Progressive Worsening of Gait and Motor Abnormalities in Older Adults With Dravet Syndrome

Arunan Selvarajah, MSc, Carolina Gorodetsky, MD, Paula Marques, MD, Quratulain Zulfiqar Ali, MD, Anne T. Berg, PhD, Alfonso Fasano, MD, PhD, and Danielle M. Andrade, MD, MSc

Neurology® 2022;98:e2204-e2210. doi:10.1212/WNL.00000000000200341

Abstract

Background and Objectives
Relative to the pediatric population, there is limited information about Dravet syndrome (DS) in adults. In addition to some of the gait abnormalities reported in children with DS (such as crouch gait and ataxia), adults with this condition have other gait and motor disturbances. Our primary objective was to examine gait and motor manifestations in adults with DS.

Methods
This study includes a prospective arm where 6 patients (mean age, 32 years) were examined through a modified version of the Unified Parkinson’s Disease Rating Scale (mUPDRS) in 2014 and again in 2019. mUPDRS scores were assigned to gait, resting tremors, facial expression, arising from a chair, posture, and body bradykinesia. The cross-sectional arm includes mUPDRS testing in patients who were not evaluated in 2014 and an instrumental gait analysis (IGA). These cross-sectional tests were done in the 2019–2020 period. The IGA was performed using ProtoKinetics software with a gait mat built with sensors and 2 cameras capturing the sagittal and coronal planes. The IGA was performed in a group of 17 patients with DS (mean age, 31 years); the control group consisted of 81 healthy individuals, whose mean age was 62 years. Regression analyses were performed for the IGA and mUPDRS data.

Results
Five out of 6 participants evaluated prospectively over 5 years experienced worsening of their parkinsonian manifestations, including gait. Two patients (47 and 51 years of age) who were initially ambulatory could no longer walk 5 years later. The cross-sectional analysis of mUPDRS in a larger group of adults showed that worse scores for arising from a chair (p = 0.04), body bradykinesia (p = 0.01), and gait (p = 0.0003) were positively associated with age. The IGA cross-sectional arm revealed that all 17 adults with DS had abnormal gait measures in all domains tested. This group of patients performed worse than the healthy and older control group.

Discussion
Although seizures may decrease in older adults with DS, this prospective and cross-sectional study showed that their motor symptoms and gait become progressively worse as they age.
Dravet syndrome (DS) is a treatment-resistant developmental and epileptic encephalopathy (DEE) with onset in the first year of life.1,2 More than 80% of patients with DS have pathogenic variants in the SCN1A gene.2,3 SCN1A encodes the Nav1.1 protein, a voltage-gated sodium channel. One of the results of decreased levels or abnormal Nav1.1 protein is a decrease in GABAergic inhibition, leading to excessive excitation.4-6 However, this protein is also expressed in other tissues. As such, it is not surprising that, in addition to seizures, patients also have slowing of cognitive development and gait problems.2,7

Relative to the pediatric population, there is limited information about DS in adults.8-12 The majority of patients continue to have refractory seizures as adults, although their convulsive seizures can be restricted to sleep periods.11,13 Myoclonic, atypical absence, and focal seizures with impaired awareness may decrease or disappear in adulthood.8,10,11,13-15 Gait abnormalities have also been reported in a few adults.10,14,16 These tend to differ from those reported in childhood.17

Parents and caregivers of adults with DS often comment that their adult child is losing certain previously acquired skills, including the ability to ambulate. To provide an objective assessment of these parental observations, we performed a prospective evaluation in a small group of patients and a cross-sectional evaluation of gait and parkinsonian manifestations in a larger group of adults with DS. We hypothesize that their gait and parkinsonian features will get worse with age.

Methods

Participants

Patients were identified at the Adult Epilepsy Genetics Clinic at Toronto Western Hospital between 2010 and 2020. Eligible participants had to have a clinical diagnosis of DS18 and be 18 years of age or older. Because some adult patients did not have a well-characterized pediatric clinical history, we only included patients who also had genetic results showing pathogenic SCN1A or GABRA1 variants in keeping with a DS diagnosis. Patients chronically exposed to antipsychotic medications were not eligible. For comparison, we used a control group consisting of 81 healthy individuals, whose mean age was 62 years.

Study Design

One arm of the study consisted of 6 patients who were prospectively studied over a period of 5 years. Their gait and motor manifestations were evaluated through the modified Unified Parkinson’s Disease Rating Scale (mUPDRS). The results of their first evaluation were published in 201414; their second evaluation, done in 2019, is reported here. Another group of 12 adults with DS (not previously evaluated) was studied in a cross-sectional manner using mUPDRS. Finally, 17 adults (including some of those who participated in the prospective study) were evaluated with instrumental gait analysis (IGA). The cross-sectional evaluations (mUPDRS and IGA) were done during 2019 and 2020.

Modified Unified Parkinson’s Disease Rating Scale

The mUPDRS has been validated for patients with DS.14,19 The measures evaluated include right and left upper limbs resting tremor, facial expression, arising from a chair, gait, posture, and body bradykinesia. The maximum possible mUPDRS points is 4 for each measure, leading to a potential 28 total points. mUPDRS evaluations were assessed by movement disorder specialists in 2014 (A.F.) and again in 2019–2020 (A.F. and C.G.).

Instrumental Gait Analysis

A formal gait assessment was completed on the Zeno Walkway Gait Analysis System (ProtoKinetics). This system has sensors built into the mat and uses 2 video cameras 90° apart, providing a sagittal and coronal view. Each patient was asked to walk on the mat for 6 feet, back and forth, for 2 attempts. The ProtoKinetics software (PKMAS) was adopted to extract the following measures: ambulation time (seconds), cadence (steps/min), double support percentage (% of time of gait spent on both feet), double support time (amount of time [seconds] of gait spent on both feet), gait cycle (begins at heel strike of one foot and continues until the heel strike of the same foot [seconds]), gait velocity (the time it takes to travel a specified distance [cm/s]), number of steps, right/left step length asymmetry (ratio of right to left step length), short/long step time asymmetry (ratio of right to left step time), single/double time ratio (the time spent on 1 foot vs 2 feet), stance percentage (% of gait spent in stance phase), stance time (time spent in stance phase [seconds]), step length (cm), stride width (cm), swing percentage (% spent in swing phase), and enhanced gait variability index (eGVI) (fluctuation of gait measures between steps). This information can provide clinicians objective data about their patients’ gait.

A chart review was performed in 2019–2020 to determine the seizure type and frequency in these participants (eTable 1, links.lww.com/WNL/B947).

Data Analysis

All data analyses were performed in GraphPad Prism 9.1.2. The gait analysis and mUPDRS scores were analyzed using the Spearman rank order correlation for associations between age and gait measures.

Glossary

DEE = developmental and epileptic encephalopathy; DS = Dravet syndrome; eGVI = enhanced gait variability index. IGA = instrumental gait analysis; mUPDRS = modified Unified Parkinson’s Disease Rating Scale; PD = Parkinson disease.
Data Access and Data Availability
The corresponding author takes full responsibility for the data, the analyses and interpretation, and the conduct of the research; has full access to all of the data; and has the right to publish any and all data, separate and apart from the guidance of any sponsor. Anonymized data not published within this article will be made available by request from any qualified investigator.

Standard Protocol Approvals, Registrations, and Patient Consents
Written consent was obtained from all patients’ caregivers. Ethics approval was granted by the University Health Network Research Ethics Board.

Results
Twenty-nine patients were eligible for the study. Given the COVID-19 pandemic, several patients’ caregivers declined to come to the hospital for this study. As a result, 18 patients were evaluated with mUPDRS (6 of them were part of the prospective study and were evaluated twice, 5 years apart [results of the first evaluation were published previously14]); 17 patients completed the IGA (Table 1). The age range was 18–51 years and mean age was 31.81 ± 9.6 years. A breakdown of the pathogenic variants is reported in Table 2. This group of adults with DS displayed a tendency to have a decrease in seizure frequency, as this group averages 2.4 convulsions per week. They also had mainly nocturnal convulsions in adulthood. Six out of 21 patients in this study were seizure-free for at least a year before the assessments were performed. Cognition was not formally evaluated, as all patients experienced moderate or severe intellectual disability. Cranial nerves were evaluated to the extent the participants collaborated for evaluation and we noted no abnormalities.

Modified Unified Parkinson’s Disease Rating Scale
In the prospective group, we observed a worsening of mUPDRS scores over a 5-year span in 5 of 6 patients (Table 3).

---

### Table 1 Study Tasks Completed by 21 Participants

| Patient ID | IGA in 2019 | mUPDRS completed in 2014 | mUPDRS completed in 2019 |
|------------|-------------|--------------------------|--------------------------|
| 1          | x           |                          |                          |
| 2          | x           |                          |                          |
| 3          | x x x       |                          |                          |
| 4          | x x x       |                          |                          |
| 5          | x           |                          |                          |
| 6          | x x x       |                          |                          |
| 7          | x x         |                          |                          |
| 8          | x x         |                          |                          |
| 9          | x x         |                          |                          |
| 10         | x x x       |                          |                          |
| 11         | x x x       |                          |                          |
| 12         | x           |                          |                          |
| 13         | x x         |                          |                          |
| 14         | x x         |                          |                          |
| 15         | x           |                          |                          |
| 16         | x x         |                          |                          |
| 17         | x           |                          |                          |
| 18         | x x         |                          |                          |
| 19         | x           |                          |                          |
| 20         | x           |                          |                          |
| 21         | x           |                          |                          |
| **Total**  | 17          | 11                       | 13                       |

Abbreviations: IGA = instrumental gait analysis; mUPDRS = modified Unified Parkinson’s Disease Rating Scale.

### Table 2 Genetic Findings

| Patient ID | Gene variant | Mutation type |
|------------|--------------|---------------|
| 1          | c.1090A>C    | Missense      |
| 2          | c.5018T>A    | Missense      |
| 3          | c.3985C>T    | Frameshift    |
| 4          | c.5488_5489delCA | Frameshift |
| 5          | c.1090A>C    | Missense      |
| 6          | c.2792G>A    | Missense      |
| 7          | c.3517+2T>C  | Splice site   |
| 8          | c.1192dupTT  | Frameshift    |
| 9          | c.2946+1G>T  | Splice site   |
| 10         | c.4168G>A    | Missense      |
| 11         | c.563A>T     | Missense      |
| 12         | c.4900delC   | Frameshift    |
| 13         | c.1028+1G>A  | Splice site   |
| 14         | c.664C>T     | Nonsense      |
| 15         | c.4762T>C    | Missense      |
| 16         | c.3705+4A>T  | Splice site   |
| 17         | c.4427_4435dupACCTGTGTTA | Frameshift |
| 18         | c.524C>T     | Missense      |
| 19         | c.3661G>C    | Missense      |
| 20         | c.4374C>A    | Missense      |
| 21         | c.865A>G     | Missense      |

*a This patient has a GABRA1 mutation.*
The only patient who improved was patient 3, who was started on levodopa after the first assessment. The 2 older patients (ages 47 and 51 at the last evaluation) were ambulatory at their first assessment in 2014, but they were no longer able to walk in 2019 when the second assessment was done. These 2 patients also received levodopa after their first evaluation, but this medication was discontinued after the patients stopped walking.

In the cross-sectional group, 12 patients were evaluated with mUPDRS only once, between 2019 and 2020. We observed a significant correlation between worse scores and older age for body bradykinesia ($p=0.01$), gait ($p=0.0003$), arising from a chair ($p=0.04$), and total score ($p=0.0004$) (Figure 1).

**Instrumental Gait Analysis**

Seventeen patients with DS completed the IGA (cross-sectional evaluation done only once in 2020). The IGA results demonstrated that several gait measures were worse in older patients (Figure 2): double support percentage ($p=0.0007$), double support time ($p=0.02$), single/double time ($p=0.003$), step length ($p=0.0001$), stride length ($p=0.0004$), stance percentage ($p=0.01$), swing percentage ($p=0.01$), and eGVI ($p=0.04$). The following measures showed a trend towards worsening function with increasing age: ambulation time, gait cycle, number of steps, and gait velocity (eFigure 1, links.lww.com/WNL/B946). In all the gait modalities evaluated, the patients with DS (mean age 31 years) performed worse than the older healthy control group, whose mean age was 62 years.

### Table 3  mUPDRS Scores in 6 Patients Completed in 2014 and 2019

| Patient number and age at first (F) and second (S) assessment, y | Resting tremor, L | Resting tremor, R | Facial expression | Arising from chair | Gait | Posture | Body bradykinesia | Total |
|---|---|---|---|---|---|---|---|---|
| 3 | 24 | 0 | 0 | 3 | 1 | 2 | 1 | 3 | 10 |
| (F) 29 | 0 | 0 | 2 | 1 | 1 | 1 | 1 | 6 |
| 4 | 23 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 2 |
| (S) 28 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 4 |
| 6 | 34 | 0 | 0 | 3 | 4 | 2 | 1 | 3 | 13 |
| (S) 39 | 0 | 0 | 3 | 2 | 2 | 4 | 3 | 14 |
| 10 | 42 | 0 | 0 | 2 | 4 | 3 | 3 | 3 | 15 |
| (S) 47 | 0 | 0 | 3 | 4 | 4 | 4 | 3 | 18 |
| 11 | 23 | 0 | 0 | 3 | 0 | 1 | 1 | 1 | 6 |
| (S) 28 | 1 | 1 | 3 | 0 | 1 | 1 | 2 | 9 |
| 12 | 46 | 0 | 0 | 2 | 4 | 3 | 1 | 3 | 12 |
| (S) 51 | 0 | 0 | 1 | 4 | 4 | 1 | 4 | 14 |

**Discussion**

Although DS is well studied in the pediatric population, there is little information regarding DS in adulthood.8-12 As such, we do not know how patients with DS age. In this study, it was observed that gait measures and parkinsonian symptoms were abnormal across all ages, but clearly worse in older patients, suggesting a progressive gait disorder. This progression was confirmed in a subgroup of patients studied prospectively. In the 5-year period that patients were followed, we found evidence of a decline in gait function and increase in parkinsonian manifestations, including 2 patients who were ambulatory in the first and were no longer able to walk in this second evaluation.

In the cross-sectional IGA, all gait measures evaluated were abnormal and worse in the older patients, in keeping with a progressive course. In addition, all gait measures were worse in the older patients.
in the DS group compared with an older healthy control group (mean age of control group was double that of patients with DS). The IGA registered a combination of increase in gait velocity, decrease in single/double time ratio, increased number of steps, and increase in eGVI. These abnormal gait findings are in keeping with gait abnormalities of patients with Parkinson disease (PD). The cadence and stride width in adults with DS was consistent across all ages, again aligning with the literature in PD, in which stride width and cadence were reported to have no apparent relationship with age in PD.

In addition, in both DS and PD there is a progressive worsening of bradykinetic gait features (step length and velocity).

Abnormal gait has long been reported in children and adolescents with DS, although parkinsonian features per se have not been reported in pediatric cohorts. Two studies in children with DS and young adults demonstrated that patients spend a significant increased amount of time in support stance, compared with typically developing peers. Similarly to younger patients with DS, our older adult DS population also spent a significantly increased amount of time in stance, and this time was longer with older age, thus representing a compensatory mechanism for the antero-posterior instability typical of parkinsonian gait disorders.

Another common gait pattern observed in children and young adolescents with DS is a crouch gait with increased flexion of the knees, ankles, and hips. In addition to the parkinsonian gait, a few of our adult patients also had crouched gait. Interestingly, a gait characterized by knee flexion has been described in patients with late stage PD.

In the current study, a subgroup of adult patients with DS was evaluated prospectively, 5 years apart. At the first evaluation, using an mUPDRS, it was observed that adults with DS had parkinsonian gait (slow pace, small steps, en bloc turning, little to no arm swing, postural instability) and other motor parkinsonian features (bradykinesia, rigidity, antecollis, and camptocormia). That group of patients was reevaluated with mUPDRS in 2019. The longitudinal data show that both gait and the other motor features have deteriorated over this 5-year period in all but 1 patient (patient 3). Two patients (patients 10 and 12) who had mUPDRS evaluation in 2014 are no longer walking in 2021. Their caregivers reported that in this period of 5 years, it became increasingly difficult to have them leave their wheelchair and even with support, their gait was too “unsafe.” The patients also started to refuse any attempts to walk. Patients 10 and 12 were started on levodopa after their first mUPDRS evaluation at the ages of 42 and 46 years, respectively. However, this medication was stopped after 2 years in both cases, as the initial benefits observed after the addition of levodopa wore off. Patient 3 was also started on levodopa after the first mUPDRS evaluation, but she was only 24 years old at that time. Patient 3 continues to derive benefits from levodopa and she is the only one who improved in the second mUPDRS evaluation. The minimal clinically important difference for motor has been reported on average to be between 2.3 and 3.3 points for the UPDRS scale. However, these studies were based on all scale items. Our study saw an average decrease of 2.2 points in 5 of 6 individuals.

Our study has a few limitations. In particular, we had a limited sample size and were unable to enroll over a third of eligible patients. The COVID-19 pandemic was the primary cause precluding us from recruiting more patients to the hospital for their IGA and mUPDRS evaluations. This also limited the sample followed prospectively (from 11 patients in 2014 to 6 patients in 2019); however, even this limited sample provides
information demonstrating the progressive nature of gait and motor deterioration in adults with DS. We also note that muscle weakness may be a potential confounding limitation in the assessment of gait. Many patients with DS use wheelchairs to travel large distances. This may lead to a disuse of lower limbs musculature and in turn influence gait assessments.31 Factors such as contraindicated medications and delayed diagnosis can potentially affect adult outcomes. It was shown that long periods of contraindicated medication intake during the first 5 years of life are correlated with worse long-term cognitive outcomes of patients with DS.32 It is unknown whether these contraindicated medications play a role in abnormal gait and motor manifestations and their progression. Almost all of the participants in this study (18/21 [85.7%]) were diagnosed in adulthood. It is likely that these patients have been misdiagnosed several times during their life. As a result, they could have been exposed to a variety of contraindicated medications for long periods of time.

This is the largest gait and motor analysis in an older adult DS population (mean age 31 years) and the first prospective study, to our knowledge, of a subgroup of these older patients. Taken altogether, the results show a progressive deterioration of gait and motor function as patients with DS age. It is unclear why such deterioration happens with age and further research should help explain not only why this happens but also if it is possible to slow or avoid this progression.

Acknowledgment
The authors thank the patients and their families and caregivers who participated in this research project.

Study Funding
This study received funding from Dravet Syndrome Foundation (grant 2019001) and Dravet Canada.

Disclosure
D.M. Andrade serves on the medical advisory board of Dravet Syndrome Foundation and Stoke Therapeutics, is on the speakers bureau for Eisai and Biocodex, and has participated in investigator-initiated research for Biocodex and Dravet Syndrome Foundation. A.T. Berg is on the speakers bureau for Biogen and the advisory board for Zogenix and Neurocrin. The remaining authors report no disclosures relevant to the manuscript. Go to Neurology.org/N for full disclosures.

The measures shown are all significantly worse with more advanced age in these adults with Dravet syndrome. Other evaluated measures that were not statistically significant are listed in eFigure 1 (links.lww.com/WNL/B946). eGVI = enhanced gait variability index.
References

1. Dravet C. Les épilepsies graves de l'enfant. Vie Med. 1978;543-548.
2. Wolff M, Cassé-Perrot C, Dravet C. Severe myoclonic epilepsy of infants (Dravet syndrome): natural history and neuropsychological findings. Epilepsia. 2006;47(suppl 2):45-48.
3. Claesz L, Del-Favero J, Ceulemans B, et al. De novo mutations in the sodium-channel gene SCN1A cause severe myoclonic epilepsy of infancy. Am J Hum Genet. 2001;68(6):1327-1332.
4. Connolly MB. Dravet syndrome: diagnosis and long-term care. Can J Neurol Sci. 2016;43(suppl 3):S3-58.
5. Chah CS, Yu FH, Westenskow RE, et al. Specific deletion of NaV1.1 sodium channels in inhibitory interneurons causes seizures and premature death in a mouse model of Dravet syndrome. Proc Natl Acad Sci USA. 2012;109(36):14466-144651.
6. Stem WM, Sander JW, Rothwell JC, Isidioya SM. Impaired intracortical inhibition demonstrated in vivo in people with Dravet syndrome. Neurology. 2017;88(17):1659-1665.
7. Do TTH, Vu DM, Huynh TTK, et al. SCN1A gene mutation and adaptive functioning in 18 Vietnamese children with Dravet syndrome. J Clin Neurol. 2017;13(1):62-70.
8. Jansen PE, Sadler LG, Harkin LA, et al. Severe myoclonic epilepsy of infancy (Dravet syndrome): recognition and diagnosis in adults. Neurology. 2006;67(12):2224-2226.
9. Gerton P, Velasová R, Dravet C. Dravet syndrome: the long-term outcome. Epilepsia. 2011 Apr 1;41(4).
10. Rifantte JJ, Coelho FM, Minassian BA, Andrade DM. Dravet syndrome: seizure control and gait in adults with different SCN1A mutations. Epilepsia. 2012;53(8):1421-1428.
11. Akiyama M, Kobayashi K, Yoshina H, Ohtsuka Y. A long-term follow-up study of Dravet syndrome up to adulthood. Epilepsia. Epdb 2010 June 1.
12. Selvarajah A, Zulfiqar Ali Q, Marques P, Rong M, Andrade DM. A systematic review of adults with Dravet syndrome. Seizure. 2021;87:39-45.
13. Takayama R, Fujisawa T, Shimogatsu H, et al. Long-term course of Dravet syndrome: a study from an epilepsy center in Japan. Epilepsia. 2014;55(4):528-538.
14. Fasano A, Borlot F, Lang AE, Andrade DM. Antecollis and levodopa-responsive parkinsonism are late features of Dravet syndrome. Neurology. 2014;82(24):2560-2561.
15. Dravet C. The core Dravet syndrome phenotype. Epilepsia. 2011;52(suppl 2):3-9.
16. Rodda JM, Scheffer IE, McMahon JM, Berkovic SF, Graham HK. Progressive gait deterioration in adolescents with Dravet syndrome. Arch Neurol. 2012;69(7):873-878.
17. Di Marco R, et al. Gait abnormalities in people with Dravet syndrome: a cross-sectional multi-center study. Eur J Paediatr Neurol. 2019;23:808-818.
18. Wurrell EC, Laux L, Donner E, et al. Optimizing the diagnosis and management of Dravet syndrome: recommendations from a North American consensus panel. Pediatr Neurol. 2017;68:18-33.
19. Aljaafari D, Fasano A, Nascimento FA, Lang AE, Andrade DM. Adult motor phenotype differentiates Dravet syndrome from Lennox-Gastaut syndrome and links SCN1A to early onset parkinsonian features. Epilepsia. Epdb 2017 Feb 10.
20. Boonstra T, Schouten A, van Vugt J, Bloem B, van der Kooij H. Anterior root gait deterioration in adolescents with Dravet syndrome. Arch Neurol. 2019;23(3):357-367.
21. Mirelman A, Bonato P, Camicioli R, et al. Gait impairments in Parkinson’s disease. Lancet Neurol. 2019;18:697-708.
22. Zaniardi AP, da Silva ES, Cosya RR, et al. Gait parameters of Parkinson’s disease compared with healthy controls: a systematic review and meta-analysis. Sci Rep. 2021;11:13.
23. Morris ME, Ianszek R, Rayas TA, Summers JJ. Ability to modulate walking cadence remains intact in Parkinson’s disease. J Neurol Neurosurg Psychiatry. 1994;57:1153-1154.
24. Verheugen H, Verbeek E, Ceulemans B, Schoonjans AS, Van De Walle P, Hallemans A. Motor development in children with Dravet syndrome. Dev Med Child Neurol. 2019;61(8):950-956.
25. Wyers L, Verheugen K, Ceulemans B, et al. The mechanics behind gait problems in patients with Dravet syndrome. Gait Posture. 2012;34:321-328.
26. Fasano A, Bloem BR. Gait disorders. Continuum. 2013;19:1344-1382.
27. Wyers L, Van De Walle P, Hoornweg A, et al. Gait deviations in patients with Dravet syndrome: a systematic review. Eur J Pediatr Neurol. 2019;23(3):357-367.
28. Djukic K, Hellmann M, Melamed E, Bent knees and tiptoeing: late manifestations of end-stage Parkinson’s disease. Mov Disord. 2004;19:1323-1328.
29. Schramm R, Gruber-Baldini AL, Anderson KE, et al. The clinically important diference on the Unified Parkinson’s Disease Rating Scale. Arch Neurol. 2010;67:64-70.
30. Horvath K, Asherman Z, Acs P, et al. Minimal clinically important difference on the motor examination part of MDS-UPDRS Parkinsonism Relat Disord. 2015;21(12):1421-1426.
31. Volpe D, Pavan D, Morris M, et al. Underwater gait analysis in Parkinson’s disease. Gait Posture. 2017;52:87-94.
32. de Lange IM, Gunning B, Sonnema ACM, et al. Influence of contraindicated medication on cognitive outcome in Dravet syndrome and age at first afebrile seizure as a clinical predictor in SCN1A-related seizure phenotypes. Epilepsia. Epdb 2011 May 11.
