Brief Report

Spatial Discrimination Threshold Abnormalities are not Detected in a Pilot Study of DYT6 Dystonia Mutation Carriers

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Abstract

Background: Spatial discrimination thresholds (SDTs) assess somatosensory integration, and provide a window into better understanding the pathophysiology of dystonia. They are abnormal in some focal dystonias, but normal in DYT1 dystonia. It is unknown whether SDTs are altered in DYT6 gene mutation carriers (C).

Methods: SDTs were assessed in 17 DYT6 C (including eight manifesting carriers), 15 DYT1 C (including seven manifesting carriers) and 34 controls, using a standardized grating orientation task. Subjects were asked to recognize the orientation of Johnson–Van Boven–Philips (JVP) dome gratings on either index fingertip until 40% or more answers were incorrect. SDTs between indexes were calculated and averaged, with a final SDT assigned to each subject, and tertiles for control SDTs were constructed.

Results: SDTs of DYT6 C or DYT1 C were comparable to those of controls, and not more likely to be in the worst tertile (p = 0.8 for DYT6 C vs. controls and p = 1.0 for DYT1 C vs. controls). This was independent of gene expression.

Discussion: DYT6 carriers do not have impaired SDTs with the JVP dome paradigm. The normal SDT pattern thus suggests shared sensory physiologic patterns with DYT1 dystonia.

Keywords: DYT6, DYT1, dystonia, sensory discrimination threshold

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Introduction

Dystonia is characterized by involuntary, sustained muscle contractions that result in twisting and repetitive movements and abnormal postures.1 Both neurophysiologic and clinical observations suggest that dystonia is associated with a disturbance of sensory integration. Clinically, there is often improvement of dystonic postures using sensory tricks (gestes antagonistes).2 Although basal ganglia dysfunction likely contributes to the pathogenesis of genetic dystonia, expanded neuronal circuits have been implicated. Positron emission tomography (PET) studies in carriers of the DYT1 dystonia mutation suggest overexcitability of the sensorimotor system,3 whereas reductions in cerebello-thalamic connectivity are thought to correlate with disease expression in both DYT1 and DYT6 gene mutation carriers.4 Several models of sensory processing dysfunction in dystonia have been proposed,5,6 and the role of somatosensory abnormalities in disease pathogenesis warrants further study.

Mapping with somatosensory evoked potentials demonstrates abnormal homuncular organization of finger representations in the primary somatosensory cortex in a primate genetics model of focal dystonia and repetitive strain injury.7 A disorganized pattern, which
correlates with dystonia severity, is also seen in humans with brachial dystonia.\(^6\) Although some functional neuroimaging studies have demonstrated decreased sensorimotor activation in dystonia (due perhaps to the heterogeneity of the cohorts of the patients examined),\(^3\) the majority of studies suggests overactivation of contralateral sensorimotor and supplemental motor cortex. Motor tasks, such as repetitive learning show activation in bilateral dorsal pre-motor and inferior parietal association cortex,\(^4\) and contralateral dorsolateral prefrontal cortex (gyrus frontalis medialis, superior frontal gyrus, fronto-orbital cortex) as well. Functional imaging also supports cortical sensory abnormalities in response to vibratory stimuli, albeit decreased, as measured by PET and \(^{15}\)O blood flow scanning where the peaks were reduced in the primary sensorimotor area and supplementary motor area in writer’s cramp.\(^1\) Although the etiology of dystonia is often unknown, two genes for primary dystonia have been elucidated, \(TOR1A\) (\(DYT1\)) and \(THAP1\) (\(DYT6\)). Based on PET and magnetic resonance imaging (MRI) abnormalities, as well as their characteristic early age of disease onset, both disorders have been hypothesized as neurodevelopmental circuit disorders of cortico-striatal-pallido-thalamocortical and cerebellar-thalamo-cortical pathways.\(^1\)

Spatial discrimination thresholds (SDTs) have been proposed as a method for understanding the role of sensory processing in different forms of dystonia through assessing the integrity of sensory integration. The SDT describes the shortest distance interval at which two stimuli applied to the same part of the body can be recognized as spatially separated and can be readily tested at the bedside.\(^2\) SDTs have been found to be normal in patients with \(DYT1\) dystonia, but impaired in subjects with focal dystonias, notably, writer’s cramp, blepharospasm, and cervical dystonia.\(^3\) Although SDT testing is less sensitive in patients with adult-onset focal dystonias than another task of sensory discrimination, the temporal discrimination threshold (TDT),\(^5\) SDT is highly portable and readily assessed.

SDT has not been evaluated in \(DYT6\) gene (\(THAP1\)) mutation carriers. As \(DYT6\) may present with focal or segmental dystonia, including writer’s cramp and cranio-cervical dystonia,\(^1\) this study was performed to establish whether SDTs are abnormal in \(DYT6\) mutation carriers, and may be an endophenotype of \(DYT6\) dystonia. Further, penetrance of the \(DYT6\) and \(DYT1\) genes is reduced, and symptoms of dystonia are present in approximately 60% of cases\(^2\) with \(DYT6\) mutations and 30–40% of those with \(DYT1\) mutations.\(^1\) As both \(DYT1\) and \(DYT6\) gene carriers who do not express symptoms may have abnormal brain circuitry, a function endophenotype of carrying the mutated \(THAP\) gene has been proposed.\(^4\) In order to determine whether SDTs could detect a sensory endophenotype of \(DYT6\) dystonia, we also performed SDTs in \(THAP1\) non-manifesting mutation carriers.

Methods

Subjects

Subjects who participated in ongoing genetic studies of dystonia and movement disorders were recruited for SDT assessment and gave informed consent. This study was approved by the Internal Review Board at Beth Israel Medical Center. For dystonia family members, mutations in \(THAP1\) and \(DYT1\) were assessed as previously reported.\(^1\) Controls were recruited from married-in or non-mutation carrying family members of probands and laboratory members. We evaluated \(DYT6\) mutation carriers (C), both with dystonia (manifesting carriers, MC) and without (non-manifesting carriers, NMC), and compared these with unaffected controls.

Sensory testing

SDTs were tested using a standardized grating orientation task, which employs plastic Johnson-Van Boven-Philips (JVP) domes (Stoelting Co, IL, http://www.stoeltingco.com/stoelting/3129/1465/1480/Physio/JVP-Domes), as has been previously reported.\(^1\) The subjects were seated facing the examiner and blindfolded, with the right index finger resting extended against a table and the distal finger fat pad facing up. Each dome was applied on the fingertips a total of 20 times for about 1–2 seconds each time, starting with the largest width grating (4.5 mm for subjects aged 46 or more and 2.5 mm for subjects aged less than 46 years) and proceeding through gradually narrower ones (the dome with the smallest width grating was 0.75 mm). The purpose of using the widest grating for the older subgroup of subjects was to account for the expected age-related decline in sensory discrimination.\(^1\) Domes were applied randomly with the gratings aligned either parallel (“down”) or perpendicular (“across”) to the axis of the finger, and with enough pressure to indent the skin by 1 mm. Prior to asking subjects to recognize the grating orientation in a blinded fashion, subjects were trained on the different orientations for each different grating size. The process continued until eight (40%) or more answers for a given grating width were incorrect. Sensory testing was then repeated on the contralateral index finger following the same paradigm. Subjects who attained 40% or more incorrect responses for the largest (4.5 mm or 2.5 mm, depending on the subject’s age at the time of testing) groove widths were assigned the threshold of the largest width tested within their age group. The SDT for each hand was calculated by linear interpolation of the 75% level of accuracy and the final SDT was calculated as the mean of both index fingers.

Data analysis

SDTs from controls were divided by age into two groups ([46 years or older and less than 46 years]. Tertiles for each group were constructed, with the third (or highest) tertile containing SDTs from the individuals with the poorest performance. Non-control subjects were then categorized based on the control tertiles. Individuals scoring in the first two tertiles were considered to have normal SDTs, and those within the third tertile were considered abnormal. The distribution of abnormal SDTs was first compared between all \(DYT6\) mutation carriers and controls (STATA10, StataCorp LP, TX). To determine whether the presence of abnormal SDTs was a disease effect rather than a gene effect, we then divided the gene mutation carrier groups into MC and NMC, and compared each of these subgroups with
controls using Fisher’s exact test. These analyses were repeated comparing DYT1 groups with controls.

As botulinum toxin type A (BntxA) has been shown to transiently improve the SDT in patients with cervical dystonia, presumably by modulating afferent cortical inputs from muscle spindles, we performed post hoc analyses on the subgroups of MC who had not received BntxA injections in the previous 3 months. We also compared SDT means stratified by age (subjects 45 years and younger or subjects older than 45 years) with controls.

**Results**

Seventy-five subjects were studied: 20 DYT6 C (including 10 DYT6 MC), 19 DYT1 C (of which 10 were DYT1 MC), and 36 healthy controls. To be eligible for the domes paradigm, subjects could not have evidence of central or peripheral neurologic abnormalities accounting for deficiencies in distal hand sensation (mainly, but not limited to, a known history or symptoms suggestive of carpal tunnel syndrome or sensory polyneuropathy), or other potential conditions that may falsely elevate their SDTs, such as the presence of heavy palmar callouses or a history of prolonged exposure to vibrating tools. After applying these exclusion criteria, a total of 66 subjects (eight DYT6 MC, nine DYT6 NMC, seven DYT1 MC, eight DYT1 NMC and 34 controls) completed the study. General characteristics of all groups are summarized in Table 1. Clinical characteristics of DYT1 MC and DYT6 MC are described in Table 2.

SDTs were not more likely to be in the worst tertile in DYT6 C compared with controls (p = 0.8), and this was independent of gene expression. That is, there was no difference between SDTs of the subgroups of DYT6 C (DYT6 MC and DYT6 NMC) when compared with controls (p = 0.2 and 1.0, respectively). Tertile distribution of SDTs for controls and DYT6 C, MC and NMC is summarized in Table 3. As expected, DYT1 C (p = 1.0), MC (p = 1.0) and NMC (p = 1.0) were not more likely to have abnormal discrimination as defined as in the upper tertile compared with controls. Sensitivity subanalysis of the smaller group of DYT6 C who did not receive BntxA injections 3 months prior to sensory testing also did not show a difference from controls (p = 0.8).

Similar to the tertile approach, examination of raw data comparing age-stratified SDT means with those of controls showed no significant differences between the groups. DYT6 C ages 45 years and younger were not different from controls (p = 0.3); DYT6 MC, NMC and control values were also not different (p = 0.7). DYT1 C younger than 46 years were not different from controls (p = 0.9), nor was the comparison of DYT1 MC, NMC and controls (p = 0.7). For individuals aged 46 years and older, comparing DYT6 C vs. controls and MC, NMC, and controls, (p = 0.9 and 0.5, respectively), and DYT1 C vs. controls (p = 0.8) was also not significant.

**Discussion**

Our results suggest that DYT6 mutation carriers, both manifesting and non-manifesting, do not have impaired SDTs. In agreement with a prior report, we further demonstrate that DYT1 MC also do not have abnormal SDTs. As similar results were noted in DYT6 and DYT1 mutation carriers, we postulate that the integrity of higher sensory circuitry assessed in the SDT paradigm is not compromised, or is compensated for, in both genetic forms of dystonia.

Neural circuit similarities have been noted in functional and MRI of both DYT1 and DYT6 dystonia carriers manifesting with dystonia. Fluorodeoxyglucose PET studies demonstrate that both DYT1 C and DYT6 C show relative metabolic increases in the pre-supplementary motor area and parietal association regions. Further, both DYT1 C and DYT6 C scanned with $^{11}$C-raclopride PET were found to have

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**Table 1. Subject Demographics**

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Median Age (years)</th>
<th>Gender (F/M)</th>
<th>Handedness (R/L)</th>
<th>Genotype</th>
<th>Median Onset Age (years)</th>
<th>Median Disease Duration (years)</th>
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</thead>
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<tr>
<td>DYT1 C</td>
<td>15</td>
<td>43.2</td>
<td>(10/5)</td>
<td>(14/1)</td>
<td>c.904_906delGAG</td>
<td>8.5</td>
<td>23.2</td>
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<tr>
<td>DYT1 MC</td>
<td>7</td>
<td>39.2</td>
<td>(4/3)</td>
<td>(6/1)</td>
<td>c.904_906delGAG</td>
<td>8.5</td>
<td>23.2</td>
</tr>
<tr>
<td>DYT1 NMC</td>
<td>8</td>
<td>48.6</td>
<td>(6/2)</td>
<td>(8/0)</td>
<td>c.904_906delGAG</td>
<td>8.5</td>
<td>23.2</td>
</tr>
<tr>
<td>DYT6 C</td>
<td>17</td>
<td>41.8</td>
<td>(11/6)</td>
<td>(13/4)</td>
<td>c.65T→R (n=6)</td>
<td>11.5</td>
<td>14.2</td>
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<tr>
<td>DYT6 MC</td>
<td>8</td>
<td>21.7</td>
<td>(5/3)</td>
<td>(6/2)</td>
<td>c.65T→R (n=1)</td>
<td>11.5</td>
<td>14.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>c.61T&gt;A (n=1)</td>
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<td></td>
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<tr>
<td>DYT6 NMC</td>
<td>9</td>
<td>47.4</td>
<td>(6/3)</td>
<td>(7/2)</td>
<td>c.65T→C (n=7)</td>
<td>11.5</td>
<td>14.2</td>
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<td></td>
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<td></td>
<td></td>
<td>c.61T&gt;A (n=2)</td>
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<tr>
<td>Controls</td>
<td>34</td>
<td>33.1</td>
<td>(16/18)</td>
<td>(34/0)</td>
<td>c.134_135insGGGT; c.137_139delAAC</td>
<td>8.5</td>
<td>23.2</td>
</tr>
</tbody>
</table>

Abbreviations: C, carriers; MC, manifesting carriers; NMC, non-manifesting carriers.

1Amish-Mennonite Founder Insertion deletion (indel) mutation c.134_135insGGGT; 137_139delAAC
Table 2. Clinical Characteristics of DYT1 and DYT6 Manifesting Carriers

<table>
<thead>
<tr>
<th>Subject</th>
<th>Age at Domes (years)</th>
<th>Age at Onset (years)</th>
<th>Symptom Duration</th>
<th>Distribution of Dystonia</th>
<th>Genotype</th>
<th>BntxA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>43.2</td>
<td>8.0</td>
<td>35.2</td>
<td>TAMRG</td>
<td>*</td>
<td>Yes</td>
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<tr>
<td>2</td>
<td>39.2</td>
<td>10.0</td>
<td>29.2</td>
<td>AMRG</td>
<td>*</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>39.6</td>
<td>9.0</td>
<td>30.6</td>
<td>AMKRG</td>
<td>*</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>23.1</td>
<td>7.0</td>
<td>16.1</td>
<td>AMG</td>
<td>*</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>23.3</td>
<td>6.0</td>
<td>17.3</td>
<td>UFLNAMKRG</td>
<td>*</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>19.0</td>
<td>13.0</td>
<td>6.0</td>
<td>ARG</td>
<td>*</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>53.5</td>
<td>12.0</td>
<td>41.5</td>
<td>A</td>
<td>*</td>
<td>No</td>
</tr>
</tbody>
</table>

Abbreviations: A, right arm; BntxA, botulinum toxin type A; F, lower face; G, left leg; J, jaw; K, trunk; L, larynx; M, left arm; N, neck; R, right leg; T, tongue; U, upper face.

1 All were right-hand dominant except subjects 7, 11, and 15.
2 Sites affected at time of Johnson–Van Boven–Philips testing.
3 Amish-Mennonite Founder Insertion deletion (indel) mutation c.134_135insGGGTT; 137_139delAAC
4 All DYT1 mutation carriers harbored c.904_906delGAG.

Table 3. Tertile Distribution of Sensory Discrimination Thresholds (SDTs) for Controls and DYT6 C Manifesting carriers (MC) and non-manifesting carriers (NMC)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>1.09–1.64</td>
<td>1.95–2.44</td>
<td>12 (35.3)</td>
<td>7 (46.7)</td>
<td>2 (28.6)</td>
<td>5 (62.5)</td>
<td>8 (47.1)</td>
<td>4 (50)</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>2nd</td>
<td>1.73–2.33</td>
<td>3.39–3.48</td>
<td>9 (26.5)</td>
<td>3 (20)</td>
<td>3 (42.9)</td>
<td>0 (0)</td>
<td>4 (23.5)</td>
<td>3 (37.5)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>3rd</td>
<td>2.38–2.87</td>
<td>3.82–3.84</td>
<td>13 (38.2)</td>
<td>5 (33.3)</td>
<td>2 (28.6)</td>
<td>3 (37.5)</td>
<td>5 (29.4)</td>
<td>1 (12.5)</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td></td>
<td>34 (100)</td>
<td>15 (100)</td>
<td>7 (100)</td>
<td>8 (100)</td>
<td>17 (100)</td>
<td>8 (100)</td>
<td>9 (100)</td>
</tr>
</tbody>
</table>

Abbreviations: MC, manifesting carriers; NMC, non-manifesting carriers.
reductions in putamen and caudate D2 receptor availability, and recent work with diffusion tensor imaging MRI also suggests that both DYT1 C and DYT6 C share two discrete areas of reduced pathway connectivity in the cerebello-thalamo-cortical projection system. However, there are also differences noted on functional imaging: raclopride PET demonstrates significantly more pronounced reductions in DYT6 than in DYT1 in striatal D2 availability. The absence of an abnormality suggests that the SDT is not mediated through the cortico-striatal-pallido-thalamocortical and cerebellar-thalamo-cortical circuits abnormal in DYT1 and DYT6 dystonia, or that there is compensation in the circuitry, which facilitates normal sensory discrimination with this task.

Although studies in non-DYT1 families suggest that SDT may identify an endophenotype of gene carriers in unaffected family members of dystonia subjects, we did not detect SDT abnormalities in either the DYT6 NMC or the DYT1 NMC. This differs from functional imaging studies, which suggest that DYT1 NMC and DYT6 NMC have striatal metabolic abnormalities accompanied by changes in D2 receptor availability.

There are several potential limitations to this study including age differences between the groups, treatment with botulinum toxin A in some subjects, paradigm sensitivity, and a relatively small sample size. The dystonia groups differed in age, with the DYT6 MC group younger than the other groups. We therefore corrected for the age-related decline in sensory discrimination by using domes with a larger width grating, and, as expected, this caused a pronounced increase in the calculated threshold of subjects with impaired sensory discrimination. Nonetheless, despite the correction, we were unable to find a significant difference in SDT's in DYT1 and DYT6 subjects compared with controls.

Additionally, one (12.5%) of our DYT6 MC and four (57%) of the DYT1 MC had received BntxA within the last 3 months prior to sensory testing. The role of BntxA in affecting sensory discrimination is still not well understood. However, it has been suggested that BntxA may modulate afferent cortical inputs from muscle spindles and cause a sensory cortical reorganization in adult-onset primary torsion dystonia patients receiving this treatment. Therefore we cannot be certain that the absence of an abnormality in SDT could be a medication-related effect. Although in their original study of DYT1 subjects, the 2 out of the 13 DYT1 MC who were on BntxA therapy did not receive injections in at least 3 months prior to testing, which argues in favor of normal SDT's in DYT1 regardless of treatment, the small sample size in their and our study precludes proper assessment of a BntxA effect.

Although we did not detect an abnormality with the JVP domes, we still not be a sufficiently sensitive test. Potential reasons include the already mentioned age-related loss of sensory discrimination and operator-dependent variations such as inconsistent pressure applied to the fingertips, a variable and inconsistent time during which the dome is applied, or inadvertent feedback to the subject subject regarding the orientation of the domes. Sensory disturbances may be mild enough in DYT1 (and perhaps also in DYT6) that SDT testing simply fails to detect them. Employment of more sensitive techniques to measure sensory integration in DYT6 carriers may prove useful. TDT is defined as the shortest time interval at which two stimuli are discerned as separate. Studies indicate that such thresholds are higher in patients with DYT1 dystonia, and cervical and focal-hand dystonia than in healthy controls. Abnormalities in the TDT may represent a reliable endophenotype in those predisposed family members who have not manifested with adult-onset focal dystonia. As TDT testing is more sensitive than SDT in adult-onset focal dystonia, it may demonstrate changes in sensory integration abnormalities in DYT6 dystonia, and should be tested in this population.

Acknowledgment

We are grateful to the study participants.

References