Brain MRI in Neurodegeneration with Brain Iron Accumulation with and without *PANK2* Mutations

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BACKGROUND AND OBJECTIVE: Patients with a clinical diagnosis of neurodegeneration with brain iron accumulation (NBIA, formerly called Hallervorden-Spatz syndrome) often have mutations in PANK2, the gene encoding pantothenate kinase 2. We investigated correlations between brain MR imaging changes, mutation status, and clinical disease features.

METHODS: Brain MRIs from patients with NBIA were reviewed by 2 neuroradiologists for technical factors, including signal intensity abnormalities in specific brain regions, presence and location of atrophy, presence of white matter abnormality, contrast enhancement, and other comments. PANK2 genotyping was performed by polymerase chain reaction amplification of patient genomic DNA followed by automated nucleotide sequencing.

RESULTS: Sixty-six MR imaging examinations from 49 NBIA patients were analyzed, including those from 29 patients with mutations in PANK2. All patients with mutations had the specific pattern of globus pallidus central hypointensity with surrounding hypointensity on T2-weighted images, known as the eye-of-the-tiger sign. This sign was not seen in any studies from patients without mutations. Even before the globus pallidus hypointensity developed, patients with mutations could be distinguished by the presence of isolated globus pallidus hyperintensity on T2-weighted images. Radiographic evidence for iron deposition in the substantia nigra was absent early in disease associated with PANK2 mutations. MR imaging abnormalities outside the globus pallidus, including cerebral or cerebellar atrophy, were more common and more severe in mutation-negative patients. No specific MR imaging changes could be distinguished among the mutation-negative patients.

CONCLUSION: MR imaging signal intensity abnormalities in the globus pallidus can distinguish patients with mutations in PANK2 from those lacking a mutation, even in the early stages of disease.

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1.5 to 59 years at the time of the examination. Ninety-four percent (94%) were done on 1.5T units. Patients ranged in age from two studies were done on 0.5T scanners, and the remainder the earliest studies were performed in 1988 on a 0.3T unit. Fourteen image sets included only T2-weighted scans. Ninety-four percent (94%) were done on 1.5T units. The remaining 42% showed signal hypointensity in this region. Among patients with a mutation, 17 of 29 scans (58%) showed hypointense nigral region on T2 imaging, and the remainder showed nigral signal hypointensity. The mean age of the patients with a mutation was 3 years and consistently predated the appearance of a hypointense globus pallidus interna (Fig 2). This finding occurred at a mean age of 3 years and clearly correlate with age or duration of symptoms. Of the 5 gadolinium contrast studies performed in patients with a mutation, none showed lesion enhancement.

Among patients with a mutation, 30 of 37 scans (81%) showed signal hypointensity in the substantia nigra pars reticulata on T2 imaging, and the remainder showed nigral signal hypointensity. The mean age of the patients with a PANK2 mutation with hypointense nigra was 25 years, compared with 13 years for those with signal hypointensity in this region ($P = 0.05$). Among patients without a mutation, 17 of 29 scans (58%) showed hypointense nigral region on T2 imaging, and the remaining 42% showed signal hypointensity in this region. Mean ages for these 2 groups did not differ significantly (17 versus 15 years).

Other MR imaging changes were seen in a minority of patients with a mutation. Mild cerebellar or cerebral atrophy was identified in 8 of 29 patients (28%). The thalamus, caudate, putamen, and white matter showed no abnormalities in any studies from patients with a mutation. In contrast, patients without a mutation were much more likely to show additional brain abnormalities, especially atrophy of the cerebellum or cerebrum (12/21, 57%) ($P < 0.05$), which was moderate to severe in 11 cases (92%), and white matter disease, which was observed in 6 of 21 cases (29%).
highly sensitive brain regions, though the basis for this sensitivity is not fully understood. This tissue damage leads to excess iron accumulation in normally iron-rich brain structures, a process that is suspected to be secondary in the pathogenesis of this disease. Thus, one would predict that radiographic evidence of tissue edema would precede that of iron accumulation, which we now show to be the case.

A second notable observation from this study is the late appearance of radiographic evidence of iron deposition in the substantia nigra pars reticulata in PKAN. This feature was widely reported in postmortem pathologic studies, which usually were done on patients who were at the end stage of their disease. A high level of iron in the substantia nigra has been included among the diagnostic criteria for NBIA; however, we have shown that it may not be evident by MR imaging early in the course of disease.

T2* effects related to abnormal iron accumulation were clearly seen at all field strengths and (as expected) were accentuated with greater degrees of T2 or T2* weighting. None of the present cases had imaging performed at 3T, which would be expected to show even greater signal intensity drop-out because of inherently greater T2* effects. As is widely appreciated, the amount of signal intensity loss in the globus pallidus and other iron-containing structures (in both health and disease) varies according to field strength, pulse sequence, exact technique, and even reading conditions, such as the window and level chosen for filming or reading. All of these considerations need to be taken into account when analyzing a case for suspected NBIA.

One limitation of this study is that we did not include normal MR imaging controls or patients with other neurologic diseases related to the basal ganglia. Normal aging and many pathologic conditions have been linked to mineralization of the basal ganglia, and this would result in hypointensity on T2-weighted images. Some toxic or metabolic conditions can also cause necrosis of the globus pallidus. The combination of mineralization and central necrosis could therefore occur in the globus pallidus in other clinical conditions. For example, an eye-of-the-tiger sign might be simulated in an older patient with normal but mineralized globi pallidi who then suffers carbon monoxide poisoning, leading to pallidal necrosis. Clearly, the clinical history and other neuroradiologic features beyond the globus pallidus need to be considered when such a morphologic lesion is encountered. Therefore, the specificity of our findings is relevant for a population of patients with NBIA but would not necessarily hold for a wider population of patients with neurodegenerative or toxic conditions.

Even after patients with PKAN are excluded, NBIA probably still includes several distinct disorders based on the range of features that are observed. Although the MR imaging findings from this study do not allow us to further stratify NBIA into discrete diseases, the other brain MR imaging abnormalities that were commonly observed in patients without the mutation may eventually lead to better ideas about pathogenesis.

Conclusion

Patients with mutations in the PANK2 gene can be distinguished from patients without the mutation by their specific brain MR imaging changes, even very early in disease. The pattern of MR imaging abnormalities in pantothenate kinase-
associated neurodegeneration evolves over time and may help to clarify the disease process.

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References