Clinical Reasoning: A 60-Year-Old Man With Ataxia, Chorea, and Mild Cognitive Impairment

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Abstract

We describe the case of a 60-year-old man with a 16-year history of gait imbalance and 15-year history of forgetfulness. The insidious onset and slow progression suggested that the disease was degenerative. Neurologic examination revealed cerebellar ataxia, chorea, and mild cognitive impairment. Brain magnetic resonance imaging revealed prominent cerebellum atrophy and diffuse atrophy in the brainstem and cerebrum. Based on neurologic manifestations, an additional patient interview and skin examination were conducted. Photosensitivity and freckling in exposed areas, which the patient did not recognize as disease symptoms, were observed. Based on acute and chronic photosensitivity and DNA repair test results, a final diagnosis was made. In patients with cerebellar ataxia, chorea, and cognitive dysfunction of unknown etiology, clinicians should explore patient history of photosensitivity and carefully examine the skin.

Section 1

A 60-year-old Japanese man with a medical history of diabetes presented with gradually progressive gait imbalance that began at 44 years of age as well as development of forgetfulness beginning at the age of 45 years. The patient did not drink alcohol in excess, reported no family history of similar symptoms or neurodegenerative disorders, and his parents were not consanguineous. There were no complaints of hearing loss or eye symptoms. His weight was 49 kg and height was 156 cm. He did not have microcephaly. The patient received a score of 28/30 on the Mini-Mental State Examination. He scored 86/100 on Addenbrooke’s Cognitive Examination III (in Japanese, 1 ≤88 reflects mild cognitive impairment), with the following subscores: attention and orientation, 18/18; memory, 23/26; fluency, 7/14; language, 24/26; and visuospatial skills, 14/16. Cranial nerve examination was significant for breakdown of smooth
pursuits without nystagmus and mild cerebellar dysarthria. Involuntary choreiform movements of the tongue and upper and lower extremities were noted (video). He had normal strength in both arms and legs. Deep reflexes in the lower limbs were absent. He had bilateral mild dysmetria and dysdiadochokinesia. His gait was normal, but tandem walking was impaired. Sensory examinations were normal. There was no Romberg sign. The Assessment and Rating of Ataxia scale was utilized and indicated a score of 8.5.

Questions for consideration:

1. What is the differential diagnosis for the patient’s presentation?
2. What is your initial approach to investigations?

Section 2

In the current case, the patient presented with generalized chorea, cerebellar ataxia, and mild cognitive impairment. The absence of deep tendon reflexes in the lower extremities could be related to diabetic neuropathy. The insidious onset and slow progression suggested that the disease was degenerative. Although the most common cause of chronic progressive chorea in adults is Huntington’s disease, cerebellar ataxia is unusual in patients with adult-onset Huntington’s disease and suggests an alternative diagnosis, such as spinocerebellar ataxia (SCA) (SCA1, 2, 3, 7, 8, 12, 17, 48), dentatorubral-pallidoluysian atrophy (DRPLA), neuroacanthocytosis, Friedreich’s ataxia, Wilson’s disease, or mitochondrial disease (Table 1). Nutritional deficiencies (vitamin B1 or B12) and infectious etiologies, such as syphilis and HIV, may present with similar manifestations. Although paraneoplastic syndrome may also present with a similar constellation of symptoms/signs, the insidious onset and slow progression over 16 years made these disorders less likely. Routine blood tests, including a complete blood count as
well as tests to assess liver function, renal profile, electrolytes, thyroid function, HIV status, and presence of syphilis were unremarkable. The patient’s levels of vitamin B1, B12, serum ceruloplasmin, and creatine kinase were normal. Acanthocytes were not detected in his peripheral blood smears. His HbA1c was 6.8%, and his blood glucose was 147 mg/dL. Nerve conduction studies revealed sensory axonal polyneuropathy. Brain magnetic resonance imaging (MRI) demonstrated prominent atrophy in the cerebellum with diffuse atrophy in the brainstem and cerebrum (Figure 1). Ataxia panel testing for diagnoses within the SCA group, including SCA1, 2, 3, 6, 7, 8, 12, 17, 31, and DRPLA, were unremarkable.

Questions for consideration:

1. What additional historic patient details could be important to obtain?
2. What further physical examinations should be performed?

Section 3
Nutritional deficiencies, syphilis, HIV, Wilson’s disease, neuroacanthocytosis, SCAs (1, 2, 3, 7, 8, and 17), and DRPLA were excluded based on unsupportive laboratory, brain MRI, and genetic analysis results. However, the differential diagnosis was broad and included mitochondrial disease, rare SCAs (12 and 48), Friedreich’s ataxia, and rare genetic disorders that usually develop in childhood, such as xeroderma pigmentosum (XP). Additional history was taken regarding sun sensitivity. The patient acknowledged photosensitivity with persistent erythema after limited sun exposure from childhood, although he did not recognize this symptom as a component of a disease. Skin examination revealed the freckling of sun-exposed regions (face, V-area of the neck, forearms, and dorsal surface of the hands) (Figure 2). Referral to dermatology revealed basal cell carcinoma of the forehead, which was excised.
Question for consideration:

1. What additional testing could confirm the diagnosis?

Section 4

DNA repair ability was assessed by measuring unscheduled DNA synthesis after irradiation with ultraviolet radiation C (UVC) using skin fibroblasts cultured from the patient. It was found to be decreased to 18% of normal cells. Based on the symptoms of acute and chronic photosensitivity and the result of the DNA repair test, a diagnosis of XP was made. The genetic complementation group of XP was determined to be XP group F (XPF) based on the host cell reactivation assay, where the UV sensitivity of cells was restored only after the transfection of plasmid containing XPF cDNA but with no other XP complementation group cDNAs. Next-generation sequencing revealed three missense variants of the ERCC4 gene. Among the detected variants, c.2395C>T [p.Arg799Trp] has been reported as a pathogenic mutation in previous studies of patients with XPF.\(^5\)\(^-\)\(^8\) Computational predictions were made regarding the effects of the two remaining variants of uncertain significance (VUS) on protein structure. The gene c.2413T>C [p.Ser805Pro] variant has not been reported in large population cohorts. Several in silico analyses, Polymorphism Phenotyping V2 (PolyPhen-2), Sorting Intolerant from Tolerant (SIFT), and Protein Variation Effect Analyzer (PROVEAN), suggest that this variant is benign, damaging, and deleterious, respectively. The gene c.2734G>A [p.Gly912Arg] is present in large population cohorts at a very low frequency. Therefore, its presence through several in silico analyses, including PolyPhen-2, SIFT, and PROVEAN, suggests that this variant is possibly damaging (PolyPhen-2 and SIFT) or neutral (PROVEAN). Based on the clinical and genetic
features, we strongly speculate that XPF is caused by compound heterozygous mutation of the ERCC4 gene, the c.2395C>T gene, and either of these two VUS.

Discussion
XP is an autosomal recessive hereditary disorder of DNA repair primarily characterized by photosensitivity and predisposition to skin cancers. XP is classified into seven complementation groups (A-G) and one variant form (XP-V). While the variant form is associated with defects in translesion synthesis, the seven complementation groups are associated with defects in nucleotide excision repair.9 Progressive neurological manifestations, including cognitive impairment, cerebellar ataxia, neuropathy, choreoathetoid involuntary movements, and sensorineural deafness, occur in about one quarter of patients with XP in Western countries and in more than half of Japanese patients with XP.4,10,11 In this case, cerebellar ataxia, chorea, and mild cognitive impairment were observed as neurological manifestations of XP. The absent deep reflexes in the lower limbs and sensory axonal neuropathy were consistent with the diagnosis of diabetic polyneuropathy and/or polyneuropathy associated with XP.

Neurological symptoms are primarily associated with XP group A (XPA) and group D (XPD) but have also been reported in patients with XP group B, XPF, and group G (XPG).9,11,12 XPA, which exhibits the lowest DNA repair ability, is the most commonly affected complementation group and manifests the most severe neurological symptoms, which develop in childhood.9 Typically, the first neurological symptoms of cognitive impairment appear before 8 years of age.10 The next neurological symptoms are generally cerebellar symptoms, which usually occur between 4 and 16 years of age, and, in conjunction with the neuropathy that appears later, cause gait disturbance.9,10 Aspiration pneumonia, laryngeal dystonia, and vocal cord paralysis lead to
death before the age of 40 years.\textsuperscript{4,10} Homozygotes of the IVS3-1G>C mutation in the XPA gene, known as the founder mutation, account for more than 85\% of the Japanese patients who have XPA and suffer from severe neurological abnormalities.\textsuperscript{4,9} In Japanese patients with XPA, motor and speech functions were reported to decline after the age of 6 years due to neurological manifestations and length-dependent polyneuropathy beginning in the first decade.\textsuperscript{9,13} On the other hand, cases of XPA mild form, XPF, and XPG, in which neurological symptoms develop in adulthood, have been reported.\textsuperscript{6–8,12,14,15} In these cases of adult-onset neurological symptoms, cerebellar ataxia, chorea, and cognitive dysfunction were the core symptoms and were accompanied by various combinations of hearing loss, neuropathy, and pyramidal tract signs.\textsuperscript{6–8,12,14,15} Therefore, XP can be a differential diagnosis for adult-onset cerebellar ataxia and chorea. XP may be undiagnosed and latent in patients with spinocerebellar degeneration of unknown etiology. In the current case, the skin manifestations were mild and were not recognized by the patient as disease symptoms. Exome sequencing in patients with suspected hereditary SCA has revealed ERCC4 mutations that have been known to cause XPF.\textsuperscript{5,7} In these patients with identified ERCC4 mutations, skin manifestations were not considered as symptoms of a disease until genetic diagnosis, as in the current case. Timely diagnosis of XP is important for initiation of education regarding sun protection and for early detection and excision of malignant skin tumors.\textsuperscript{4} The available pharmacological therapy for neurological manifestations of XP is limited to symptomatic treatment. Because oxidative stress and mitochondrial dysfunction are presumed to be pathological mechanisms, antioxidant therapies such as coenzyme Q\textsubscript{10} supplementation have been investigated as a possible pharmacological approach.\textsuperscript{16} In patients with cerebellar ataxia, chorea, and cognitive dysfunction of unknown etiology, clinicians should examine history of photosensitivity and carefully assess the skin, keeping XP in mind as a differential diagnosis.
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Figure legends

Figure 1. Brain magnetic resonance imaging

A-C: axial T2-weighted images, D: sagittal T1-weighted image

Brain magnetic resonance imaging shows severe cerebellar atrophy (A, D) and diffuse atrophy in the brainstem and cerebrum (B, C).
Figure 2. Photographs

Face (A, B), legs (C), arms (D) photographs of the patient demonstrate freckling in the photo-
exposed areas (arrow heads) (A, B, D). Note the clear demarcation with the zones usually
protected by clothes (A, C, D).
Supplemental material

Video.

Segment 1: Involuntary choreiform movements were noted in the upper limbs. Segment 2: Hypermetria was observed in his right upper limb. Segment 3: Incoordination was observed in his right lower limb on knee-to-heel test.
### Table. Differential diagnoses for adult-onset chorea and cerebellar ataxia of a degenerative nature

<table>
<thead>
<tr>
<th>Differential diagnosis</th>
<th>Age of onset (years)</th>
<th>Inheritance</th>
<th>Clinical features</th>
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</thead>
<tbody>
<tr>
<td>SCA1</td>
<td>20–50</td>
<td>AD</td>
<td>Pyramidal signs</td>
</tr>
<tr>
<td>SCA2</td>
<td>20–50</td>
<td>AD</td>
<td>Pyramidal signs, Parkinsonism, Bulging eyes</td>
</tr>
<tr>
<td>SCA3</td>
<td>5–70</td>
<td>AD</td>
<td>Progressive external ophthalmoplegia, Pyramidal signs, Bulging eyes, Progressive external ophthalmoplegia, Pyramidal signs, Dystonic-rigid extrapyramidal signs</td>
</tr>
<tr>
<td>SCA7</td>
<td>10–30</td>
<td>AD</td>
<td>Retinal dystrophy</td>
</tr>
<tr>
<td>SCA8</td>
<td>20–40</td>
<td>AD</td>
<td>Drown-out slowness of speech</td>
</tr>
<tr>
<td>SCA12</td>
<td>30–50</td>
<td>AD</td>
<td>Cognitive and psychiatric changes, Action tremor</td>
</tr>
<tr>
<td>SCA17</td>
<td>20–50</td>
<td>AD</td>
<td>Cognitive and psychiatric changes, Parkinsonism</td>
</tr>
<tr>
<td>SCA48</td>
<td>30–50</td>
<td>AD</td>
<td>Cognitive and psychiatric changes, Seizures, Cognitive and psychiatric changes, Seizures, Cognitive and psychiatric changes, Self-injurious orofacial dyskinesia, Cognitive and psychiatric changes, Peripheral neuropathy, Cardiomyopathy, Scoliosis, Foot deformities, Cognitive and psychiatric changes, Dystonia, Kayser-Fleischer rings, Liver disease</td>
</tr>
<tr>
<td>DRPLA</td>
<td>5–70</td>
<td>AD</td>
<td>Cognitive and psychiatric changes, Cognitive and psychiatric changes, \ Self-injurious orofacial dyskinesia, Cognitive and psychiatric changes, Peripheral neuropathy, Cardiomyopathy, Scoliosis, Foot deformities, Cognitive and psychiatric changes, Dystonia, Kayser-Fleischer rings, Liver disease</td>
</tr>
<tr>
<td>Chorea-acanthocytosis</td>
<td>20–40</td>
<td>AR</td>
<td>Self-injurious orofacial dyskinesia, Cognitive and psychiatric changes, Peripheral neuropathy, Cardiomyopathy, Scoliosis, Foot deformities, Cognitive and psychiatric changes, Dystonia, Kayser-Fleischer rings, Liver disease</td>
</tr>
<tr>
<td>Friedreich’s ataxia</td>
<td>Before 25</td>
<td>AR</td>
<td>Cognitive and psychiatric changes, Peripheral neuropathy, Cardiomyopathy, Scoliosis, Foot deformities, Cognitive and psychiatric changes, Dystonia, Kayser-Fleischer rings, Liver disease</td>
</tr>
<tr>
<td>Wilson’s disease</td>
<td>6–50</td>
<td>AR</td>
<td>Cognitive and psychiatric changes, Dystonia, Kayser-Fleischer rings, Liver disease</td>
</tr>
<tr>
<td>Condition</td>
<td>Age of Onset</td>
<td>Inheritance</td>
<td>Associated Conditions</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<tr>
<td>Aceruloplasminemia</td>
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<td>McLeod neuroacanthocytosis syndrome</td>
<td>Before 40</td>
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<td>Mitochondrial disease</td>
<td>Before 70</td>
<td>Maternal</td>
<td>Cognitive and psychiatric changes, Hearing loss, Short stature, Peripheral neuropathy</td>
</tr>
</tbody>
</table>

Abbreviations: SCA, spinocerebellar ataxia; AD, autosomal dominant; DRPLA, dentatorubral-pallidoluysian atrophy; AR, autosomal recessive
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