%, are shown. The optimal cut-off levels determined by receiver-operating characteristic analysis were at 1.95 and 1.60 in the early and delayed images, respectively

dopaminergic function assessed by ^{11}C-CFT uptake and disease stage determined according to the HY scale.

It has been reported that cardiac ^{123}I-MIBG uptake in patients with PD is significantly lower than that in patients with other parkinsonian syndromes [1–7]; this result corresponds to our results. Several reports suggest that the severity of motor impairment and disease duration are correlated with reduced ^{123}I-MIBG uptake in patients with PD [1, 2, 5, 6]; however, some other findings deny such correlations, similar to ours [3, 4, 7, 8]. This discrepancy is presumably explained by the fact that the degree of cardiac ^{123}I-MIBG uptake in patients in HY 1 and 2 of PD varies greatly among different studies. Difficult definitive diagnosis of PD in early and mild cases may also be because of the great variation. On the other hand, almost all patients in the advanced stage of PD have shown very low ^{123}I-MIBG uptake in both the previous and the present studies. Li et al. reported that cardiac sympathetic denervation progresses over time and that the rate of decrease in the number of sympathetic terminals appears to be at least as high as that of nigrostriatal dopaminergic terminals [35]. Therefore, we considered that although the onset of cardiac sympathetic denervation varied among the patients with PD, severe cardiac sympathetic denervation occurred in all of the patients by the terminal stage of PD. In regard to the association with a sympathetic symptom, it was reported that reduced ^{123}I-MIBG uptake does not always mean the existence of a sympathetic symptom [1, 3, 4, 7]. Also in this study, of the three patients in stage 4 of the HY scale who showed very low ^{123}I-MIBG uptake (Fig. 3), two had orthostatic hypotension; however, the remaining one patient had no cardiovascular sympathetic symptom and showed no abnormality in the head-up tilt test. In contrast to ^{123}I-MIBG uptake, the decrease in ^{11}C-CFT uptake in the whole striatum and in each of its three subregions significantly correlated with disease progression represented by the HY stages, as reported previously [14, 16, 22]. Considering the causal pathophysiological mechanism of PD, this is reasonable because ^{11}C-CFT uptake directly indicates nigrostriatal dopaminergic function.

We investigated the sensitivity and specificity of cardiac ^{123}I-MIBG scintigraphy in diagnosing PD and differentiating the patients with PD from the other patients with chief complaints of parkinsonian symptoms. Similar to the

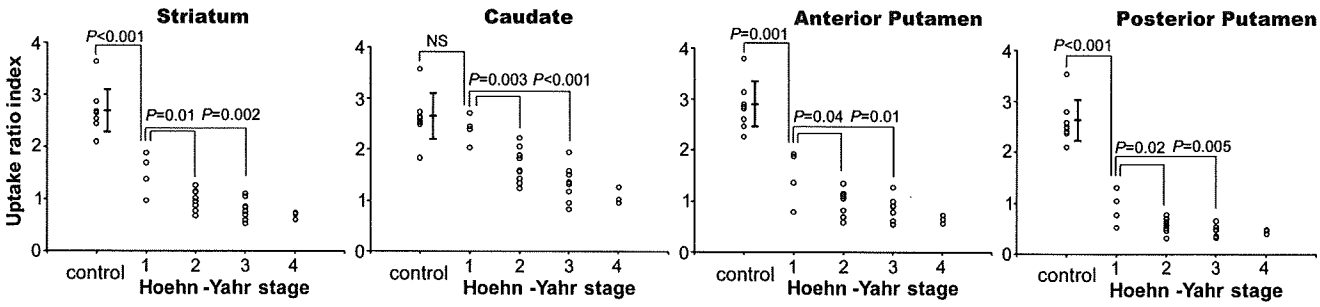

Fig. 4 Relation between the HY stage and uptake ratio index of ^{11}C-CFT in the whole striatum, caudate, anterior putamen and posterior putamen of patients with PD. In all four graphs, the uptakes in the patients in HY 1 of PD are significantly higher than those in the patients in HY 2 and 3 of PD. The uptakes in the caudate of patients in HY 1 of PD are not significantly higher than those in the caudate of controls, while the uptakes in the whole striatum, anterior putamen and posterior putamen of patients in HY 1 of PD are significantly higher than those in the corresponding regions of the controls. The *vertical bar* represents the mean ± SD of controls. *NS* not significant

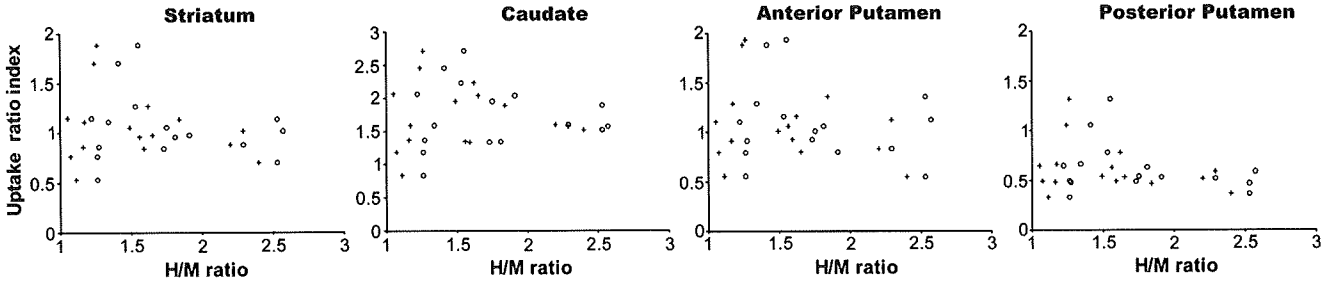

Fig. 5 Relation between the H/M ratio and uptake ratio index of ^{11}C-CFT in the whole striatum, caudate, anterior putamen and posterior putamen of patients with PD. Correlation was evaluated for 16 patients who underwent the two examinations (scintigraphy and PET) within 6 months. In all four graphs, no significant correlations are observed between the early images (*open circles*) and delayed images (*plus signs*)

previous meta-analysis of studies with a total of 246 PD cases [36], in both early and delayed images our study showed high specificity for the overall cases and high sensitivity for the advanced cases. However, early cases tended to have relatively lower sensitivity in both images, although the sample size and methodology greatly differed among the studies. Thus, our results suggested that even in the case of sustained cardiac ^{123}I-MIBG uptake, the possibility of PD should not be denied and follow-up clinical examinations, including ^{123}I-MIBG scintigraphy, should be conducted, especially in early and mild PD cases.

No definite correlation was found either between cardiac ^{123}I-MIBG uptake and striatal ^{11}C-CFT uptake or between cardiac ^{123}I-MIBG uptake and subregional ^{11}C-CFT uptake in the PD group. Two groups have reported the association between the functional impairment of the nigrostriatal dopaminergic system and that of the cardiac sympathetic system [8, 37]. Spiegel et al. (n=18) found a correlation between the two indices, i.e. ^{123}I-MIBG and ^{11}C-CFT uptake, while Raffel et al. (n=9) found no correlation between them. This discrepancy may be explained as follows. The functional impairment of both the nigrostriatal dopaminergic and cardiac sympathetic systems increases with disease progression, as described earlier; hence, a correlation was observed in some studies. On the other hand, there is no report that suggests a direct cause-effect relationship between the functional impairment of the nigrostriatal dopaminergic system and that of the cardiac sympathetic system. Thus, a statistically significant correlation between the functional impairments of the two systems may depend on the sample size and methodology. However, the functional impairments of the two systems would, in fact, occur and progress independently. Sometimes, impairment of the cardiac sympathetic function may precede that of the nigrostriatal dopaminergic function, while at other times, the latter may precede the former.

This is the first report wherein PD and NPD patterns in dopamine PET findings were defined on the basis of the results which have been confirmed as follows. In presynaptic DAT images, three characteristic changes are observed [14–16, 22]. First, the reduction in the ^{11}C-CFT uptake in the striatum begins from the posterior putamen, representing the initial locus of PD [38]. Second, the uptake ratio of the posterior putamen to the caudate is less than 1. Third, one putamen is usually more affected than the other, reflecting asymmetric degeneration. In fact, Fig. 4 shows that the ^{11}C-CFT uptake in the posterior putamen markedly decreased in the early stage of PD, while that in the caudate was relatively constant in the early stage. In postsynaptic D_2R images, putaminal uptake is normal or mildly upregulated in untreated PD, presumably as a compensatory response to decrease in presynaptic dopamine [17–19]. On the other hand, in treated or longstanding PD, the uptake restores to the normal level in the putamen and most often decreases in the caudate; this is presumably as a result of long-term downregulation due to chronic dopaminergic therapy or structural adaptation of the postsynaptic dopaminergic system to the progressive degeneration of nigrostriatal neurons [17, 19, 21]. In fact, in vitro studies have reported that the densities of striatal D_2Rs are maintained even in the advanced stage [39, 40].

On the basis of the earlier mentioned characteristic changes, especially in the posterior putamen, we defined the PD and NPD patterns such that false-negative cases should be as few as possible, because the aim was to reinforce the published clinical criteria. For defining the PD pattern, we considered that ^{11}C-CFT uptake in the posterior putamen of the patients should be less than that in the caudate of the patients and less than 50% of the mean uptake in normal controls. This percentage (i.e. 50%) was selected (1) on the basis of previous PET reports and considered suitable to distinguish normal from affected individuals [14–16, 22] and (2) on the basis of previous reports of in vitro studies, stating that parkinsonian symptoms appear when 80% of the striatal dopamine is lost or 50% of the nigral cells degenerate [38, 41]. Asymmetric uptake was not defined because of the difficulty in determining the intraindividual differences in

the uptake on the left and right sides. However, all 24 patients with PD showed asymmetric uptake. In the ^{11}C-raclopride PET image, since the uptake in the putamen was not less than the normal range, we considered that the uptake in the posterior putamen was normal or increased. For defining the NPD pattern, presynaptic function was not determined because the degree of the presynaptic dysfunction varies with diseases. In the ^{11}C-raclopride PET image, we considered that the uptake in the posterior putamen was normal or decreased because the uptake was not more than the normal range, except for Lewy body disease.

Conclusions

In early and mild PD cases, cardiac ^{123}I-MIBG scintigraphy is of limited value in the diagnosis of PD, because the sensitivity was indicated to be less than 70%. However, because of its high specificity for the overall cases and high sensitivity for the advanced cases, cardiac ^{123}I-MIBG scintigraphy may assist in the diagnosis of PD in a complementary role with the dopaminergic neuroimaging. Disease progression indicated by the HY stages has a stronger association with the nigrostriatal dopaminergic function assessed by striatal ^{11}C-CFT uptake than with the cardiac sympathetic function assessed by cardiac ^{123}I-MIBG uptake. The impairment of the two functions would occur and progress independently.

Acknowledgments The authors thank Mr. Keiichi Kawasaki, Dr. Masaya Hashimoto, and Ms. Hiroko Tsukinari for their technical assistance and useful discussions. This work was supported by grant-in-aid for Scientific Research (B) No. 20390334 (Ki.I.) from the Japan Society for the Promotion of Science and a grant (06-46) (Ki.I.) from the Program for Promotion of Fundamental Studies in Health Sciences of the National Institute of Biomedical Innovation of Japan, and a grant-in-aid for Neurological and Psychiatric Research (S.M., Y.S., and Ke.I.), and Research fo Longevity (S.M., Y.S., and Ke.I.) from the Ministry of Health, Labor, and Welfare of Japan, a grant-in-aid for Long-Term Comprehensive Research on Age-associated Dementia from the Tokyo Metropolitan Institute of Gerontology (K.K., S.M., and Ke.I.).

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Acta Neurol Scand 2010: 121: 127–130 DOI: 10.1111/j.1600-0404.2009.01272.x

ACTA NEUROLOGICA
SCANDINAVICA

Clinical Commentary

Less protease-resistant PrP in a patient with sporadic CJD treated with intraventricular pentosan polysulphate

Terada T, Tsuboi Y, Obi T, Doh-ura K, Murayama S, Kitamoto T, Yamada T, Mizoguchi K. Less protease-resistant PrP in a patient with sporadic CJD treated with intraventricular pentosan polysulphate. Acta Neurol Scand: 2010: 121: 127–130.

Treatment with intraventricular pentosan polysulphate (PPS) might be beneficial in patients with Creutzfeldt–Jakob disease. We report a 68-year-old woman with sporadic Creutzfeldt–Jakob disease who received continuous intraventricular PPS infusion (1–120 μg/kg/day) for 17 months starting 10 months after the onset of clinical symptoms. Treatment with PPS was well tolerated but was associated with a minor, transient intraventricular hemorrhage and a non-progressive collection of subdural fluid. The patient's overall survival time was well above the mean time expected for the illness but still within the normal range. Post-mortem examination revealed that the level of abnormal protease-resistant prion protein in the brain was markedly decreased compared with levels in brains without PPS treatment. These findings suggest that intraventricular PPS infusion might modify the accumulation of abnormal prion proteins in the brains of patients with sporadic Creutzfeldt–Jakob disease.

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Key words: Creutzfeldt–Jakob disease; intraventricular infusion; pentosan polysulphate; prion protein

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Accepted for publication September 3, 2009

Introduction

Current options for the treatment of Creutzfeldt–Jakob disease (CJD) do not slow or halt disease progression. Treatment with pentosan polysulphate (PPS), a large polyglycoside molecule with anti-thrombotic and anti-inflammatory properties, administered intraventricularly to bypass the blood brain barrier can both prolong the survival period and reduce the extent of abnormal prion protein (PrP) deposition in the brains of rodent prion disease models (1). The safety and efficacy of intraventricular PPS treatment in humans with CJD, however, remains largely unknown (2–6). We report a patient with sporadic CJD (sCJD) treated with continuous intraventricular PPS administration starting 10 months after the onset of clinical symptoms.

Case report

The patient was a 68-year-old woman with neither a family history of prion disease nor previous history of neurological disease. She had never received cadaveric growth hormone injection, a dura mater transplant, or a cornea transplant. She noticed unsteadiness of gait and forgetfulness at the age of 65 years. One month later, unsteadiness and intellectual deterioration progressed and myoclonic jerks appeared. Cerebrospinal fluid analysis was normal except for an increased concentration of neuron-specific enolase (66 ng/ml, normal < 25) and the presence of 14-3-3 protein. EEGs showed periodic spike/slow–wave complexes (spike–wave complexes). Diffusion-weighted MRI showed abnormal high-intensity signals in the head of the caudate nucleus, putamen and insular cortex.

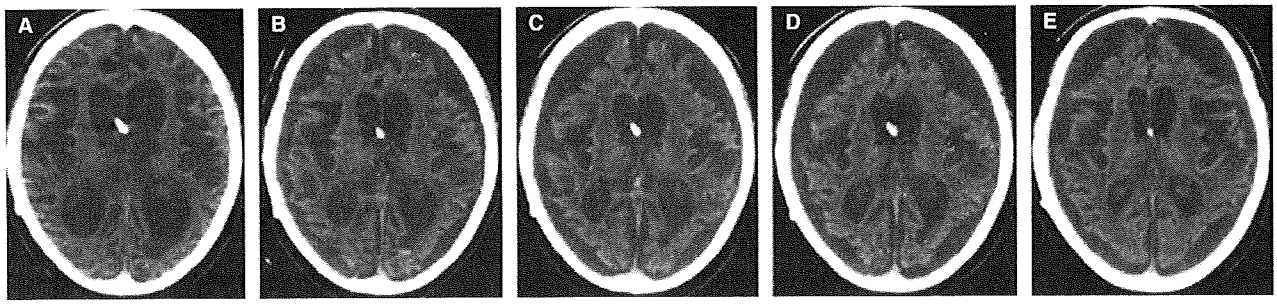

Figure 1. Sequential follow-up CT scans from 12 to 17 months after start of intraventricular PPS infusion. (A) Non-enhanced CT scan 12 months after start of intraventricular PPS infusion. Note the severe cortical and subcortical atrophy with enlargement of ventricular system. (B) Non-enhanced CT scan 13 months after start of intraventricular PPS infusion. Note the subdural fluid collection and the small sedimentation of blood in the left posterior horn. (C, D, E) Non-enhanced CT scan 14, 15, 17 months after start of intraventricular PPS infusion, respectively. The blood sedimentation in the posterior horn disappeared next month and subdural fluid collections were not progressing. No intraventricular hemorrhage was noted in scan E which was taken 7 days before death.

Genetic analysis of the *PrP* gene revealed methionine homozygosity at codon 129 and no mutations. The patient continued to deteriorate and became doubly incontinent, bed-bound and mute. Five months after the onset of symptoms, she developed akinetic mutism. Seven months after onset, the myoclonic jerks and spike–wave complexes disappeared. Ten months after onset, treatment with intraventricular PPS administration commenced under signed informed consent from her family. She received implantation of a right ventricular catheter and an epigastric subcutaneous drug infusion pump (Archimedes; 20-ml reservoir, flow rate 0.5 ml/24 h; Codman & Shurtleff Inc, Raynham, MA, USA). Using a reported protocol (5), infusion of intraventricular PPS (SP 54; bene-Arzneimittel GmbH, Munich, Germany) was started at 1 μg/kg/day, with subsequent escalation to the dose of 60 μg/kg/day 7 months later, and to the target dose of 120 μg/kg/day 15 months later, which continued until she died. However, her clinical condition did not improve and she still displayed akinetic mutism. A series of brain CT examinations demonstrated progressive brain atrophy, a transient intraventricular minor hemorrhage at the time of 13 months later, and a non-progressive collection of subdural fluid until 7 days before death (Fig. 1). Her clinical condition did not deteriorate from the time of 12 to 16 months. Monthly blood cell counts and coagulation measurements were normal. Twenty-seven months after onset, at age 68 years, the patient died of pneumonia which occurred 11 days before death and was aggravated.

Methods

Autopsy was performed within 2 h after death. The right temporal pole of the brain was dissected out and stored at −70°C. The other parts of the brain were fixed in neutral buffered formalin. Sections of representative areas of the brain were stained with hematoxylin–eosin, Klüver–Barrera and immunohistochemical methods.

Immunohistochemical staining

The following primary antibodies were used: anti-phosphorylated α-synuclein (monoclonal; Wako, Osaka, Japan), anti-phosphorylated tau (AT8, monoclonal; Fitzgerald, Concord, MA, USA), anti-amyloid β 1–42 (polyclonal; IBL, Takasaki, Japan) and anti-PrP (3F4, monoclonal; Signet, Dedham, MA, USA).

Prion protein analysis

Protease-resistant PrP was extracted from cerebral tissues of this and other sCJD patients as previously described (7). Samples were subjected to 13.5% SDS-PAGE and transferred to polyvinylidene fluoride membrane. 3F4 antibody was used as the primary antibody. Anti-mouse EnVision (Dako, Glostrup, Denmark) was used as the secondary antibody. Enhanced chemiluminescence detection (Amersham Bioscience, Little Chalfont, UK) was used to visualize Western blots. The signal intensities of the blots were quantified with Quantity One software using an imaging device, Vasa Doc 5000 (Bio-Rad Laboratories, Hercules, CA, USA) (7).

For quantitative comparison of protease-resistant PrP levels, we initially analyzed 10-fold diluted samples derived from 0.5 mg wet-weight brain tissue from the temporal pole to identify suitable dilutions. For controls, we included frontal lobe tissues from three sCJD patients (all homozygous for methionine at codon 129 of the *PrP* gene) not treated with intraventricular PPS infusion: two with a type 1 pattern of protease-resistant PrP signals in Western blot analysis (sCJD MM1) whose brains were uniformly, severely atrophied similarly to the

patient's brain, and one with cortical-type sCJD and a type 2 pattern (sCJD MM2C).

Results

Post-mortem neuropathology

The unfixed brain weighed 660 g and showed walnut-shaped severe atrophy. A massive intraventricular hematoma was present. The shape of blood cells in the hematoma was completely preserved, with no infiltration by reactive cells such as macrophages and glial cells. The PPS infusion catheter had been correctly inserted into the right lateral ventricle, and the source of hemorrhage could not be identified. There was extensive, symmetrical cortical atrophy, but the hippocampi were relatively spared.

Microscopy demonstrated extensive neuronal loss and spongiosis in most areas of the cerebral cortices, with collapsed cytoarchitecture. Axonal loss with secondary myelin loss was present in the central white matter, accompanied by a cellular reaction containing both astrocytes and microglial cells throughout the areas of myelin damage. There was widespread gliosis in the basal ganglia, thalami and cerebellar molecular layer. The cerebellar granular layer showed marked neuronal loss with gliosis and axonal loss, accompanied by secondary myelin loss in the cerebellar white matter. Lewy bodies, amyloid plaques and neurofibrillary tangles were not observed. PrP staining showed a widespread synaptic pattern in the cerebral cortices, basal ganglia and thalami. Synaptic staining was also present in the molecular layer of the cerebellum, with intense coarse deposits in the granular layer. No plaque-like PrP deposits were identified in any brain regions. The findings were consistent with the diagnosis of sCJD. There was no laterality in the extent of the neuronal loss, spongiosis, gliosis or synaptic PrP deposition.

Prion protein analysis

Western blot analysis of protease-resistant PrP showed a type 1 pattern (Fig. 2) identical to those of the two classical sCJD MM1 cases. Protease-resistant PrP levels were 1/3 to 1/8 of those in the sCJD patients with no intraventricular PPS treatment.

Discussion

Here, we present a patient with sCJD who was treated with intraventricular PPS for 17 months. The PPS dose of 120 μg/kg/day was well tolerated

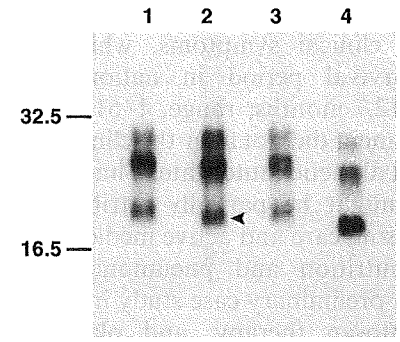

Figure 2. Comparative Western blot analysis of protease-resistant PrP. Protease-resistant PrP is categorized into three types based on the pattern of glycoform and mobility of PrP bands in Western blot analysis. Protease-resistant PrP, type 1, from the brain of this patient (threefold-diluted, lane 2) and three control subjects with sCJD: lane 1, 30-fold-diluted brain sample from an sCJD MM1 subject (65-year-old woman with a survival time of 11 months); lane 3, 20-fold-diluted brain sample from another sCJD MM1 subject (74-year-old woman with a survival time of 16 months); and lane 4, 40-fold-diluted brain sample from an sCJD MM2C subject. An unglycosylated PrP band from this patient (lane 2, arrowhead) mapped slightly lower than those in the other sCJD MM1 subjects (lanes 1 and 3). We normalized signal intensity to the band in lane 2 ($100/mm^2$). After dilution powers were also considered, the corrected signal intensities for lanes 1, 3 and 4 were $680/mm^2$, $300/mm^2$ and $770/mm^2$, respectively.

but was associated with a minor, transient intraventricular hemorrhage and collection of subdural fluid. A fresh intraventricular hematoma found during autopsy probably occurred at the agonal stage, because blood cell shape was preserved and there was no inflammatory cell infiltration. Moreover, this intraventricular hematoma is unlikely to alter the patient's clinical course, because pneumonia which occurred 11 days before death was rapidly aggravated to respiratory failure responsible for her death, and no intraventricular hemorrhage was detected on CT scan 7 days before death.

Pentosan polysulphate is a candidate anti-prion compound that has shown efficacy in animal models (1, 8, 9), and has been administered by intraventricular infusion in several patients (2–6). Thrombocytopenia and abnormal coagulation can occur occasionally with PPS but did not occur in our patient. A minor, transient intraventricular hemorrhage and a non-progressive collection of subdural fluid appeared during PPS treatment but did not influence clinical progression. These findings may have resulted from a pressure imbalance within the intraventricular or subdural spaces caused by PPS infusion, although this speculation requires further proof. Overall, a PPS dose of 120 μg/kg/day seems well-tolerated and does not cause major adverse effects in CJD patients (2–6).

This patient survived for 27 months after the onset of clinical symptoms, which exceeds the mean survival period in national surveillance studies (12.7 months; range, 1–61) in Japan (10). PPS treatment did not alter the clinical course from the initial akinetic mute state. Thus, her prolonged survival might be partially attributable to both good nursing care and active medical interventions for malnutrition and pneumonia. The present study is a preliminary case study in a sCJD patient with pentosan therapy, and placebo-controlled study with PPS infusion will be needed in the future.

Prion protein deposition was not dramatically different between the hemisphere implanted with the catheter and the opposite hemisphere, unlike data reported in a rodent model (1). Here, the treatment started at an advanced clinical stage that may have already involved extensive PrP deposition, whereas treatment in the rodent model started before PrP deposition. In addition, difference of cerebrospinal fluid flow dynamics in the brain ventricular system between rodents and humans might contribute to the discrepancy. However, we found lower levels of abnormal protease-resistant PrP here than in other untreated sCJD patients, suggesting that PPS infusion might suppress the accumulation of abnormal PrP in the brain.

This speculation requires to be further evaluated, because there are possibilities that the gap of abnormal PrP levels between the patient and the control subjects might be attributable to the difference in disease durations or brain sampling regions, or to the regional variety of abnormal PrP deposition. These possibilities could not be evaluated in the present study because of limited sample availability.

Acknowledgements

The intraventricular PPS trial in this case was supported by a grant from the Japanese Ministry of Health, Labor and Welfare (H19-nanji-ippan-006).

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Cerebrospinal fluid metabolite and nigrostriatal dopaminergic function in Parkinson's disease

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Key Words: cerebrospinal fluid, dopamine transporter, homovanillic acid, Parkinson's disease, positron emission tomography, ^{11}C-CFT

Running title: Correlation between HVA and DAT

ABSTRACT

Objectives: The purpose of this study was to evaluate the association between cerebrospinal fluid (CSF) homovanillic acid (HVA) concentrations and nigrostriatal dopaminergic function assessed by positron emission tomography (PET) imaging with carbon-11-labeled 2β-carbomethoxy-3β-(4-fluorophenyl)-tropane (^{11}C-CFT), which can measure the dopamine transporter (DAT) density, in Parkinson's disease (PD). **Methods:** ^{11}C-CFT PET scans and CSF examinations were performed on 21 patients with PD, and 6 patients with non-parkinsonian syndromes (NPS) as a control group. **Results:** In the PD group, CSF HVA concentrations were significantly correlated with the striatal uptake of ^{11}C-CFT ($r = 0.76$, $P < 0.01$). However, in the NPS group, two indexes were within the normal range. **Conclusions:** In PD, CSF HVA concentrations correlate with nigrostriatal dopaminergic function. Therefore, CSF HVA concentrations may be an additional surrogate marker for estimating the remaining nigrostriatal dopaminergic function in case that DAT imaging is unavailable.