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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии
საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებშიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman (Кириллица)**, для текста на грузинском языке следует использовать **AcadNusx**. Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи.** Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - <http://www.spinesurgery.ru/files/publish.pdf> и http://www.nlm.nih.gov/bsd/uniform_requirements.html. В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректур авторам не высылаются, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or computer-printed on a single side of standard typing paper, with the left margin of 3 centimeters width, and 1.5 spacing between the lines, typeface - **Times New Roman (Cyrillic)**, print size - 12 (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf

In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

**Articles that Fail to Meet the Aforementioned
Requirements are not Assigned to be Reviewed.**

ავტორთა საყურადღებო!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე, დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx**. შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემავჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრაფიის ფოტოსურათები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შედეგების ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფხიხლებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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CORTICOBASAL SYNDROME PRESENTING AS A PROGRESSIVE HEMIPARETIC SYNDROME: A CASE REPORT

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Abstract.

Background: Corticobasal syndrome (CBS) is a rare, clinically heterogeneous neurodegenerative syndrome most commonly associated with corticobasal degeneration (CBD), a 4-repeat tauopathy. CBS presents with asymmetric motor and cortical features, but diagnosis remains challenging, as clinicopathologic concordance is imperfect and other conditions such as Alzheimer's disease (AD), progressive supranuclear palsy (PSP), and frontotemporal lobar degeneration (FTLD) can present with similar phenotypes.

Case presentation: We report the case of a 55-year-old woman with a four-year history of progressive, right-sided spastic hemiparesis and rigidity. Electroneuromyography (ENMG) revealed isolated upper motor neuron (UMN) findings with no lower motor neuron (LMN) involvement. Brain MRI demonstrated cortical atrophy in perirolandic regions, and dopamine transporter (DaT) SPECT imaging revealed a marked, unilateral presynaptic dopaminergic deficit. No sensory, cerebellar, or autonomic features were observed, and levodopa challenge test yielded no benefit. FDG-PET and tau-PET imaging were not performed due to unavailability at our center.

Discussion: The marked clinical asymmetry, dopaminergic deficit strongly support a diagnosis of CBS. While CBD remains the most probable underlying pathology, differential diagnoses include PSP, AD, multiple system atrophy (MSA), idiopathic Parkinson's disease (PD), and, less likely, Mills syndrome or other UMN syndromes. Mills syndrome was considered due to asymmetric UMN findings but was excluded due to parkinsonism, cortical atrophy, and presynaptic dopaminergic loss. This case underscores the diagnostic complexity of CBS, particularly in resource-limited settings where advanced imaging tools are unavailable.

Conclusion: CBS should be considered a leading diagnosis in patients presenting with asymmetric parkinsonism, UMN findings, especially when supported by DaT-SPECT abnormalities. This case highlights the importance of comprehensive clinical evaluation and multimodal imaging in differentiating CBS from other neurodegenerative syndromes.

Key words. Corticobasal syndrome, corticobasal degeneration, tauopathy, parkinsonism, DaT-SPECT, neurodegeneration.

Introduction.

Corticobasal syndrome (CBS) is a complex neurodegenerative syndrome first described by Rebeiz et al. in 1968 with clinical features including alien limb phenomena, apraxia, and rigidity, which have remained central to the syndrome's recognition [1]. Initially considered synonymous with corticobasal degeneration (CBD), a specific tauopathy identified post-mortem, CBS was

thought to represent a singular disease entity. However, recent advances have clarified that CBS is a phenotypic syndrome that can result from a variety of underlying pathologies, including tauopathies like CBD and progressive supranuclear palsy (PSP), as well as Alzheimer's disease (AD) and frontotemporal lobar degeneration (FTLD) [2,3].

Epidemiologically, CBS remains a rare condition, with an estimated incidence of approximately 0.6–0.9 cases per 100,000 person-years and a prevalence of 4.9–7.3 per 100,000 individuals [3]. The typical age of onset is in the sixth to seventh decade, with a slight female predilection. Clinically, CBS manifests with asymmetric limb rigidity, dystonia, apraxia, cortical sensory deficits, and sometimes alien limb phenomena, but these features are not pathognomonic, complicating diagnosis [3]. The clinical heterogeneity reflects the underlying molecular diversity, with recent studies emphasizing the importance of integrating neuroimaging and molecular markers for accurate diagnosis.

Advances in neuroimaging have provided valuable tools; MRI often reveals asymmetric cortical atrophy, particularly in perirolandic and parietal regions, correlating with clinical signs [4]. Functional imaging techniques like FDG-PET can demonstrate hypometabolism in frontoparietal areas, aiding differentiation from other conditions [3]. Most notably, tau PET imaging with tracers such as 18F-florbetapir offers promising in vivo visualization of tau pathology, facilitating more accurate differentiation of tauopathies like CBD from other neurodegenerative diseases [5,6].

Despite these advances, in vivo diagnosis remains challenging due to limited availability of advanced imaging modalities and the overlap of clinical features. The heterogeneity of underlying pathologies necessitates a comprehensive approach incorporating clinical assessment, neuroimaging, and molecular markers. Emerging research suggests that multimodal imaging, including diffusion tensor imaging and functional MRI, enhances diagnostic accuracy, particularly in atypical parkinsonian syndromes [7,8].

This descriptive case report adds further information to the available CBS literature and underscores diagnostic challenges, especially in resource-limited settings without access to advanced imaging.

Case Presentation.

A 55-year-old right-handed woman presented with a one-year history of progressive weakness in her right leg. Initially distal, the weakness gradually involved the proximal leg and later ascended to affect the right arm. There was no history of trauma, visual changes, cognitive complaints, or sensory disturbances.

Neurological examination revealed intact cranial nerves, with no facial asymmetry, normal gag reflex, and preserved

ocular motility. Higher cortical functions were intact. Motor examination demonstrated increased tone in the right limbs, particularly at the wrist and elbow. Motor strength on the right side was mildly to moderately reduced, graded 4/5 proximally and 4-/5 distally on the Medical Research Council (MRC) scale. The left side remained neurologically normal. Pathological reflexes were present on the right, including positive Babinski and Hoffmann signs. Deep tendon reflexes were brisk on the right and normal on the left. There was no rest, postural or kinetic tremor, rapid alternating movements revealed slight bradykinesia in the right hand. Gait examination showed right-sided spasticity and decreased arm swing; postural reflex was intact. Sensory and cerebellar examinations were unremarkable. There were no respiratory or autonomic symptoms.

Investigations.

MRI of the cervical and thoracic segments of the spinal cord showed no abnormalities (not shown). Brain MRI showed asymmetric cortical atrophy in perirolandic and parietal regions, but with no other significant findings suggestive of ischemic changes, mass lesion or other structural abnormalities (Figure 1). Cerebrospinal fluid analysis revealed normal cell count, protein, and glucose levels. Oligoclonal bands were absent.

Dopamine Transporter Scan (DaT Scan) was performed which showed a reduction in the uptake of the radioactive dopamine in the left putamen comparatively to the right (Figure 2).

Electroneuromyography (ENMG) revealed an isolated UMN pattern without signs of active denervation or chronic reinnervation. No fasciculations or fibrillations were identified.

Laboratory studies, including tumor markers: CEA, CA-125, AFP, CA 19-9, paraneoplastic autoantibodies Anti-Hu (ANNA-1), Anti-CV2/CRMP5, Anti-Amphiphysin, Anti-Ma2, Anti-GAD65, Ganglioside Antibodies, serum B12, copper, autoimmune panel: ANA, ANCA, Anti-ds DNA, Anti-CCP, were normal and infectious panels (syphilis, HIV, HTLV-1) were negative. There was no family history of neurological disease.

Despite the mild extrapyramidal findings, based on the findings in the DaT-Scan, a levodopa challenge test was performed, which showed no improvement of the patient's signs.

Outcome.

Over a 3-year follow-up period, the patient demonstrated slow but steady progression of right-sided upper motor neuron signs. The weakness and spasticity modestly worsened, with further reduction in distal strength and increased muscle tone in the right upper and lower limbs. However, there was no involvement of the contralateral (left) side, and no development of lower motor neuron signs such as fasciculations or muscle atrophy. Cognitive function remained intact, and there were no behavioral changes or symptoms suggestive of frontotemporal dementia. Extrapyramidal signs remained stable and confined

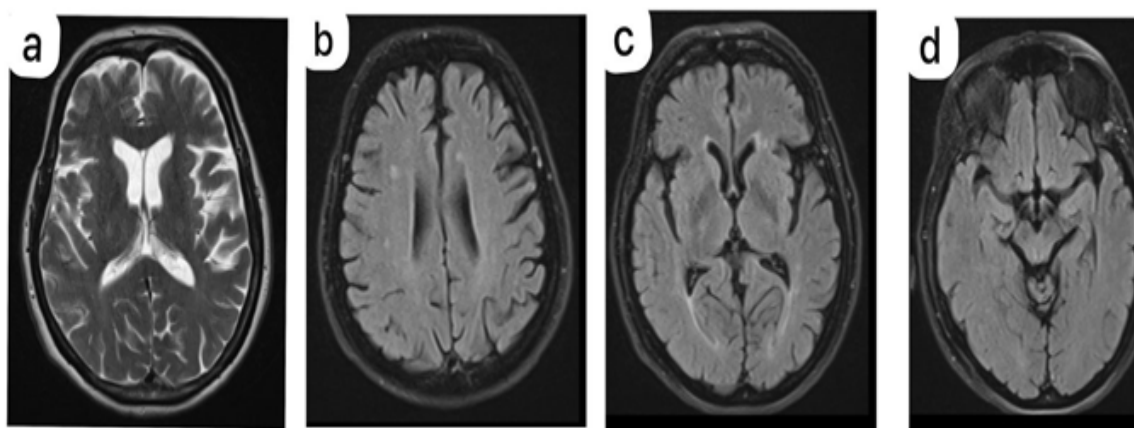


Figure 1. Axial T2 (a) and Fluid-Attenuated Inversion Recovery (b, c, d) MRI images of the brain showing asymmetric cortical atrophy in perirolandic and parietal regions (b).

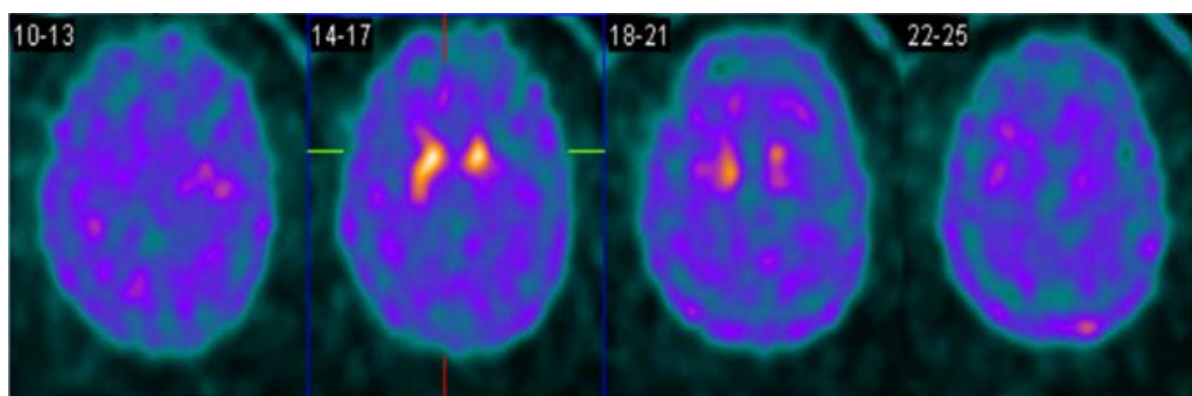


Figure 2. Dopamine transporter scan showing reduction in the uptake of the radioactive dopamine in the left putamen.

to the right side, without new Parkinsonian features. Repeat imaging and neurophysiological studies showed no significant changes.

Discussion.

This case illustrates an atypical presentation of corticobasal syndrome (CBS) in a 55-year-old woman with progressive, right-sided hemiparesis, upper motor neuron (UMN) signs, and mild asymmetric Parkinsonism. CBS typically presents with asymmetric limb rigidity, dystonia, apraxia, and cortical sensory deficits, alien limb syndrome, but these features are not universally observed [2,3]. Nevertheless, the combination of progressive asymmetric UMN involvement, levodopa-resistant Parkinsonism, and unilateral presynaptic dopaminergic deficit on DaT-SPECT strongly supports a diagnosis of CBS [2,7].

The 2013 Armstrong criteria stratify cases into probable or possible CBD based on motor and cortical findings [2]. Our patient fulfills criteria for possible CBS, with progressive asymmetric parkinsonism, UMN signs, levodopa resistance, and exclusion of alternative causes. Motor-predominant phenotypes may precede cortical involvement, consistent with this presentation [9].

CBS is a clinical syndrome with heterogeneous neuropathology. Originally thought to be synonymous with corticobasal degeneration (CBD), a 4-repeat tauopathy affecting cortex and basal ganglia [2], post-mortem studies have demonstrated that CBS can also result from PSP, Alzheimer's disease (AD), or frontotemporal lobar degeneration (FTLD) [3]. PSP and MSA were considered but deemed unlikely due to the absence of early postural instability, vertical gaze palsy, axial rigidity, and autonomic dysfunction [10]. AD was also improbable given preserved cognition and limited cortical atrophy [11].

In this patient, progressive right-sided UMN signs initially prompted a consideration of Mills syndrome [12]; however, the concurrent Parkinsonism and abnormal DaT-SPECT findings—neither characteristic of Mills syndrome—excluded this diagnosis.

Neuroimaging supported the CBS diagnosis. While MRI findings are not pathognomonic, asymmetric cortical atrophy in perirolandic and parietal regions correlates with motor deficits [4]. Advanced imaging, including FDG-PET and tau-PET, can further aid diagnosis by revealing frontoparietal hypometabolism and in vivo tau pathology [5,9]. Although unavailable in this case, DaT-SPECT revealed unilateral presynaptic dopaminergic dysfunction, consistent with an atypical parkinsonian syndrome and reinforcing the CBS diagnosis [7].

Management remains symptomatic. Dopaminergic therapies often provide limited benefit. Supportive care—including physiotherapy, occupational therapy, dystonia management with botulinum toxin, speech therapy, and nutritional support—aims to preserve function and quality of life. Prognosis is generally poor, with many patients progressing to severe disability within 5–8 years [9].

Conclusion.

This case highlights the diagnostic complexity of CBS, particularly in motor-predominant presentations without

overt cortical signs. Comprehensive clinical assessment, supplemented by functional imaging such as DaT-SPECT, is critical to distinguish CBS from other neurodegenerative syndromes. Emerging imaging modalities, including tau-PET, promise improved in vivo differentiation of CBD from alternative pathologies, which will ultimately inform more targeted therapeutic strategies. Clinicians should maintain a high index of suspicion for CBS in patients with asymmetric UMN signs and Parkinsonism, recognizing the profound implications for prognosis and patient care.

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