

TABLE 452-1 ETIOLOGY OF MOTOR NEURON DISORDERS

Diagnostic Category	Investigation
Structural lesions	MRI scan of head (including foramen magnum and cervical spine)
Parasagittal or foramen magnum tumors	
Cervical spondylosis	
Chiari malformation of syrinx	
Spinal cord arteriovenous malformation	
Infections	CSF exam, culture
Bacterial—tetanus, Lyme	Lyme titer
Viral—poliomyelitis, herpes zoster	Anti-viral antibody
Retroviral—myelopathy	HTLV-1 titers
Intoxications, physical agents	24-h urine for heavy metals
Toxins—lead, aluminum, others	Serum lead level
Drugs—strychnine, phenytoin	
Electric short, x-irradiation	
Immunologic mechanisms	Complete blood count ^a
Plasma cell dyscrasias	Sedimentation rate ^a
Autoimmune polyradiculopathy	Total protein ^a
Motor neuropathy with conduction block	Anti-GM1 antibodies ^a
Paraneoplastic	Anti-Hu antibody
Paracarcinomatous	MRI scan, bone marrow biopsy
Metabolic	Fasting blood sugar ^a
Hypoglycemia	Routine chemistries including calcium ^a
Hyperparathyroidism	PTH
Hyperthyroidism	Thyroid function ^a
Deficiency of folate, vitamin B ₁₂ , vitamin E	Vitamin B ₁₂ , vitamin E, folate ^a
Malabsorption	Serum zinc, copper ^a
Deficiency of copper, zinc	24-h stool fat, carotene, prothrombin time
Mitochondrial dysfunction	Fasting lactate, pyruvate, ammonia Consider mtDNA
Hyperlipidemia	Lipid electrophoresis
Hyperglycinuria	Urine and serum amino acids CSF amino acids
Hereditary disorders	WBC DNA for mutational analysis
Superoxide dismutase	
TDP43	
FUS/TLS	
Androgen receptor defect (Kennedy's disease)	
Hexosaminidase deficiency	
Infantile a-glucosidase deficiency (Pompe's disease)	

^aShould be obtained in all cases.

Abbreviations: CSF, cerebrospinal fluid; FUS/TLS, fused in sarcoma/translocated in liposarcoma; HTLV-1, human T-cell lymphotropic virus; MRI, magnetic resonance imaging; PTH, parathyroid; WBC, white blood cell.

452 Amyotrophic Lateral Sclerosis and Other Motor Neuron Diseases

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AMYOTROPHIC LATERAL SCLEROSIS

Amyotrophic lateral sclerosis (ALS) is the most common form of progressive motor neuron disease. It is a prime example of a neurodegenerative disease and is arguably the most devastating of the neurodegenerative disorders.

PATHOLOGY

The pathologic hallmark of motor neuron degenerative disorders is death of lower motor neurons (consisting of anterior horn cells in the spinal cord and their brainstem homologues innervating bulbar muscles) and upper, or corticospinal, motor neurons (originating in layer five of the motor cortex and descending via the pyramidal tract to synapse with lower motor neurons, either directly or indirectly via interneurons) (Chap. 30). Although at its onset ALS may involve selective loss of function of only upper or lower motor neurons, it ultimately causes progressive loss of both categories of motor neurons. Indeed, in the absence of clear involvement of both motor neuron types, the diagnosis of ALS is questionable. In a subset of cases, ALS arises concurrently with frontotemporal dementia (Chap. 448); in these instances, there is degeneration of frontotemporal cortical neurons and corresponding cortical atrophy.

Other motor neuron diseases involve only particular subsets of motor neurons (Tables 452-1 and 452-2). Thus, in bulbar palsy and spinal muscular atrophy (SMA; also called *progressive muscular atrophy*),

the lower motor neurons of brainstem and spinal cord, respectively, are most severely involved. By contrast, pseudobulbar palsy, primary lateral sclerosis (PLS), and familial spastic paraplegia (FSP) affect only upper motor neurons innervating the brainstem and spinal cord.

In each of these diseases, the affected motor neurons undergo shrinkage, often with accumulation of the pigmented lipid (lipofuscin) that normally develops in these cells with advancing age. In ALS, the motor neuron cytoskeleton is typically affected early in the illness. Focal enlargements are frequent in proximal motor axons; ultrastructurally, these "spheroids" are composed of accumulations of neurofilaments and other proteins. Commonly in both sporadic and familial