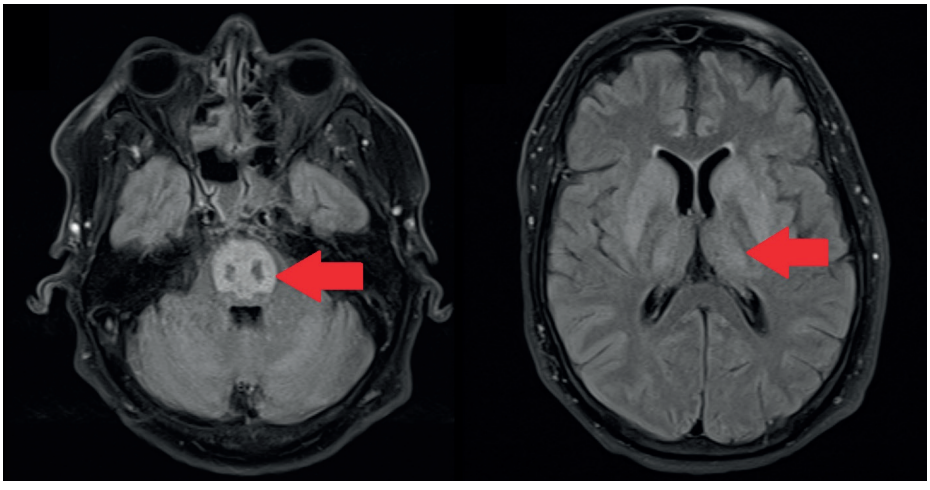
Figure 1. Axial T2-weighted FLAIR magnetic resonance brain scan images showing signal change (broad red arrows) with restricted diffusion around the central pons (but sparing the pontine cortical spinal tracts) and involving both thalami and basal ganglia around the posterior limb of the internal capsule bilaterally.



LEARNING POINTS

- Diuretics and a history of alcohol excess are risk factors for hyponatraemia.
- Careful management of the correction of hyponatraemia with concomitant hypokalaemia must be considered.
- The initial neurological deficit cannot be used as a prognostic indicator in the overall likely outcome of these patients.

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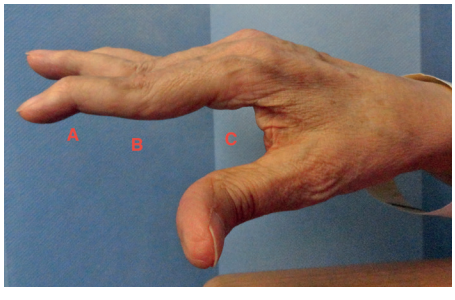
Striatal hand in a woman with Parkinson's disease

A 69-year-old woman with a 20-year history of Parkinson's disease was noted to have deformities of the small joints of her hands, particularly on the right (*Figure 1*). The patient recalled first noticing joint changes 8 years ago, and they had become more exaggerated since, causing considerable functional difficulty. The patient denied having had pain, swelling, redness or stiffness. On examination she demonstrated unilateral resting tremor in her right hand and marked bradykinesia. She has a deep brain neurostimulation implant and takes Co-Careldopa for control of her motor symptoms.

Striatal hand, reported in around one fifth of patients with Parkinson's disease (highly variable incidence reporting), is one of the postural deformities of this condition (Spagnolo et al, 2014). *Figure 1* shows characteristic flexion of the distal interphalangeal and metacarpal-phalangeal joints, with extension of the proximal interphalangeal joints. The finding of striatal hand has 100% specificity for Parkinson's disease (Spagnolo et al, 2014), and may occur at any point in the disease course, including before cardinal clinical findings of Parkinson's disease (Bal et al, 2003; Ashour et al, 2005). However, the presence of striatal hand generally indicates more severe motor symptoms (Spagnolo et al, 2014) and increased rigidity (Reynolds and Petropoulous, 1965). Joint deformities tend to lateralize to the side of the initial motor symptoms (Spagnolo et al, 2014).

Striatal hand may be differentiated from rheumatoid arthritis by the absence of synovitis, radiographic changes such as osteopenia and erosions, and negative anti-citrullinated peptide antibodies and rheumatoid factor testing (Aydoğ et al, 2005). In this case, the joint changes were markedly unilateral, occurring on the same side as this woman's tremor. **BJHM**

Figure 1. Characteristic flexion of the distal interphalangeal (A) and metacarpal-phalangeal joints (C), with extension of the proximal interphalangeal joints (B).



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