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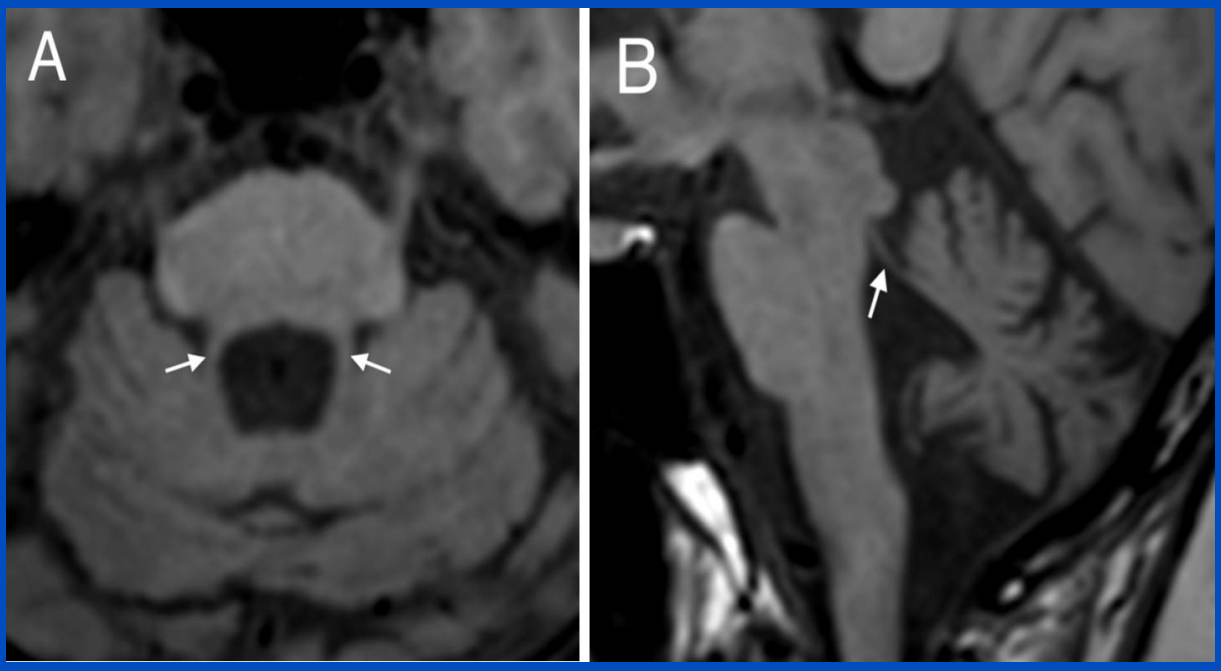

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The Brunei International Medical Journal (BIMJ) is a six monthly peer reviewed official publication of the Ministry of Health under the auspices of the Clinical Research Unit, Ministry of Health, Brunei Darussalam.

The BIMJ publishes articles ranging from original research papers, review articles, medical practice papers, special reports, audits, case reports, images of interest, education and technical/innovation papers, editorials, commentaries and letters to the Editor. Topics of interest include all subjects that relate to clinical practice and research in all branches of medicine, basic and clinical including topics related to allied health care fields. The BIMJ welcomes manuscripts from contributors, but usually solicits reviews articles and special reports. Proposals for review papers can be sent to the Managing Editor directly. Please refer to the contact information of the Editorial Office.

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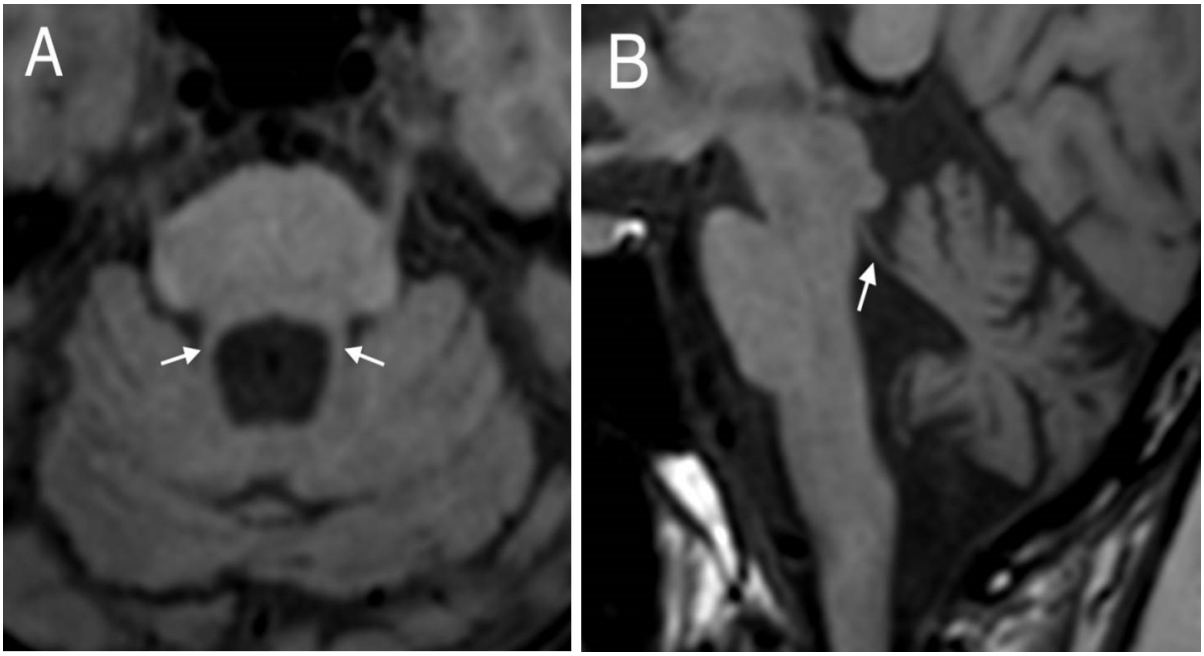

Figure 1

A 62-year-old woman with no known comorbidities presented with two years history of progressive imbalance, resulting in difficulty in walking. Within one year after the presentation, she was wheelchair bound. She later developed unilateral tremors, more on the right upper limb which caused trouble in feeding and writing. On examination, her blood pressure was 131/73 mmHg, with no evidence of postural hypotension. The pulse rate was 85 beats per minute and regular. Cranial nerve examination revealed no nystagmus or vertical gaze palsy. There was no motor weakness in the upper and lower limbs, and no cerebellar signs as evidenced by negative finger-to-nose test and dysdiadochokinesia. Mild resting tremor on the right side was noted, but no obvious bradykinesia was seen. Assessment of the gait revealed inability to perform tandem gait. Blood investigations and nerve conduction studies were normal. Therefore, a magnetic resonance imaging (MRI) of the brain was arranged.

What is the diagnosis?

***Answer**: refer to page 123*

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DISCLOSURE: There is no conflict of interest and consent has been obtained from patient for use of this image.

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(*Refer to page 122*)

ANSWER: PROGRESSIVE SUPRA-NUCLEAR PALSY (PSP)

Figure 1: A) Axial T1 weighted MRI image showing atrophy of the superior cerebellar peduncles (white arrows). Note the dilatation of the fourth ventricle medial to the peduncles, B) Sagittal T1 weighted MRI image showing atrophy of the superior cerebellar peduncle (white arrow). The inferior colliculus is noted superiorly, and anteriorly it is bordered by the body of the pons. No hummingbird sign is noted

The Parkinson-plus syndromes are an entity of neurodegenerative diseases that includes progressive supranuclear palsy (PSP), multiple system atrophy (MSA), and corticobasal degeneration (CBD). Unlike Idiopathic Parkinson's Disease (IPD), Parkinson-plus syndromes deteriorate faster and their response to the regular dopamine-based treatments are poor. The differentiation of these Parkinson-plus syndromes from IPD is undoubtedly challenging, but crucial, as the treatment approach and prognosis are different.[1]

The most common MRI findings for PSP includes midbrain atrophy (i.e Mickey Mouse sign; due to enlargement of third ventricle) and hummingbird sign (due to flattening of superior aspect of the midbrain). These findings, when present, are able to discriminate PSP from MSA and IPD with sensitivity of 100% and specificity of 100%. [2]

The MRI in this case however, did not show the typical radiological findings of midbrain atrophy, instead there was evidence of superior cerebellar peduncle (SCP) atrophy with dilatation of the fourth ventricle which are characteristic findings of PSP [Figure 1A-B]. The SCP contains fibres from the dentate nucleus in the cerebellum. The loss of these fibres is the primary basis of the postural instability in these patients.[3]

It is important to differentiate PSP from IPD, as IPD has good response to levodopa and other dopamine agonists. On the other hand, patients with MSA who present with postural instability can be managed efficiently with mineralocorticoids. Unfortunately, the treatment approach to PSP is more arduous, and requires a multidisciplinary approach that mainly consists of symptomatic treatment to help alleviate the symptoms.[1]

CONFLICT OF INTEREST

The author(s) declared no conflict of interest in this work.

CONSENT

Consent has been obtained from patient and hospital authority to publish this article.

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