The Clinical Spectrum of Parkinson`s Disease

by

F. GERSTENBRAND, W. POEWE, G. RANSMAYR

(University Clinic for Neurology, Innsbruck, Austria)

Clinical symptomatology and course of progression in Parkinson Syndrom exhibit such a wide variability that From a clinical point of view idiopathic Parkinson's disease does not appear to view idiopathic Parkinson's Disease does not appear to be a homogenous entity. This view is also supported by the conflicting data Found in the literature regarding the role of heredity in parkinsonism BARBEAU and POUCHER, 1982, DUVOISIN e.a. 1981.
This particular aspect has led BARBEAU and Pourcher 1982 to postulate the existence of a familial sub-group of Parkinson's disease.

On the basis of difference in clinical course BIRKMAYER et.al.(1974) and DANIELCZYK et al. (1980) have postulated the existence of a "benign" and "malignant" type of Parkinson's disease. Finally, the uneven distribution of mental changes as depression and dementia among Parkinson patients is a further argument for the Existence of subgroups of the disease as is the variability of the cardinal symptoms rigidity, akinesia and tremor as such.

We analyzed the clinical spectrum of symptoms and course Of progression in 196 of our Parkinson patients to define possible subgroups of the disease. 42% of our cases exhibited an equal severity of the cardinal symptoms rigidity, akinesia and tremor and were thus defined as "equivalent type of Parkinson's disease"; rate of progression was moderate in this group. 33% of the patients

showed prevailing of akinesia and rigidity over little or no tremor and were defined as "akineto-rigid-type of Parkinson's disease". Rate of progression in this group was slightly faster than in the equivalent type. 24% of our patients could be assigned to a "tremordominant type of Parkinson's disease". In this group women were found twice as frequent as men and rate of progression was slow.

Moderate to severe depression was found in 36% of our Patients, women being again affected twice as frequent as men. Depression was associated significantly more frequent with the equivalent or akineto-rigid type than with the tremordominant type. In the depressive group of patients clinical course of parkinsonism was generally faster.

Dementia of moderate to severe intensity was present in 32%, again being associated with the "equivalent" or "akineto-rigid" type. Severity of dementia was solely correlated to the age of patients. Prognosis was worst in this group.

The severity of autonomic symptoms in the form hypotension and neurogenic bladder disturbances justified only 3 of 196 patients to be regarded as borderline to Shv-Drager-Syndrome. Optomotoric disturbances and dysarthria in 2 of our akineto-rigid patients made them appear as borderline to Steele-Richardson-Olziewski-Syndrome.

In summarizing the clinical spectrum of Parkinson's disease shows such a variability of symptoms that the identification of sub-groups is possible. The different clinical subgroups seem to have a different course of progression. This prognostic aspect as well as the question of heredity in the sub-groups of parkinsonism has to be clarified further. At this point, however, idiopathic Parkinson's disease does not appear to be a

homogenous entity.

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