Sir, We have read with great interest the article by Wu and Hallett (2013) entitled ‘The cerebellum in Parkinson’s disease’. These authors reviewed related anatomical, clinical and neurophysiological findings, and discussed the possible roles of the cerebellum in the pathophysiology of Parkinson’s disease. They pointed out that Parkinson’s disease is associated with pathological and structural changes in the cerebellum, and also stated that functional neuroimaging has demonstrated increased activation of the cerebellum in Parkinson’s disease. Furthermore, tremor and cerebellar involvement is discussed in Parkinson’s disease, and a primary dysfunction in the cerebello-thalamo-cortical circuit, particularly the vermis/paravermis region, is thought to be responsible for the occurrence of resting tremor. Another assumption is that functional or structural changes in the cerebellum may contribute to non-motor symptoms in Parkinson’s disease. The authors propose that the major role of the cerebellum in Parkinson’s disease includes pathological and compensatory effects, and that pathological changes in the cerebellum might be induced by dopaminergic degeneration (Wu and Hallet, 2013).

Spinocerebellar ataxias (SCA) are defined as a group of autosomal dominant ataxic disorders caused by degeneration of the cerebellum and its afferent and efferent connections (Schöls et al., 2004). Besides ataxia, SCA have a wide range of neurological symptoms including extrapyramidal signs, such as parkinsonism. The most common SCA worldwide is spinocerebellar ataxia type 3 (SCA3) or Machado-Joseph disease (Pedroso et al., 2012). Interestingly, a specific phenotype of SCA3 classically described in patients of African origin, is comprised by pure parkinsonism without ataxia. Also, parkinsonism, especially the akinetic-rigid syndrome, has been described in patients with SCA, particularly SCA2, SCA3 and SCA17, and is a common condition in Asian patients (Schöls et al., 2000; Schmitz-Hübsch et al., 2008). In a Brazilian series of 104 patients with Machado-Joseph disease, parkinsonism was seen in eight cases and there was no relationship with CAG repeat size or age of symptom onset. It should be noted that levodopa is an effective treatment in this group of patients with SCA3 (Teive et al., 2012). But what is the reason for the presence of parkinsonism in SCA?

Considering pathological studies in SCA3, atrophy of the pons, basal ganglia, medulla oblongata, multiple cranial nerve nuclei, thalamus, and the frontal, parietal, temporal, occipital and limbic lobes have been observed (Rub et al., 2008). Of note, degeneration of the substantia nigra is not an unusual pathological finding (Fig. 1). As for neuroimaging features, hyperechogenicity of the substantia nigra has been observed through transcranial sonography in patients with SCA3, similarly to Parkinson’s disease, although no correlation between echogenicity and parkinsonian features has been found (Pedroso et al., 2011). In addition, single-photon emission computed tomography (SPECT) with 99mTc-TRODAT-1, a dopamine transporter (DAT) radiotracer restricted to the striatum, discloses significant reductions of dopamine transporter density in the caudate and putamen of patients with SCA3, as well as in Parkinson’s disease (Braga-Neto et al., 2012). Anatomical and biochemical findings have previously suggested the existence of connections between the cerebellum and basal ganglia and more recent studies have shown that the cerebellum influences glutamatergic and dopaminergic striatal activity (Delis et al., 2013). This is in line with Wu and Hallet (2013), when they presumed that pathological changes in the cerebellum might be induced by dopaminergic degeneration; perhaps...
Parkinsonism in primary cerebellar disorders is related to cerebello-thalamo-cortical circuit involvement and basal ganglia impairment.

References


