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## Spatial reorganization of putaminal dopamine D2-like receptors in cranial and hand dystonia

Kevin J. Black

*Washington University School of Medicine in St. Louis*

Abraham Z. Snyder

*Washington University School of Medicine in St. Louis*

Jonathan W. Mink

*University of Rochester*

Veeral N. Tolia

*Pediatrix Medical Group*

Fredy J. Revilla

*University of Cincinnati - Main Campus*

*See next page for additional authors*

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**Authors**

Kevin J. Black, Abraham Z. Snyder, Jonathan W. Mink, Veeral N. Tolia, Fredy J. Revilla, Stephen M. Moerlein, and Joel S. Perlmutter

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3

4 **Authors:**

5 Kevin J. Black, M.D. (1-4)

6 Abraham Z. Snyder, M.D., Ph.D. (2,3)

7 Jonathan W. Mink, M.D., Ph.D. (7)

8 Veeral N. Tolia, M.D. (8)

9 Fredy J. Revilla, M.D. (9)

10 Stephen M. Moerlein, Ph.D. (3,5)

11 Joel S. Perlmutter, M.D. (2-4,6)

12

13 **Affiliations:**

14 Departments of (1) Psychiatry, (2) Neurology, (3) Radiology, (4) Anatomy & Neurobiology,  
15 (5) Biochemistry and Molecular Biophysics, and (6) Program in Physical Therapy, Washington  
16 University School of Medicine, St. Louis, MO 63110

17 (7) Departments of Neurology, Neurobiology & Anatomy, Brain & Cognitive Sciences, and  
18 Pediatrics, University of Rochester, Rochester, NY

19 (8) Pediatrix Medical Group, Sunrise, FL

20 (9) Gardner Family Center for Parkinson's Disease and Movement Disorders, University of  
21 Cincinnati College of Medicine, University of Cincinnati, Cincinnati, OH

22

23 **Corresponding author:**

24 Joel S. Perlmutter, M.D.

25 Campus Box 8225

26 4525 Scott Ave.

27 St. Louis, MO 63110

28 email: joel@npg.wustl.edu

29

1 **Abstract**

2           The putamen has a somatotopic organization of neurons identified by correspondence of  
3 firing rates with selected body part movements, as well as by complex, but organized,  
4 differential cortical projections onto putamen. In primary focal dystonia, putaminal binding of  
5 dopamine D<sub>2</sub>-like receptor radioligands is quantitatively decreased, but it has not been known  
6 whether selected parts of the putamen are differentially affected depending upon the body part  
7 affected by dystonia. The radioligand [<sup>18</sup>F]spiperone binds predominantly to D<sub>2</sub>-like receptors in  
8 striatum. We hypothesized that the spatial location of [<sup>18</sup>F]spiperone binding within the putamen  
9 would differ in patients with dystonia limited to the hand versus the face, and we tested that  
10 hypothesis using positron emission tomography and magnetic resonance imaging. To address  
11 statistical and methodological concerns, we chose a straightforward but robust image analysis  
12 method. An automated algorithm located the peak location of [<sup>18</sup>F]spiperone binding within the  
13 striatum, relative to a brain atlas, in each of 14 patients with cranial dystonia and 8 patients with  
14 hand dystonia. The mean (left and right)  $|x|$ ,  $y$ , and  $z$  coordinates of peak striatal binding for each  
15 patient were compared between groups by t test. The location of peak [<sup>18</sup>F]spiperone binding  
16 within the putamen differed significantly between groups (cranial dystonia  $z <$  hand dystonia  $z$ ,  
17  $p = 0.016$ ). We conclude that in primary focal dystonia, dopamine D<sub>2</sub>-like receptors are  
18 distributed differently in the putamen depending on the body part manifesting dystonia.  
19

1 **Introduction**

2           Dystonia is a clinical syndrome of involuntary muscle contractions producing either  
3 sustained or intermittent abnormal postures of different body parts [1]. Primary dystonias are  
4 distinguished from secondary dystonias by absence of identifiable insults such as stroke, birth  
5 injury, or drug reaction. Dystonia restricted to a specific part of the body is called focal dystonia  
6 and is usually primary. Two examples of focal dystonia are cranial dystonia, with sustained  
7 involuntary eyelid closure frequently associated with lower facial grimacing, and hand cramp,  
8 with excessive co-contractions of agonist and antagonist hand or forearm muscles during specific  
9 tasks such as writing.

10           The pathophysiology of primary focal dystonia is only partially understood [2,3,4,5,6].  
11 However, dopamine D2-like receptor binding in the putamen is abnormally low [2,7,8,9,10,11].  
12 Although the neurological manifestation is focal, it is unclear whether the decrease in D2-like  
13 binding is uniform throughout the putamen or whether it is somatotopically related to the body  
14 part affected. In other words, D2-like receptors may be more affected in a part of the putamen,  
15 corresponding to the focal change in behavior.

16           We investigated this question by comparing the spatial distribution of [<sup>18</sup>F]spiperone  
17 binding in patients with cranial dystonia to the distribution in patients with hand cramp. We  
18 hypothesized that if the focal distribution of clinical signs corresponded to a focal abnormality of  
19 the putamen, then the spatial distribution of [<sup>18</sup>F]spiperone would differ between the two types of  
20 dystonia.

21

22 **Methods**

23           *Ethics Statement.* The study was approved by the Washington University Human Studies

1 Committee, and all subjects gave written informed consent.

2         *Patients.* A movement disorders specialist examined all subjects and made the diagnosis  
3 of primary cranial dystonia (with predominant involuntary eyelid squeezing and excessive  
4 blinking) or primary hand dystonia based upon typical clinical characteristics [12]. Each person  
5 also completed the Edinburgh Handedness Inventory [13], Mini-Mental State Examination [14],  
6 and Hamilton Depression Rating Scale [15]. Exclusion criteria included evidence of dementia,  
7 depression, dystonia affecting any other part of the body, drug abuse, other neurologic illness or  
8 exposure to drugs known to affect dopamine receptors. There were 14 patients with cranial  
9 dystonia (1 left-handed, 10 women, median age 54.5, range 46-79), and 8 patients with hand  
10 cramp (2 left-handed, 6 women, median age also 54.5, range 25-68). In a secondary analysis, we  
11 examined data from 10 normals who were studied contemporaneously using the same methods  
12 (1 left-handed, 5 women, median age 63.5, range 24-76). Data from some subjects were included  
13 in a prior report [7].

14         *Magnetic resonance image (MRI) acquisition.* Sagittal MPRAGE (TR = 9.7ms, TE = 4ms,  
15 and flip angle=12°) images were acquired with a 1.5T Siemens Magnetom scanner [16]. The 3D  
16 field of view was 256×256×160 mm with voxel dimensions 1×1×1.25mm. The main field was  
17 shimmed and the transmitter tuned before each study.

18         *Radioligand.* [<sup>18</sup>F]Spiperone was prepared using a microwave-facilitated synthetic  
19 pathway [17]. The radiopharmaceutical had ≥95% radiochemical purity and a specific activity ≥  
20 2000 Ci/mmol.

21         *Positron emission tomography (PET) image acquisition.* PET data were acquired with a  
22 Siemens ECAT 953b camera in the 2D wobble mode. The spatial characteristics of this  
23 instrument have been extensively documented [18,19]. In the 2D wobble mode it produces 31 2D

1 images with an intrinsic resolution of approximately 5.4mm (full width half maximum; FWHM)  
2 in plane and 4.2mm axially. Three to 5 mCi of [ $^{18}\text{F}$ ]spiperone was injected intravenously, and  
3 PET scans began immediately with tracer injection. Scan lengths began at 60 seconds and  
4 increased to 10 minutes, for a total of 3 hours. The images were reconstructed with a ramp filter  
5 using measured attenuation. During the scan, patients were at rest with eyes closed in a quiet,  
6 darkened room. They were observed frequently and had essentially no dystonic movements  
7 during the scan.

8 *Image processing: overview.* The reconstructed PET images were corrected for inter-scan  
9 head movement and registered to a standard atlas [20] using the procedure described below [21].  
10 This procedure yielded, for each subject, an atlas-transformed [ $^{18}\text{F}$ ]spiperone PET image  
11 weighted to reflect specific binding (“late image”). The late images then were used to examine  
12 diagnosis-dependent changes in putaminal [ $^{18}\text{F}$ ]spiperone distribution. Although only the late  
13 images were analyzed for group differences in [ $^{18}\text{F}$ ]spiperone activity, all the acquired PET data  
14 were used in computing the PET-MRI image registrations, to maximize the reliability of this  
15 critical step [see also ref. 22, Supplementary Information].

16 *Preliminary PET image processing.* The decay-corrected, reconstructed PET data  
17 acquired during each 3 hour scan were divided into 18 frames, each frame representing 10  
18 minutes of scanning. (The first 3 such frames were created by simple addition of data originally  
19 acquired in 2- or 5-minute bins). We called the first 7 ten-minute frames “early” and the last 3  
20 ten-minute frames “late”, leaving 8 “middle” frames. The cutoff times dividing these three  
21 groups were chosen to give images on which tracer distribution primarily reflected blood flow  
22 (early) or specific binding (late) [23,24; see also Discussion]. All frames within each group were  
23 aligned to the middle frame of that group by rigid body (6 parameter affine) transformations

1 using difference image variance minimization as the objective function [25]. Early, middle and  
2 late composite images then were produced by conventional resampling and averaging using 3D  
3 linear interpolation.

4 *PET-MRI alignments.* The early, middle and late composite PET images and the MP-  
5 RAGE image were mutually coregistered. Rigid body alignments corresponding to all image  
6 pairs within the group were computed using, as the objective function, a variant of the image  
7 intensity gradient correlation method of Andersson et al. [26]. On the basis of these alignments,  
8 rigid body transforms were computed bringing each of the 3 composite PET images into register  
9 with the MP-RAGE. Translational and rotational alignment inconsistency was estimated by  
10 comparing the transforms relating each pair of images. The estimated transform inconsistency  
11 typically was only ~0.3 root mean square (rms) mm total for translation and ~0.3 rms degree  
12 total for rotation. In no case did these quantities exceed 0.5 rms mm or 0.5 rms degree.

13 *Atlas transformation.* Each subject's MRI was transformed to atlas space by optimizing  
14 the linear fit to an atlas target image [20,25]. Finally, the late PET image was transformed into  
15 atlas space by matrix multiplication and trilinear interpolation. The accuracy of this method has  
16 been demonstrated [22,27,28].

17 *Peak search and statistics.* For each subject, the late image was smoothed to 7mm final  
18 FWHM resolution using a Butterworth filter, and then searched with an automated algorithm  
19 which reports the center of mass of intensity peaks in the image [29]. Center of mass was  
20 computed over a spherical volume of interest with 6mm radius (see Figure 1 for an example).  
21 The coordinates of peak activity in left and right putamen were averaged for each subject using  
22 the absolute value of the  $x$  coordinate. Several previous studies have indicated that patients with  
23 unilateral hand cramp have bilateral physiologic abnormalities [30,31,32], and for the cranial



1 dystonia patients no left-right difference would be predicted. The mean  $|x|$ ,  $y$ , and  $z$  coordinates in  
2 cranial vs. hand dystonia were compared using unpaired t-tests. We report uncorrected  $p$  values  
3 since the three coordinates are not independent, but note that the conservative Bonferroni  
4 correction would accept  $p < 0.017$  as significant.

## 6 **Results**

7         The peak location of putaminal [ $^{18}\text{F}$ ]spiperone binding differed significantly between  
8 groups (see Table 1 and Figure 2). Descriptively, the cranial dystonia subjects' peaks were more  
9 medial, anterior and inferior than the hand cramp patients', but only the  $z$  dimension difference  
10 was statistically significant.

11         Since patients in the two dystonia groups could not be perfectly matched by age, we  
12 examined whether a difference in mean age was likely to account for the results. This was  
13 performed by plotting peak  $z$  coordinate versus age in a separate group of normal volunteers;  
14 images were analyzed exactly as for the dystonia patients. As shown in Figure 3, in this small  
15 sample there is no evidence for an age effect (Pearson's  $r = -0.1$ ). Furthermore, from the best  
16 linear fit to this data, the predicted  $z$  value for the mean age (61.3) of the cranial dystonia patients  
17 is 4.3, while the predicted  $z$  value for the mean age (51.6) of the hand cramp patients is 4.4. The  
18 observed difference between the two dystonia groups is 21 times greater than this small  
19 difference attributable to age.

## 21 **Discussion**

22         The spatial distribution of [ $^{18}\text{F}$ ]spiperone binding in the putamen differs in cranial and  
23 hand dystonia. This demonstrates differential spatial distribution of receptors within the putamen

1 corresponding to localized behavioral manifestation of dystonia.

2           We and others have shown that average D<sub>2</sub>-like binding over the whole putamen is 25-30%  
3 lower in focal dystonia than in normal controls [7,8,9,10,11]. (Increased binding of certain D<sub>2</sub>-  
4 like ligands in dopa-responsive dystonia is not comparable, as these ligands are displaceable by  
5 dopamine, so decreased dopamine synthesis increases their binding even if receptors are normal  
6 [33,34,35] or decreased [36].) Decreased D<sub>2</sub>-like receptor binding corresponds to numerous other  
7 suggestions that dopaminergic dysfunction may be involved in the pathophysiology of focal  
8 dystonias [2,3,4,6,37,38,39].

9           What has not been clear is whether this decrease is homogeneous throughout the putamen.  
10 If so, other factors would presumably determine which body part manifests dystonic symptoms.  
11 This is consistent with the notion of a “two-hit” animal model of dystonia [40,41,42].  
12 Alternatively, different focal dystonias in humans might all feature an average decrease in  
13 putaminal D<sub>2</sub>-like receptor binding, but changes in the distribution of D<sub>2</sub>-like receptors within  
14 the putamen might dictate which body parts were affected. The present study reveals a difference  
15 in the spatial distribution of D<sub>2</sub>-like receptors between patients with dystonia affecting the hand  
16 or face, and we speculate that the difference may prove to be somatotopic.

17           Several lines of evidence indicate that there is a somatotopic organization in the putamen  
18 [43]. Pathway anatomy in monkeys has shown that projections from the face, arm, and leg  
19 representations in somatosensory and motor cortex terminate in a topographic pattern that  
20 preserves the somatotopic separation of these body areas [44,45,46,47,48,49,50]. The  
21 somatotopic arrangement is such that the legs are represented laterally, anteriorly and dorsally in  
22 the putamen, the face is represented medially, posteriorly and ventrally, and the arm is  
23 represented between these (Figure 4). The somatotopy has been confirmed by studies of neuronal

1 activity related to movement of different body parts and by activation of discrete movements by  
2 microstimulation in different areas in putamen [46]. The presence of somatotopy in the human  
3 putamen has been shown with functional MRI blood oxygen level dependent (BOLD) activation  
4 during self-paced flexion-extension of fingers or toes [51].

5         The work of Graybiel and colleagues has indicated that the anatomical relationship  
6 between somatotopically identified regions of cerebral cortex and putamen is not simple [49].  
7 One area of cortex projects to multiple areas in putamen, and closely related cortical areas (e.g.  
8 thumb and fifth finger representations) project to overlapping areas. Thus, there are convergent  
9 and divergent projections in the corticostriatal projection [52]. However, projections from non-  
10 adjacent body part representations in cortex have little or no overlap in putamen. Thus, despite  
11 the complex pattern and multiple representations, face, arm and leg are represented separately.  
12 These non-overlapping representations conform to the overall organization described above with  
13 leg dorsal, lateral, and anterior to face, and arm in between.

14         Delmaire and colleagues [53] demonstrated that this normal somatotopic representation  
15 in putamen was disrupted in patients with writer's cramp (task-specific focal dystonia of the  
16 hand). In healthy control subjects, repetitive movements of the toes led to BOLD activation in  
17 the superior part of the contralateral putamen, lip movements activated the inferior putamen, and  
18 finger movement activation in the putamen was between them. By contrast, writer's cramp  
19 patients had no such gradient. As in the present study, the abnormality was limited to the  
20 superior-inferior axis.

21         Several limitations of our work should be addressed. The precise nature of the group  
22 difference in distribution of radiotracer binding is not revealed by the methods chosen for this  
23 study. Since overall putaminal D2R binding is decreased in focal dystonias, one would like to

1 know whether focal decreases in [<sup>18</sup>F]spiperone binding exist and where they are located within  
2 the putamen. Thus a search for a local minimum in [<sup>18</sup>F]spiperone binding in putamen might  
3 seem more intuitive. However, numerical searches for local minima in a small region of high  
4 signal are likely to identify the putaminal boundary. Another approach would be to compare  
5 [<sup>18</sup>F]spiperone binding at each voxel. However, given the available number of subjects and the  
6 high image variance, we did not predict adequate power to find a group difference while  
7 correcting for multiple comparisons at ~1000 voxels [54]. Furthermore, the normal spatial  
8 distribution of [<sup>18</sup>F]spiperone binding within the putamen is not well characterized at the  
9 resolution of PET. Finally, one would like to know whether receptor binding at a given voxel is  
10 quantitatively lower or higher than normal. Unfortunately, the counting statistics in  
11 [<sup>18</sup>F]spiperone PET images are inadequate to confidently quantify absolute radioligand binding  
12 on a pixel-by-pixel basis using validated tracer kinetic analysis techniques. Faced with these  
13 difficulties, we chose to characterize the spatial distribution of radiotracer using a  
14 straightforward and reliable method, namely location of peak binding in a radiographic image.  
15 This method is robust even with low-resolution images and relatively small group sizes, and  
16 provided adequate statistical power to verify our main hypothesis that putaminal D2-like  
17 dopamine receptors are distributed differently in patients with dystonia in different body parts.  
18 However, these advantages were bought at a price: this method does not permit us to identify the  
19 location in putamen most pertinent to pathophysiology, or to clarify whether the binding at the  
20 identified peak is abnormally high or low in either patient group compared to normal. Still, we  
21 have shown that there is a difference in D2-like receptor distribution between cranial dystonia  
22 and hand cramp.

23 We use the “late” image alone to make inferences about the location of receptor binding,

1 rather than apply a full tracer analysis to quantify radioligand binding [24,55]. This is valid in the  
2 present context. For valid comparisons of radioligand specific binding between two groups, it is  
3 necessary to apply a tracer kinetic model that includes measurements of not only regional  
4 radioligand concentration but also regional blood flow, blood volume, time-dependent measures  
5 of radioactivity in arterial blood and the accumulation of radiolabeled metabolites. Using these  
6 data and parameter estimation methods, it is possible to estimate specific binding of the  
7 radioligand binding [7,23,24]. However, the present analysis does not require these additional  
8 steps, since the peripheral blood measurements are the same for analyzing every part of the  
9 putamen, and the small differences that could exist in blood flow and blood volume in different  
10 parts of the putamen would not appreciably affect the estimate of radioligand binding [55].  
11 Therefore, identifying the location of peak radioactivity in a single subject is equivalent to  
12 identifying the location of peak radioligand binding in that subject, but does not provide an  
13 absolute measure of specific binding that would permit quantitative comparisons across subject  
14 groups.

15       Using the whole brain to compute atlas registration improves reliability since there is  
16 more data upon which to perform the co-registration, but may be less sensitive to additional  
17 changes in receptor distribution which might be detected by a putamen-only atlas. Also, although  
18 our results most likely reflect differences in dopamine receptors, only about 70% of  
19 [<sup>18</sup>F]spiperone specific binding sites in primate striatum are attributable to D<sub>2</sub>-like dopamine  
20 receptors with the remainder composed of serotonin S<sub>2</sub> receptors [24]. At the time that these  
21 studies were performed, [<sup>18</sup>F]spiperone was the only D<sub>2</sub>-like radioligand available to us; more  
22 robust receptor measurements may be possible using the D<sub>2</sub>-specific radioligand  
23 (*N*-methyl)benperidol [56,57]. An additional potential limitation in interpreting our results is that

1 the different location of peak binding could reflect either neurochemical or anatomical  
2 differences between groups. However, an MRI study in these patients showed no group  
3 difference in putamen volume [54], suggesting that the difference is likely to reflect altered  
4 receptor distribution rather than anatomical changes. In this study we cannot resolve whether the  
5 observed differences in striatal [<sup>18</sup>F]spiperone binding are involved in the production of  
6 symptoms or whether they arise in response to the repeated dystonic movements; however,  
7 results in a rodent model and in human non-manifesting DYT1 gene carriers are more consistent  
8 with the former possibility [10,58]. Additionally, a recent study suggests that D<sub>3</sub> rather than D<sub>2</sub>  
9 receptors may be responsible for the abnormal putaminal D<sub>2</sub>-like receptor binding in focal  
10 dystonia [57]. Nevertheless, all these issues are tangential to the main finding of a receptor  
11 difference in putamen that corresponds to a focal difference in behavior.

12 In conclusion, patients with dystonia affecting different body parts have a different  
13 spatial distribution of [<sup>18</sup>F]spiperone binding in the putamen that may reflect the previously  
14 demonstrated somatotopic organization of putamen. This demonstrates that focal behavioral  
15 manifestations of disease can correspond to focal neurotransmitter receptor changes in striatum.

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21 10 November 1998 ([F1000Posters 2013; 4:117](#)).

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4

5

1 **Figure Legends**

2

3 Figure 1.

4 **Title:** Matched coronal sections from the MP-RAGE (top) and late image (bottom) for one  
5 subject

6 **Legend:** The lines in each image cross at the location of peak putaminal [ $^{18}\text{F}$ ]spiperone binding  
7 in this subject.

8

9 Figure 2.

10 **Title:** Peak [ $^{18}\text{F}$ ]spiperone binding in striatum (atlas  $z$  coordinate) in cranial and hand dystonia

11 **Legend:** The location of peak [ $^{18}\text{F}$ ]spiperone binding in striatum (atlas  $z$  coordinate) is graphed  
12 for each subject according to which part of the body is affected by dystonia. On average, the  
13 peak was 2.1mm more superior in the hand cramp group than in the group with cranial dystonia  
14 affecting the face.

15

16 Figure 3.

17 **Title:** Peak putaminal [ $^{18}\text{F}$ ]spiperone binding does not vary significantly with age

18 **Legend:** The location of peak [ $^{18}\text{F}$ ]spiperone binding in striatum (atlas  $z$  coordinate) is graphed  
19 versus age, for a group of normal volunteers. There is no meaningful correlation of this measure  
20 with age, and the line which best fits the data has a nearly flat slope.

21

22 Figure 4.

23 **Title:** Somatotopy represented on a coronal section of the putamen

24 **Legend:** Fig. 3A from ref. [43], used by permission.

25

1 **Table 1.** Mean location in atlas space of peak [ $^{18}\text{F}$ ]spiperone binding, by group (mm).

2

	$ x $	$y$	$z$
cranial dystonia	23.9	0.4	2.8
hand cramp	24.5	-0.5	4.9
$p$	0.372	0.588	<b>0.016</b>

3