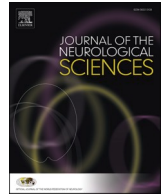




Contents lists available at ScienceDirect

## Journal of the Neurological Sciences

journal homepage: [www.elsevier.com/locate/jns](http://www.elsevier.com/locate/jns)

## Prodromal language impairment in genetic frontotemporal dementia within the GENFI cohort

Kiran Samra<sup>a</sup>, Amy M. MacDougall<sup>b</sup>, Arabella Bouzigues<sup>a</sup>, Martina Bocchetta<sup>a</sup>, David M. Cash<sup>a</sup>, Caroline V. Greaves<sup>a</sup>, Rhian S. Convery<sup>a</sup>, John C. van Swieten<sup>c</sup>, Lize Jiskoot<sup>c</sup>, Harro Seelaar<sup>c</sup>, Fermin Moreno<sup>d,e</sup>, Raquel Sanchez-Valle<sup>f</sup>, Robert Laforce<sup>g</sup>, Caroline Graff<sup>h,i</sup>, Mario Masellis<sup>j</sup>, Maria Carmela Tartaglia<sup>k</sup>, James B. Rowe<sup>l</sup>, Barbara Borroni<sup>m</sup>, Elizabeth Finger<sup>n</sup>, Matthias Synofzik<sup>o,p</sup>, Daniela Galimberti<sup>q,r</sup>, Rik Vandenberghe<sup>s,t,u</sup>, Alexandre de Mendonça<sup>v</sup>, Chris R. Butler<sup>w,x</sup>, Alex Gerhard<sup>y,z</sup>, Simon Ducharme<sup>aa,ab</sup>, Isabelle Le Ber<sup>ac,ad,ae,af</sup>, Pietro Tiraboschi<sup>ag</sup>, Isabel Santana<sup>ah,ai</sup>, Florence Pasquier<sup>aj,ak,al</sup>, Johannes Levin<sup>am,an,ao</sup>, Markus Otto<sup>ap</sup>, Sandro Sorbi<sup>aq,ar</sup>, Jonathan D. Rohrer<sup>a,1</sup>, Lucy L. Russell<sup>a,\*</sup>, on behalf of the Genetic FTD Initiative (GENFI)

<sup>a</sup> Dementia Research Centre, Department of Neurodegenerative Disease, UCL Queen Square Institute of Neurology, London, UK

<sup>b</sup> Department of Medical Statistics, London School of Hygiene and Tropical Medicine, London, UK

<sup>c</sup> Department of Neurology, Erasmus Medical Centre, Rotterdam, Netherlands

<sup>d</sup> Cognitive Disorders Unit, Department of Neurology, Donostia University Hospital, San Sebastian, Spain

<sup>e</sup> Neuroscience Area, Biodonostia Health Research Institute, San Sebastian, Gipuzkoa, Spain

<sup>f</sup> Alzheimer's disease and Other Cognitive Disorders Unit, Neurology Service, Hospital Clínic, Institut d'Investigacions Biomèdiques August Pi I Sunyer, University of Barcelona, Barcelona, Spain

<sup>g</sup> Clinique Interdisciplinaire de Mémoire, Département des Sciences Neurologiques, CHU de Québec, and Faculté de Médecine, Université Laval, QC, Canada

<sup>h</sup> Center for Alzheimer Research, Division of Neurogeriatrics, Department of Neurobiology, Care Sciences and Society, Bioclinicum, Karolinska Institutet, Solna, Sweden

<sup>i</sup> Unit for Hereditary Dementias, Theme Aging, Karolinska University Hospital, Solna, Sweden

<sup>j</sup> Sunnybrook Health Sciences Centre, Sunnybrook Research Institute, University of Toronto, Toronto, Canada

<sup>k</sup> Tanz Centre for Research in Neurodegenerative Diseases, University of Toronto, Toronto, ON, Canada

<sup>l</sup> Department of Clinical Neurosciences, University of Cambridge, UK

<sup>m</sup> Neurology Unit, Department of Clinical and Experimental Sciences, University of Brescia, Brescia, Italy

<sup>n</sup> Department of Clinical Neurological Sciences, University of Western Ontario, London, ON, Canada

<sup>o</sup> Department of Neurodegenerative Diseases, Hertie-Institute for Clinical Brain Research and Center of Neurology, University of Tübingen, Tübingen, Germany

<sup>p</sup> Center for Neurodegenerative Diseases (DZNE), Tübingen, Germany

<sup>q</sup> Fondazione Ca' Granda, IRCCS Ospedale Policlinico, Milan, Italy

<sup>r</sup> University of Milan, Centro Dino Ferrari, Milan, Italy

<sup>s</sup> Laboratory for Cognitive Neurology, Department of Neurosciences, KU Leuven, Leuven, Belgium

<sup>t</sup> Neurology Service, University Hospitals Leuven, Leuven, Belgium

<sup>u</sup> Leuven Brain Institute, KU Leuven, Leuven, Belgium

<sup>v</sup> Laboratory of Neurosciences, Institute of Molecular Medicine, Faculty of Medicine, University of Lisbon, Lisbon, Portugal

<sup>w</sup> Nuffield Department of Clinical Neurosciences, Medical Sciences Division, University of Oxford, Oxford, UK

<sup>x</sup> Department of Brain Sciences, Imperial College London, UK

<sup>y</sup> Division of Neuroscience and Experimental Psychology, Wolfson Molecular Imaging Centre, University of Manchester, Manchester, UK

<sup>z</sup> Departments of Geriatric Medicine and Nuclear Medicine, University of Duisburg-Essen, Germany

<sup>aa</sup> Department of Psychiatry, McGill University Health Centre, McGill University, Montreal, Québec, Canada

<sup>ab</sup> McConnell Brain Imaging Centre, Montreal Neurological Institute, McGill University, Montreal, Québec, Canada

<sup>ac</sup> Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP – Hôpital Pitié-Salpêtrière, Paris, France

<sup>ad</sup> Centre de Référence des Démences rares ou Précoces, IM2A, Département de Neurologie, AP-HP – Hôpital Pitié-Salpêtrière, Paris, France

<sup>ae</sup> Département de Neurologie, AP-HP – Hôpital Pitié-Salpêtrière, Paris, France

<sup>af</sup> Reference Network for Rare Neurological Diseases (ERN-RND)

<sup>ag</sup> Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy

<sup>ah</sup> University Hospital of Coimbra (HUC), Neurology Service, Faculty of Medicine, University of Coimbra, Coimbra, Portugal

<sup>ai</sup> Center for Neuroscience and Cell Biology, Faculty of Medicine, University of Coimbra, Coimbra, Portugal

\* Corresponding author at: Dementia Research Centre, Department of Neurodegenerative Disease, UCL Institute of Neurology, Queen Square, London WC1N 3BG, UK.

E-mail address: [l.russell@ucl.ac.uk](mailto:l.russell@ucl.ac.uk) (L.L. Russell).

<https://doi.org/10.1016/j.jns.2023.120711>

Received 30 October 2022; Received in revised form 1 June 2023; Accepted 8 June 2023

Available online 10 June 2023

0022-510X/© 2023 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

<sup>aj</sup> Univ Lille, France

<sup>ak</sup> Inserm 1172, Lille, France

<sup>al</sup> CHU, CNR-MAJ, Labex Distalz, LiCEND Lille, France

<sup>am</sup> Department of Neurology, Ludwig-Maximilians Universität München, Munich, Germany

<sup>an</sup> German Center for Neurodegenerative Diseases (DZNE), Munich, Germany

<sup>ao</sup> Munich Cluster of Systems Neurology (SyNergy), Munich, Germany

<sup>ap</sup> Department of Neurology, University of Ulm, Germany

<sup>aq</sup> Department of Neurofarba, University of Florence, Italy

<sup>ar</sup> IRCCS Fondazione Don Carlo Gnocchi, Florence, Italy

## ARTICLE INFO

### Keywords:

Frontotemporal dementia

Language

Genetic

Progranulin

*C9orf72*

*MAPT*

## ABSTRACT

**Objective:** To identify whether language impairment exists presymptomatically in genetic frontotemporal dementia (FTD), and if so, the key differences between the main genetic mutation groups.

**Methods:** 682 participants from the international multicentre Genetic FTD Initiative (GENFI) study were recruited: 290 asymptomatic and 82 prodromal mutation carriers (with *C9orf72*, *GRN*, and *MAPT* mutations) as well as 310 mutation-negative controls. Language was assessed using items from the Progressive Aphasia Severity Scale, as well as the Boston Naming Test (BNT), modified Camel and Cactus Test (mCCT) and a category fluency task. Participants also underwent a 3 T volumetric T1-weighted MRI from which regional brain volumes within the language network were derived and compared between the groups.

**Results:** 3% of asymptomatic (4% *C9orf72*, 4% *GRN*, 2% *MAPT*) and 48% of prodromal (46% *C9orf72*, 42% *GRN*, 64% *MAPT*) mutation carriers had impairment in at least one language symptom compared with 13% of controls. In prodromal mutation carriers significantly impaired word retrieval was seen in all three genetic groups whilst significantly impaired grammar/syntax and decreased fluency was seen only in *C9orf72* and *GRN* mutation carriers, and impaired articulation only in the *C9orf72* group. Prodromal *MAPT* mutation carriers had significant impairment on the category fluency task and the BNT whilst prodromal *C9orf72* mutation carriers were impaired on the category fluency task only. Atrophy in the dominant perisylvian language regions differed between groups, with earlier, more widespread volume loss in *C9orf72*, and later focal atrophy in the temporal lobe in *MAPT* mutation carriers.

**Conclusions:** Language deficits exist in the prodromal but not asymptomatic stages of genetic FTD across all three genetic groups. Improved understanding of the language phenotype prior to phenoconversion to fully symptomatic FTD will help develop outcome measures for future presymptomatic trials.

## 1. Introduction

Frontotemporal dementia (FTD) is a common cause of young onset dementia and leads to progressive behavioural, language, and motor dysfunction. It is autosomal dominantly inherited in around a third of individuals [33], with the main genetic causes being mutations in progranulin (*GRN*), microtubule-associated protein tau (*MAPT*) and chromosome 9 open reading frame 72 (*C9orf72*) [42]. The study of healthy ‘at-risk’ individuals who have a first-degree relative with a confirmed genetic mutation allows a window into the earliest stages of the disease. The Genetic FTD Initiative (GENFI) study has studied such individuals with the aim of improving the understanding of the presymptomatic period of FTD. A greater understanding of the stages that precede symptom onset within each mutation group will allow for better stratification and monitoring of disease progression in future prevention trials of disease-modifying therapies [35].

Although behavioural change is the commonest symptom in FTD, language problems are also seen very frequently [16]. If language is the first and predominant symptom, the diagnosis is primary progressive aphasia (PPA), with three subtypes described: non-fluent variant (nfvPPA), semantic variant (svPPA) and logopenic variant PPA (lvPPA). However, a substantial minority of patients do not fit criteria for any of the three and are called PPA-not otherwise specified (PPA-NOS). In genetic FTD, around 40% of symptomatic *GRN* mutation carriers have PPA, roughly split between those with a nfvPPA phenotype and those with PPA-NOS. In contrast, PPA is uncommon in people with *C9orf72* or *MAPT* mutations (<5%) [44]. However, language symptoms are reported in all three mutation groups [5,31], and are also seen in people with behavioural variant FTD (bvFTD) [10,13] with 60–80% of mutation carriers in each genetic group having some linguistic difficulties [36]. It will therefore be important, independent of the subsequent phenotype, to identify what language features can be detected prior to phenoconversion to fully symptomatic status when considering

development of outcome measures for presymptomatic clinical trials.

This study therefore aims to identify the salient linguistic features of presymptomatic mutation carriers and the key differences between the main genetic mutation groups (*C9orf72*, *GRN*, and *MAPT*). Based on previous literature, we hypothesise that the earliest changes will be seen in the *C9orf72* group [2,4,39,40], with more linguistic deficits in the *GRN* group (Samra et al., in press; [38], and more focal impairment, particularly in semantic knowledge, in the *MAPT* mutation carriers [5,19]. Neuroimaging analysis is hypothesized to show parallel findings, with early atrophy in the language brain regions in *C9orf72* [2,40], and more focal loss that may not be evident until prodromal or symptomatic stages in *GRN* and *MAPT* mutation carriers [4], with the medial temporal lobe particularly affected in the *MAPT* group [3,27,43].

## 2. Methods

### 2.1. Participants

Participants were recruited from the fifth data freeze of the GENFI study between 20 January 2012 and 30 May 2019, including sites in the UK, Canada, Belgium, France, Germany, Italy, the Netherlands, Portugal, Spain and Sweden. Languages spoken were of those countries i.e. English, French, German, Italian, Dutch, Portuguese, Spanish and Swedish. All aspects of the study were approved by local ethics committees, and written informed consent was obtained from all participants.

Participants underwent a standardised clinical assessment including a history, neurological examination, neuropsychometric assessment, the Mini-Mental State Examination (MMSE), and the CDR® plus NACC FTLD global score [26]. The CDR® plus NACC FTLD was used to classify mutation carriers as either presymptomatic (global score of 0, asymptomatic, or 0.5, prodromal) or fully symptomatic (score  $\geq 1$ ). In total there were 372 mutation carriers with a CDR® plus NACC FTLD global

score of 0 (asymptomatic, 290 participants) or 0.5 (prodromal, 82 participants): 148 *C9orf72* (111 asymptomatic, 37 prodromal), 161 *GRN* (130 asymptomatic, 31 prodromal), and 63 *MAPT* (49 asymptomatic, 14 prodromal) individuals. Controls in the study consisted of all mutation-negative family members with a CDR® plus NACC FTLD global score of 0 or 0.5, which was 310 participants in total. Demographics are shown in Table 1.

## 2.2. Language assessment

Language was assessed by a clinician using the GENFI clinical questionnaire, which is based on the Progressive Aphasia Severity Scale (PASS) [37]. This contains ten language symptoms scored as per a CDR scale i.e., 0 = asymptomatic, 0.5 = questionable/very mild, 1 = mild, 2 = moderate and 3 = severe: impaired articulation, decreased fluency, impaired grammar/syntax, impaired word retrieval, impaired speech repetition, impaired sentence comprehension, impaired single word comprehension, dyslexia (acquired impairment of reading), dysgraphia (acquired impairment of writing), and impaired functional communication. The assessment consists of a semi-structured interview with inclusion of both the participant and an informant to generate an overall clinician-judged score for each symptom. An overall PASS score can be generated from summing each of the individual language symptom scores.

**Table 1**

Demographics, clinical scores, severity of linguistic symptoms, cognitive task data and regional brain volumes for asymptomatic and prodromal mutation carriers. Data are shown as mean (standard deviation). Bold items are significantly impaired compared to controls. For significant group differences: <sup>a</sup>compared to asymptomatic *C9orf72* mutation carriers, <sup>b</sup>compared to asymptomatic *GRN* mutation carriers, <sup>c</sup>compared to asymptomatic *MAPT* mutation carriers; <sup>d</sup>compared to prodromal *MAPT* mutation carriers. No comparisons were made between asymptomatic and prodromal mutation carriers. Abbreviations: bvFTD, behavioural variant frontotemporal dementia; TIV, total intracranial volume.

	Controls	Asymptomatic mutation carriers			Prodromal mutation carriers		
		<i>C9orf72</i>	<i>GRN</i>	<i>MAPT</i>	<i>C9orf72</i>	<i>GRN</i>	<i>MAPT</i>
Number of participants	310	111	130	49	37	31	14
% Male	44	41	34	39	41	48	29
% Right-handed	93	91	89	90	92	90	100
Age (years)	46.0 (12.7)	44.4 (11.8)	45.8 (12.2)	<b>39.2 (10.4)<sup>ab</sup></b>	49.4 (11.2)	<b>51.8 (13.2)</b>	45.7 (12.6)
Education (years)	14.5 (3.3)	14.4 (3.0)	14.7 (3.4)	14.4 (3.3)	14.1 (2.6)	14.0 (4.0)	13.5 (2.4)
MMSE	29.3 (1.0)	29.2 (1.2) <sup>bc</sup>	29.4 (0.9)	29.5 (0.8)	<b>28.5 (2.1)</b>	28.5 (2.4)	28.2 (2.3)
CDR® plus NACC FTLD Global score	0.1 (0.2)	0.0 (0.0)	0.0 (0.0)	0.0 (0.0)	<b>0.5 (0.0)</b>	<b>0.5 (0.0)</b>	<b>0.5 (0.0)</b>
CDR® plus NACC FTLD Sum of Boxes	0.2 (0.4)	0.0 (0.0)	0.0 (0.0)	0.0 (0.0)	<b>1.1 (0.8)</b>	<b>1.0 (0.8)</b>	<b>1.0 (0.8)</b>
Progressive Aphasia Severity Scale	0.1 (0.5)	0.0 (0.2)	0.0 (0.1)	0.0 (0.1)	<b>0.9 (1.5)</b>	<b>1.2 (2.3)</b>	<b>0.6 (0.5)</b>
<b>Linguistic symptoms</b>							
Impaired articulation	0.01 (0.06)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	<b>0.11 (0.27)</b>	0.08 (0.23)	0.04 (0.13)
Decreased fluency	0.01 (0.08)	0.00 (0.05)	0.00 (0.00)	0.00 (0.00)	<b>0.08 (0.19)</b>	<b>0.15 (0.32)</b>	0.04 (0.13)
Impaired grammar/syntax	0.01 (0.10)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	<b>0.08 (0.19)<sup>d</sup></b>	<b>0.23 (0.55)<sup>d</sup></b>	0.00 (0.00)
Impaired word retrieval	0.06 (0.18)	0.01 (0.08)	0.02 (0.10)	0.01 (0.07)	<b>0.19 (0.32)</b>	<b>0.32 (0.63)</b>	<b>0.39 (0.35)</b>
Impaired speech repetition	0.00 (0.04)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.03 (0.11)	0.02 (0.09)	0.00 (0.00)
Impaired sentence comprehension	0.00 (0.03)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.08 (0.25)	0.06 (0.21)	0.00 (0.00)
Impaired single word comprehension	0.00 (0.03)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.04 (0.18)	0.05 (0.15)	0.04 (0.13)
Dyslexia	0.01 (0.13)	0.02 (0.19)	0.00 (0.00)	0.00 (0.00)	0.14 (0.47)	0.10 (0.24)	0.04 (0.13)
Dysgraphia	0.01 (0.13)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.11 (0.38)	<b>0.10 (0.20)</b>	0.04 (0.13)
Impaired functional communication	0.01 (0.14)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.05 (0.16)	0.13 (0.34) <sup>d</sup>	0.00 (0.00)
<b>Cognitive tasks</b>							
Boston Naming Test (/30)	27.9 (1.9)	27.3 (3.1)	27.9 (1.9)	27.6 (2.1)	27.5 (3.4)	26.7 (3.7)	<b>25.7 (3.9)</b>
Modified Camel and Cactus Test (/32)	30.3 (1.7)	29.9 (2.2)	30.4 (1.4)	30.0 (2.1)	29.4 (2.8)	29.4 (2.2)	29.5 (2.5)
Category Fluency (max in 60s)	24.4 (6.4)	23.6 (6.4) <sup>b</sup>	25.2 (5.4)	24.3 (5.8)	<b>21.6 (6.0)</b>	23.0 (6.3)	<b>22.1 (4.1)</b>
<b>Regional left hemisphere brain volumes (as a % of TIV)</b>							
Inferior frontal gyrus	0.57 (0.08)	<b>0.56 (0.07)<sup>b</sup></b>	0.58 (0.06)	0.59 (0.07)	0.57 (0.08)	0.53 (0.07)	0.57 (0.05)
Insula	0.37 (0.04)	<b>0.36 (0.04)<sup>b</sup></b>	0.37 (0.03)	0.38 (0.04)	<b>0.35 (0.05)</b>	0.35 (0.04)	0.35 (0.05)
Motor cortex	1.40 (0.16)	1.39 (0.11) <sup>b</sup>	1.44 (0.12)	1.38 (0.09) <sup>b</sup>	<b>1.33 (0.15)</b>	1.36 (0.13)	1.41 (0.07)
Temporal pole	0.49 (0.07)	0.49 (0.05)	0.49 (0.05)	0.49 (0.06)	<b>0.47 (0.06)</b>	0.48 (0.06)	0.46 (0.09)
Superior temporal gyrus	0.49 (0.06)	<b>0.48 (0.05)<sup>b</sup></b>	0.49 (0.05)	0.48 (0.05) <sup>b</sup>	0.47 (0.05)	0.46 (0.06)	0.47 (0.05)
Supratemporal region	0.42 (0.06)	<b>0.41 (0.05)<sup>bc</sup></b>	0.42 (0.05)	0.43 (0.05)	<b>0.39 (0.04)</b>	0.39 (0.05)	<b>0.39 (0.04)</b>
Angular gyrus	0.53 (0.08)	0.53 (0.07)	0.54 (0.08)	0.54 (0.07)	<b>0.50 (0.08)</b>	0.52 (0.09)	0.54 (0.08)

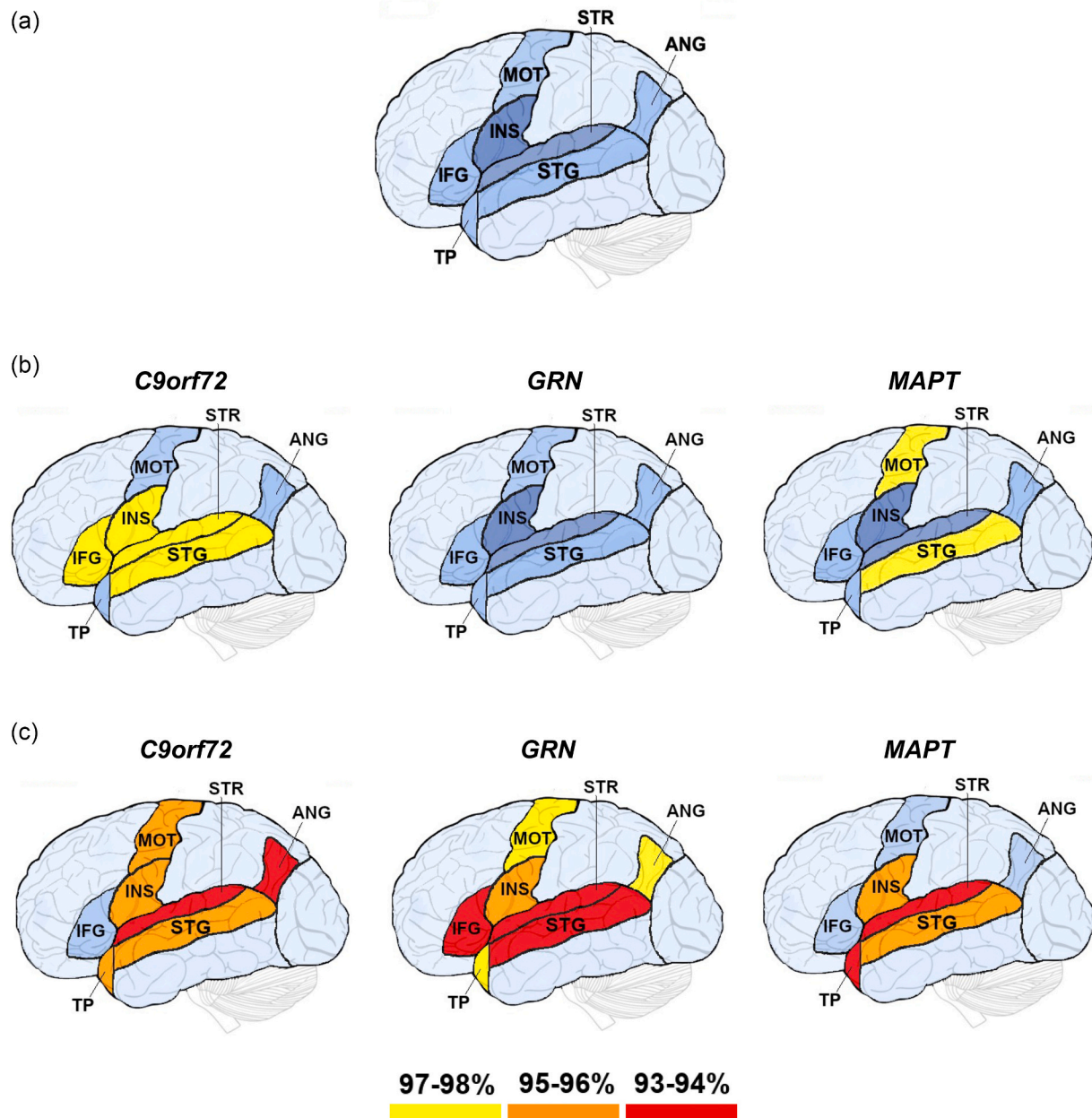
## 2.3. Cognitive assessment

Within the GENFI neuropsychology battery, the 30-item version of the Boston Naming Test [12,23] (BNT), the modified Camel and Cactus Test [28] (mCCT) and category fluency (animals) were the linguistic measures used.

## 2.4. Imaging

630 participants had a 3 T volumetric T1-weighted magnetic resonance imaging (MRI) scan (205 Philips Achieva, 145 Siemens Prisma, 151 Siemens Trio, 119 Siemens Skyra, 10 GE Signa HD) of sufficient quality to be analysed: 281 controls and 349 presymptomatic mutation carriers (136 *C9orf72*, 154 *GRN*, and 59 *MAPT* mutation carriers) of whom 274 were asymptomatic (104 *C9orf72*, 124 *GRN*, and 46 *MAPT* mutation carriers) and 75 were prodromal (32 *C9orf72*, 30 *GRN*, and 13 *MAPT* mutation carriers).

Volumetric MRI scans were first bias field corrected and whole brain parcellated using the geodesic information flow (GIF) algorithm [6], which is based on atlas propagation and label fusion. We focused on key language regions, calculating grey matter volumes of the cortex for seven left hemisphere perisylvian regions (Fig. 1a): inferior frontal gyrus, insula, motor cortex, temporal pole, superior temporal gyrus, supratemporal region, and angular gyrus [8,15,41]. All measures were expressed as a percentage of total intracranial volume (TIV) computed



**Fig. 1.** (a) Left perisylvian regions included in the MR imaging analysis are shown in this artificial representation of the lateral surface of the brain, with the insula and supratemporal region shown in darker blue to represent that they are deeper structures within the sylvian fissure, and region of interest volumes in each (b) asymptomatic and (c) prodromal genetic group as a percentage of mean control volume: IFG, inferior frontal gyrus; INS, insula; MOT, motor cortex; TP, temporal pole; STG, superior temporal gyrus; STR, supratemporal region; ANG, angular gyrus. The darkest colours represent areas of lowest brain volume as per the key. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

with SPM12 v6470 (Statistical Parametric Mapping, Wellcome Trust Centre for Neuroimaging, London, UK) running under Matlab R2014b (Math Works, Natick, MA, USA) [24].

## 2.5. Statistical analysis

All statistical analyses were performed using Stata/MP 16.1. Statistical tests of normality were performed using the Shapiro-Wilk test. Demographics were compared between groups using either linear regression (age and education) or a chi-squared test (sex). Linear regressions adjusting for age and sex were used to compare the MMSE, CDR® plus NACC FTLD and PASS scores as well as the cognitive tasks and regional brain volumes between groups. Individual linguistic symptoms were compared in each disease group versus controls using

linear regressions adjusting for age and sex, and 95% bias-corrected bootstrapped confidence intervals with 2000 repetitions (as there was minimal variation from zero in severity scores for the control group), and between genetic groups using an ordinal logistic regression adjusting for age and sex. As the same disease process is likely to be causing the linguistic deficits within each genetic group at the different stages, we combined the asymptomatic and prodromal mutation carriers into a single presymptomatic cohort for each genetic group in order to examine the strength of association between language-associated brain regions and both individual language symptoms and linguistic tasks. This was performed using Spearman rank correlations uncorrected for multiple comparisons.



### 3. Results

#### 3.1. Demographics

There was no evidence for differences between the groups in terms of either years of education or sex. The asymptomatic *MAPT* mutation carriers were approximately five years younger than controls ( $p < 0.001$ , Table 1) and the other two asymptomatic mutation carrier groups ( $p = 0.004$  when compared to *C9orf72*,  $p < 0.001$  when compared to *GRN*); the prodromal *GRN* mutation carriers were older than controls ( $p = 0.020$ ) (Table 1).

#### 3.2. Disease severity

There was some evidence that the MMSE was lower in asymptomatic *C9orf72* mutation carriers compared to other asymptomatic mutation carrier groups ( $p = 0.034$  when compared to *GRN*,  $p = 0.022$  when compared to *MAPT*) but no other asymptomatic groups were significantly different than controls. Prodromal *C9orf72* mutation carriers had a significantly lower MMSE compared with controls ( $p = 0.017$ ) but there were no other prodromal group differences. In comparison the CDR® plus NACC FTLD was impaired in all three prodromal mutation carrier groups (but not asymptomatic mutation carriers) compared with controls (all  $p < 0.001$ ). There was no evidence of differences in CDR® plus NACC FTLD between the disease groups.

#### 3.3. Language symptoms

3% of the asymptomatic mutation carriers had impairment in at least one language symptom (4% of the *C9orf72* group, 4% of the *GRN* group and 2% of the *MAPT* group) whilst 48% of the prodromal mutation carriers had impairment in at least one language symptom (46% of the *C9orf72* group, 42% of the *GRN* group and 64% of the *MAPT* group) (Table 1, Fig. 2). In comparison, only 13% of the controls showed any impairment. The PASS score was significantly higher than controls in each of the prodromal groups (*C9orf72*:  $p = 0.003$ ; *GRN*:  $p = 0.008$ ; *MAPT*:  $p = 0.002$ ), but not in the asymptomatic groups (Table 1).

None of the language symptoms were significantly abnormal in the asymptomatic mutation carriers compared with controls (Table 1, Fig. 2). However, impairment was seen in at least one symptom within each of the genetic groups in the prodromal mutation carriers. All three groups had impaired word retrieval compared with controls: severity mean 0.19 (standard deviation 0.32), frequency 30% in the *C9orf72* expansion carriers, 0.32 (0.63), 29% in the *GRN* mutation carriers, 0.39 (0.35), 64% in the *MAPT* mutation carriers, and 0.06 (0.18), 10% in controls. Both prodromal *C9orf72* and *GRN* groups had significantly impaired grammar/syntax and decreased fluency compared with controls: for grammar/syntax - severity mean 0.08 (0.19), frequency 16% in the *C9orf72* expansion carriers, 0.23 (0.55), 19% in the *GRN* mutation carriers and 0.01 (0.10), 2% in controls; for fluency - severity mean 0.08 (0.19), frequency 16% in the *C9orf72* expansion carriers, 0.15 (0.32), 19% in the *GRN* mutation carriers and 0.01 (0.08), 3% in controls. Lastly, *C9orf72* expansion carriers also had impaired articulation compared with controls: severity mean 0.11 (0.27), frequency 16% in the *C9orf72* expansion carriers, and 0.01 (0.06), 2% in controls, whilst *GRN* mutation carriers had significant dysgraphia compared with controls: severity mean 0.10 (0.20), frequency 19% in the *GRN* mutation carriers, and 0.01 (0.13), 2% in controls.

#### 3.4. Cognitive assessment

No differences were seen in the linguistic tasks compared with controls in the asymptomatic genetic groups. However, prodromal *C9orf72* expansion carriers were significantly impaired in category fluency (21.6 (6.0)) compared with controls (24.4 (6.4),  $p = 0.011$ ). Prodromal *MAPT* mutation carriers were also significantly impaired on the category

fluency task (22.1 (4.1),  $p = 0.027$ ) as well as the BNT (25.7 (3.9), compared with 27.9 (1.9) in controls,  $p = 0.027$ ).

#### 3.5. Imaging analysis

The asymptomatic *C9orf72* group had significantly reduced regional brain volumes compared with controls in a number of regions (Table 1, Fig. 1b): insula (97% of mean control volume,  $p = 0.024$ ), inferior frontal gyrus (98%,  $p = 0.036$ ), superior temporal gyrus (98%,  $p = 0.036$ ) and supratemporal region (98%,  $p = 0.018$ ). No significant differences were seen in the *GRN* or *MAPT* asymptomatic groups. Regional volumes were also significantly reduced in the prodromal *C9orf72* group: insula (95% of mean control volume,  $p = 0.005$ ) and supratemporal region (93%,  $p = 0.008$ ) as well as temporal pole (96%,  $p = 0.047$ ), motor (95%,  $p = 0.008$ ) and angular gyrus (94%,  $p = 0.032$ ). In the prodromal *MAPT* mutation carriers, the supratemporal region was significantly reduced in volume (93%,  $p = 0.001$ ), with the temporal pole also reduced to a similar extent (94%, but not significantly different to controls,  $p = 0.274$ ). No volumes were significantly different to controls in the prodromal *GRN* group.

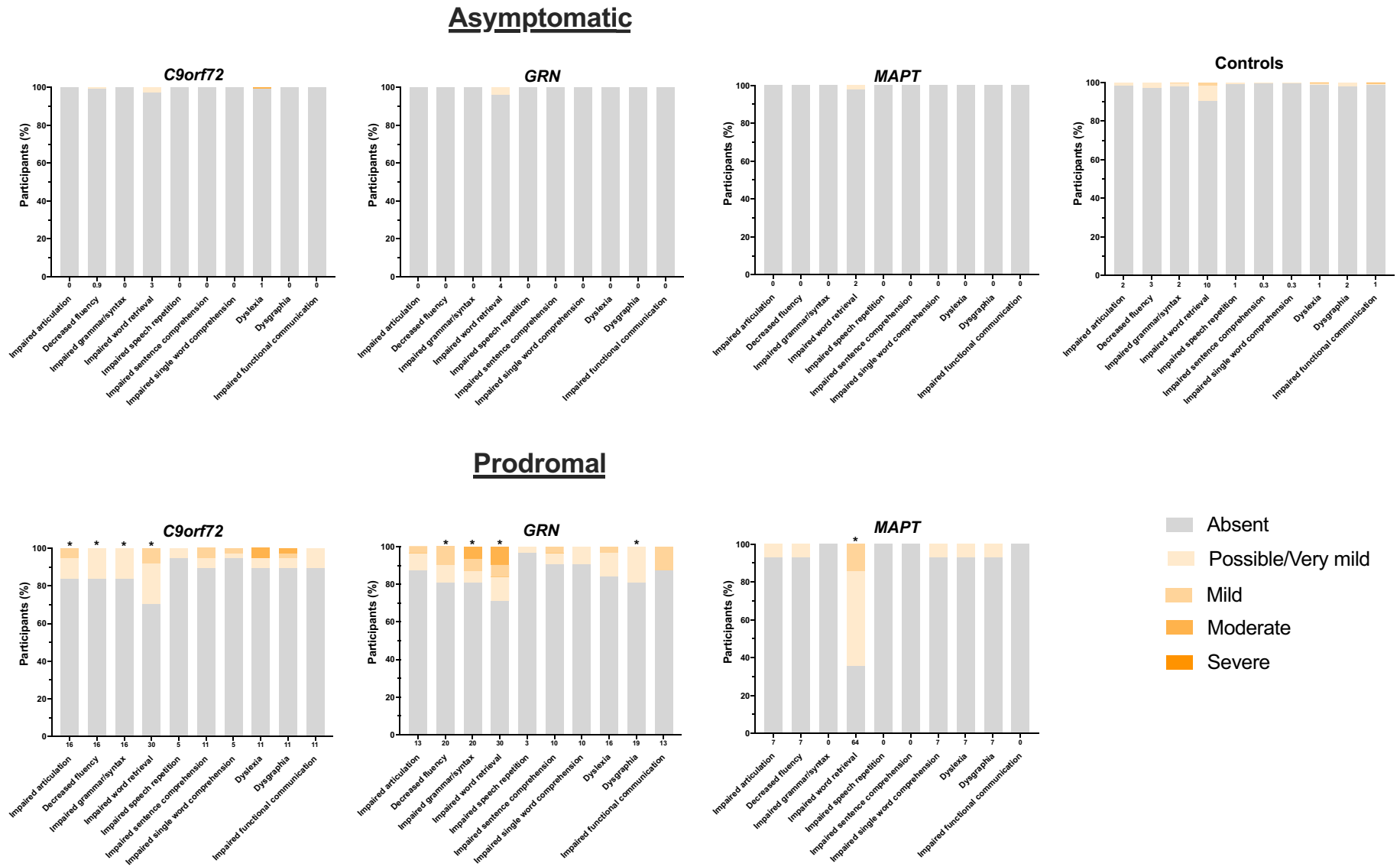
For linguistic symptoms, dysgraphia in *C9orf72* mutation carriers significantly negatively correlated with volume of the insula ( $r = -0.20$ ,  $p = 0.029$ ) and angular gyrus ( $r = -0.19$ ,  $p = 0.031$ ) (Supplementary Table 1). In the *GRN* mutation carriers decreased fluency negatively correlated with volumes of the inferior frontal gyrus ( $r = -0.21$ ,  $p = 0.013$ ), insula ( $r = -0.18$ ,  $p = 0.035$ ) and angular gyrus ( $r = -0.17$ ,  $p = 0.048$ ), impaired grammar/syntax negatively correlated with supratemporal region volume ( $r = -0.19$ ,  $p = 0.031$ ), impaired word comprehension negatively correlated with inferior frontal gyrus volume ( $r = -0.18$ ,  $p = 0.043$ ), and impaired functional communication negatively correlated with volumes of the inferior frontal gyrus ( $r = -0.20$ ,  $p = 0.022$ ), insula ( $r = -0.19$ ,  $p = 0.025$ ) and supratemporal region ( $r = -0.18$ ,  $p = 0.038$ ). No correlations were seen in the *MAPT* mutation group.

In the *C9orf72* group there were no correlations between scores on the linguistic cognitive tasks and brain volumes (Supplementary Table 2). In the *GRN* group, there was a significant positive correlation between category fluency score and insula volume:  $r = 0.21$ ,  $p = 0.017$ . In *MAPT* mutation carriers a positive correlation was seen between mCCT score and insula volume ( $r = 0.29$ ,  $p = 0.031$ ).

### 4. Discussion

In this study we have shown that language impairment occurs in the prodromal period of all three major genetic forms of FTD, with overlapping but distinct features. Impaired word retrieval was seen in all three groups and both decreased fluency and impaired grammar/syntax were seen in the *C9orf72* and *GRN* groups, but impaired articulation was only seen in the *C9orf72* mutation carriers. Impairment on a category fluency task was seen in both *C9orf72* and *MAPT* mutation carriers but only the *MAPT* group performed significantly worse on a test of naming. Atrophy was seen in core language network areas as early as the asymptomatic stage in *C9orf72* expansion carriers with volume loss in temporal regions in *MAPT* mutation carriers prodromally.

All three groups had impaired word retrieval. Such deficits can be due to multiple different underlying linguistic difficulties including both semantic and lexical access impairment as well as problems in non-linguistic cognitive domains impacting on the language system. (Note should be made however that 10% of controls also had impaired word retrieval, representing the fact that this is a common symptom in the general population and in those presenting with subjective cognitive impairment, where the underlying causes are often unclear [21,25]). It is likely that different mechanisms underpin the difficulties in the three genetic groups, with semantic problems predominating in *MAPT* mutations [29], and impairment of lexical access (or mixed problems) in the other two genetic groups [34]. Such an impairment of lexical retrieval



**Fig. 2.** The percentage of participants in each of the asymptomatic and prodromal groups and controls who score 0 = absent, 0.5 = very mild/questionable, 1 = mild, 2 = moderate, or 3 = severe for each linguistic symptom: y-axis shows all participants in each group (100%), x-axis shows the different linguistic symptoms. Values along the bottom of x-axis represent the frequency (%) with which the symptom is present in any category above zero (i.e. 0.5 to 3). An asterisk above the bar indicates that the symptom severity is significantly greater than controls.

can lead to decreased fluency, which was seen here in *C9orf72* and *GRN* mutation carriers, although nonfluency can also occur due to other underlying linguistic deficits including problems with grammar (also seen in both *C9orf72* and *GRN* mutation carriers), or impaired articulation (seen in the *C9orf72* mutation carriers alone). The presence of significant linguistic deficits occurring prodromally in all three groups highlights the importance of including a language component in any clinical rating scale of genetic FTD.

Nearly half of the *C9orf72* expansions had language difficulties, with this group showing significant impairment of word retrieval, grammar/syntax, fluency and articulation as well as poor performance on the category fluency task. Whilst these features are often seen in people with nonfluent variant PPA (and therefore may be thought to herald such a diagnosis), such a presentation in symptomatic *C9orf72* mutation carriers is uncommon [11]. In fact, these features are also seen alongside prominent behavioural change in those with a symptomatic diagnosis of bvFTD [36], and are not necessarily the initial symptom at phenoconversion. Furthermore, impaired articulation can be related to non-linguistic impairments such as dysarthria which is a feature of the bulbar presentation of amyotrophic lateral sclerosis, another phenotype of *C9orf72* expansions [17]. Interestingly, atrophy of quite a number of the language network regions was seen even at the asymptomatic stage, with further atrophy prodromally. This is consistent with previous studies showing widespread atrophy in presymptomatic *C9orf72* mutation carriers [2,40], including early involvement of more posterior regions, as seen here in the angular gyrus, where atrophy correlated with impairment of writing in this group.

Similar to the *C9orf72* group, just under half of the prodromal *GRN* mutation carriers had language symptoms with significant difficulties in word retrieval, fluency, grammar/syntax and dysgraphia. In contrast, however, in a previous GENFI study (Samra et al., in press) over 40% of symptomatic *GRN* mutation carriers had a PPA phenotype, either nfvPPA or PPA-NOS. It may well be therefore that some of the prodromal mutation carriers in this study are destined to develop PPA, but it is important to note that other studies (Le [22,36]) have shown that over 50% of people with *GRN*-associated bvFTD also have linguistic deficits (as secondary features to the behavioural change): at present it is not possible to predict exactly who will develop which phenotype. Unlike the other two groups none of the language network regional volumes were significantly lower than controls. This is consistent with previous studies [2] showing that atrophy occurs quite late in the presymptomatic period. However, a number of symptoms (including decreased fluency and impairment on the category fluency task) correlated with atrophy in the inferior frontal gyrus and insula, regions both known to be affected in *GRN*-associated PPA and bvFTD (Samra et al., in press; [36]).

Although only one linguistic symptom was significantly abnormal in the prodromal *MAPT* mutation group, impaired word retrieval occurred in 64% of carriers. Consistent with this impairment, the prodromal *MAPT* group also had significant difficulties on both the naming and category fluency task. As mentioned above, this is likely to be due to semantic impairment, a feature previously described in *MAPT* mutations ((Samra et al., in press; [5,28–30]). Whilst anomia can rarely be the presenting symptom leading to a diagnosis of svPPA in people with *MAPT* mutations, it is more commonly a secondary (albeit prominent) feature in those presenting with personality change and diagnosed with bvFTD [1,7,19,32,36]. The imaging analysis here showed the largest percentage volume loss compared with controls prodromally was in the left supratemporal region and temporal pole. The anterior temporal lobe is an important part of the semantic network [18,20] although a correlation of mCCT score and insula volume suggests other areas are likely to be important in language function in *MAPT* mutation carriers.

#### 4.1. Limitations

Although the GENFI study is one of the largest genetic FTD cohorts worldwide, there were modest numbers in each group after stratification and further studies aiming to replicate this data will be helpful. Another limitation was the limited availability of language cognitive tests within the GENFI battery. With a lack of validated cross-language verbal linguistic tasks the multilingual GENFI study has focused on non-verbal or already validated tasks in its cognitive battery. Moreover, non-linguistic deficits may impact performance on tasks such as category fluency or the mCCT, where executive dysfunction can lead to impairments [9,14]. Lastly, it is currently impossible to predict whether a presymptomatic mutation carrier with language features will go on to develop bvFTD, PPA or another clinical syndrome. Future longitudinal studies in GENFI and other familial FTD cohorts will be important to better understand phenoconversion and to establish which features predict particular FTD phenotypes during the prodromal period.

#### 4.2. Conclusions

In summary, linguistic deficits seem to occur when individuals with genetic FTD enter the prodromal phase, with important differences being shown between the three genetic groups both in terms of clinical features and the pattern of atrophy in the key language network regions. The study highlights the importance of including language symptoms in any clinical rating scale for genetic FTD, particularly when considering staging of the disease and for monitoring disease progression.

#### Ethics approval and consent to participate

All GENFI sites had local ethical approval for the study, and all participants gave written informed consent.

#### Funding

The Dementia Research Centre is supported by Alzheimer's Research UK, Alzheimer's Society, Brain Research UK, and The Wolfson Foundation. This work was supported by the National Institute for Health Research (NIHR) Queen Square Dementia Biomedical Research Unit and the University College London Hospitals Biomedical Research Centre, the Leonard Wolfson Experimental Neurology Centre (LWENC) Clinical Research Facility, and the UK Dementia Research Institute, which receives its funding from UK DRI Ltd., funded by the UK Medical Research Council, Alzheimer's Society and Alzheimer's Research UK. This work was also supported by the MRC UK GENFI grant (MR/M023664/1), the Italian Ministry of Health (CoEN015 and Ricerca Corrente), the Canadian Institutes of Health Research as part of a Centres of Excellence in Neurodegeneration grant, a Canadian Institutes of Health Research operating grant, the Alzheimer's Society grant (AS-PG-16-007), the Bluefield Project and the JPND GENFI-PROX grant (2019–02248). MB is supported by a Fellowship award from the Alzheimer's Society, UK (AS-JF-19a-004-517). JDR is supported by the Miriam Marks Brain Research UK Senior Fellowship and has received funding from an MRC Clinician Scientist Fellowship (MR/M008525/1) and the NIHR Rare Disease Translational Research Collaboration (BRC149/NS/MH). JBR is funded by the Wellcome Trust (103838) and the National Institute for Health Research Cambridge Biomedical Research Centre. This work was funded by the Deutsche Forschungsgemeinschaft (DFG, German Research Foundation) under Germany's Excellence Strategy within the framework of the Munich Cluster for Systems Neurology (EXC 2145 SyNergy – ID 390857198). RV's work is supported by the Mady Browaeys Fonds voor Onderzoek naar Frontotemporale Degeneratie. Several authors of

this publication (JCvS, MS, RSV, AD, MO, RV, JDR) are members of the European Reference Network for Rare Neurological Diseases (ERN-RND) - Project ID No 739510.

### Declaration of Competing Interest

The authors declare that they have no competing interests.

### Genetic FTD Initiative (GENFI)

Author	Affiliation
Annabel Nelson	Department of Neurodegenerative Disease, Dementia Research Centre, UCL Queen Square Institute of Neurology, London, UK
David L Thomas	Neuroimaging Analysis Centre, Department of Brain Repair and Rehabilitation, UCL Institute of Neurology, Queen Square, London, UK
Emily Todd	Department of Neurodegenerative Disease, Dementia Research Centre, UCL Queen Square Institute of Neurology, London, UK
Hanya Benotmane	UK Dementia Research Institute at University College London, UCL Queen Square Institute of Neurology, London, UK
Jennifer Nicholas	Department of Medical Statistics, London School of Hygiene and Tropical Medicine, London, UK
Rachelle Shafei	Department of Neurodegenerative Disease, Dementia Research Centre, UCL Queen Square Institute of Neurology, London, UK
Carolyn Timberlake	Department of Clinical Neurosciences, University of Cambridge, Cambridge, UK
Thomas Cope	Department of Clinical Neuroscience, University of Cambridge, Cambridge, UK
Timothy Rittman	Department of Clinical Neurosciences, University of Cambridge, Cambridge, UK
Alberto Benussi	Centre for Neurodegenerative Disorders, Department of Clinical and Experimental Sciences, University of Brescia, Brescia, Italy
Enrico Premi	Stroke Unit, ASST Brescia Hospital, Brescia, Italy
Roberto Gasparotti	Neuroradiology Unit, University of Brescia, Brescia, Italy
Silvana Archetti	Biotechnology Laboratory, Department of Diagnostics, ASST Brescia Hospital, Brescia, Italy
Stefano Gazzina	Neurology, ASST Brescia Hospital, Brescia, Italy
Valentina Cantoni	Centre for Neurodegenerative Disorders, Department of Clinical and Experimental Sciences, University of Brescia, Brescia, Italy
Andrea Arighi	Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Neurodegenerative Diseases Unit, Milan, Italy; University of Milan, Centro Dino Ferrari, Milan, Italy
Chiara Fenoglio	Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Neurodegenerative Diseases Unit, Milan, Italy; University of Milan, Centro Dino Ferrari, Milan, Italy
Elio Scarpini	Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Neurodegenerative Diseases Unit, Milan, Italy; University of Milan, Centro Dino Ferrari, Milan, Italy
Giorgio Fumagalli	Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Neurodegenerative Diseases Unit, Milan, Italy; University of Milan, Centro Dino Ferrari, Milan, Italy
Vittoria Borracci	Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy
Giacomina Rossi	Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy
Giorgio Giaccone	Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy
Giuseppe Di Fede	Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy
Paola Caroppo	Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy
Sara Prioni	Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy
Veronica Redaelli	Fondazione IRCCS Istituto Neurologico Carlo Besta, Milano, Italy
David Tang-Wai	The University Health Network, Krembil Research Institute, Toronto, Canada
Ekaterina Rogaeva	Tanz Centre for Research in Neurodegenerative Diseases, University of Toronto, Toronto, Canada
Miguel Castelo-Branco	Faculty of Medicine, University of Coimbra, Coimbra, Portugal
Morris Freedman	Baycrest Health Sciences, Rotman Research Institute, University of Toronto, Toronto, Canada
Ron Keren	The University Health Network, Toronto Rehabilitation Institute, Toronto, Canada
Sandra Black	Sunnybrook Health Sciences Centre, Sunnybrook Research Institute, University of Toronto, Toronto, Canada
Sara Mitchell	Sunnybrook Health Sciences Centre, Sunnybrook Research Institute, University of Toronto, Toronto, Canada
Christen Shoesmith	Department of Clinical Neurological Sciences, University of Western Ontario, London, Ontario, Canada
Robart Bartha	Department of Medical Biophysics, The University of Western Ontario, London, Ontario, Canada; Centre for Functional and Metabolic Mapping, Robarts Research Institute, The University of Western Ontario, London, Ontario, Canada
Rosa Rademakers	Center for Molecular Neurology, University of Antwerp
Jackie Poos	Department of Neurology, Erasmus Medical Center, Rotterdam, Netherlands
Janne M. Papma	Department of Neurology, Erasmus Medical Center, Rotterdam, Netherlands
Lucia Giannini	Department of Neurology, Erasmus Medical Center, Rotterdam, Netherlands
Rick van Minkelen	Department of Clinical Genetics, Erasmus Medical Center, Rotterdam, Netherlands
Yolande Pijnenburg	Amsterdam University Medical Centre, Amsterdam VUmc, Amsterdam, Netherlands
Benedetta Nacmias	Department of Neuroscience, Psychology, Drug Research and Child Health, University of Florence, Florence, Italy
Camilla Ferrari	Department of Neuroscience, Psychology, Drug Research and Child Health, University of Florence, Florence, Italy
Cristina Polito	Department of Biomedical, Experimental and Clinical Sciences "Mario Serio", Nuclear Medicine Unit, University of Florence, Florence, Italy
Gemma Lombardi	Department of Neuroscience, Psychology, Drug Research and Child Health, University of Florence, Florence, Italy
Valentina Bessi	Department of Neuroscience, Psychology, Drug Research and Child Health, University of Florence, Florence, Italy
Michele Veldsman	Nuffield Department of Clinical Neurosciences, Medical Sciences Division, University of Oxford, Oxford, UK
Christin Andersson	Department of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden
Hakan Thonberg	Center for Alzheimer Research, Division of Neurogeriatrics, Karolinska Institutet, Stockholm, Sweden
Linn Öijerstedt	Center for Alzheimer Research, Division of Neurogeriatrics, Department of Neurobiology, Care Sciences and Society, Bioclinicum, Karolinska Institutet, Solna, Sweden; Unit for Hereditary Dementias, Theme Aging, Karolinska University Hospital, Solna, Sweden
Vesna Jelic	Division of Clinical Geriatrics, Karolinska Institutet, Stockholm, Sweden
Paul Thompson	Division of Neuroscience and Experimental Psychology, Wolfson Molecular Imaging Centre, University of Manchester, Manchester, UK

(continued on next page)

### Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

### Acknowledgments

We thank the research participants and their families for their contribution to the study.



(continued)

Author	Affiliation
Tobias Langheinrich	Division of Neuroscience and Experimental Psychology, Wolfson Molecular Imaging Centre, University of Manchester, Manchester, UK; Manchester Centre for Clinical Neurosciences, Department of Neurology, Salford Royal NHS Foundation Trust, Manchester, UK
Albert Lladó	Alzheimer's disease and Other Cognitive Disorders Unit, Neurology Service, Hospital Clínic, Barcelona, Spain
Anna Antonell	Alzheimer's disease and Other Cognitive Disorders Unit, Neurology Service, Hospital Clínic, Barcelona, Spain
Jaume Olives	Alzheimer's disease and Other Cognitive Disorders Unit, Neurology Service, Hospital Clínic, Barcelona, Spain
Mircea Balasa	Alzheimer's disease and Other Cognitive Disorders Unit, Neurology Service, Hospital Clínic, Barcelona, Spain
Nuria Bargalló	Imaging Diagnostic Center, Hospital Clínic, Barcelona, Spain
Sergi Borrego-Ecija	Alzheimer's disease and Other Cognitive Disorders Unit, Neurology Service, Hospital Clínic, Barcelona, Spain
Ana Verdelho	Department of Neurosciences and Mental Health, Centro Hospitalar Lisboa Norte - Hospital de Santa Maria & Faculty of Medicine, University of Lisbon, Lisbon, Portugal
Carolina Maruta	Laboratory of Language Research, Centro de Estudos Egas Moniz, Faculty of Medicine, University of Lisbon, Lisbon, Portugal
Catarina B. Ferreira	Laboratory of Neurosciences, Faculty of Medicine, University of Lisbon, Lisbon, Portugal
Gabriel Miltenberger	Faculty of Medicine, University of Lisbon, Lisbon, Portugal
Frederico Simões do Couto	Faculdade de Medicina, Universidade Católica Portuguesa
Alazne Gabilondo	Cognitive Disorders Unit, Department of Neurology, Donostia University Hospital, San Sebastian, Gipuzkoa, Spain; Neuroscience Area, Biodonostia Health Research Institute, San Sebastian, Gipuzkoa, Spain
Ana Gorostidi	Neuroscience Area, Biodonostia Health Research Institute, San Sebastian, Gipuzkoa, Spain
Jorge Villanua	OSATEK, University of Donostia, San Sebastian, Gipuzkoa, Spain
Marta Cañada	CITA Alzheimer, San Sebastian, Gipuzkoa, Spain
Mikel Tainta	Neuroscience Area, Biodonostia Health Research Institute, San Sebastian, Gipuzkoa, Spain
Miren Zulaica	Neuroscience Area, Biodonostia Health Research Institute, San Sebastian, Gipuzkoa, Spain
Myriam Barandiaran	Cognitive Disorders Unit, Department of Neurology, Donostia University Hospital, San Sebastian, Gipuzkoa, Spain; Neuroscience Area, Biodonostia Health Research Institute, San Sebastian, Gipuzkoa, Spain
Patricia Alves	Neuroscience Area, Biodonostia Health Research Institute, San Sebastian, Gipuzkoa, Spain; Department of Educational Psychology and Psychobiology, Faculty of Education, International University of La Rioja, Logroño, Spain
Benjamin Bender	Department of Diagnostic and Interventional Neuroradiology, University of Tübingen, Tübingen, Germany
Carlo Wilke	Department of Neurodegenerative Diseases, Hertie-Institute for Clinical Brain Research and Center of Neurology, University of Tübingen, Tübingen, Germany; Center for Neurodegenerative Diseases (DZNE), Tübingen, Germany
Lisa Graf	Department of Neurodegenerative Diseases, Hertie-Institute for Clinical Brain Research and Center of Neurology, University of Tübingen, Tübingen, Germany
Annick Vogels	Department of Human Genetics, KU Leuven, Leuven, Belgium
Mathieu Vandenbulcke	Geriatric Psychiatry Service, University Hospitals Leuven, Belgium; Neuropsychiatry, Department of Neurosciences, KU Leuven, Leuven, Belgium
Philip Van Damme	Neurology Service, University Hospitals Leuven, Belgium; Laboratory for Neurobiology, VIB-KU Leuven Centre for Brain Research, Leuven, Belgium
Rose Bruffaerts	Department of Biomedical Sciences, University of Antwerp, Antwerp, Belgium; Biomedical Research Institute, Hasselt University, 3500 Hasselt, Belgium
Koen Poesen	Laboratory for Molecular Neurobiomarker Research, KU Leuven, Leuven, Belgium
Pedro Rosa-Neto	Translational Neuroimaging Laboratory, McGill Centre for Studies in Aging, McGill University, Montreal, Québec, Canada
Serge Gauthier	Alzheimer's disease Research Unit, McGill Centre for Studies in Aging, Department of Neurology & Neurosurgery, McGill University, Montreal, Québec, Canada
Agnès Camuzat	Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France
Alexis Brice	Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France; Reference Network for Rare Neurological Diseases (ERN-RND)
Anne Bertrand	Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France; Inria, Aramis project-team, F-75013, Paris, France; Centre pour l'Acquisition et le Traitement des Images, Institut du Cerveau et la Moelle, Paris, France
Aurélié Funkiewiez	Centre de référence des démences rares ou précoces, IM2A, Département de Neurologie, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France; Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France
Daisy Rinaldi	Centre de référence des démences rares ou précoces, IM2A, Département de Neurologie, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France; Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France; Inria, Aramis project-team, F-75013, Paris, France; Centre de référence des démences rares ou précoces, IM2A, Département de Neurologie, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France
Dario Saracino	Hôpital Pitié-Salpêtrière, Paris, France
Olivier Colliot	Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France; Inria, Aramis project-team, F-75013, Paris, France; Centre pour l'Acquisition et le Traitement des Images, Institut du Cerveau et la Moelle, Paris, France
Sabrina Sayah	Sorbonne Université, Paris Brain Institute – Institut du Cerveau – ICM, Inserm U1127, CNRS UMR 7225, AP-HP - Hôpital Pitié-Salpêtrière, Paris, France
Catharina Prix	Neurologische Klinik, Ludwig-Maximilians-Universität München, Munich, Germany
Elisabeth Wlasich	Neurologische Klinik, Ludwig-Maximilians-Universität München, Munich, Germany
Olivia Wagemann	Neurologische Klinik, Ludwig-Maximilians-Universität München, Munich, Germany
Sandra Loosli	Neurologische Klinik, Ludwig-Maximilians-Universität München, Munich, Germany
Sonja Schönecker	Neurologische Klinik, Ludwig-Maximilians-Universität München, Munich, Germany
Tobias Hoegen	Neurologische Klinik, Ludwig-Maximilians-Universität München, Munich, Germany
Jolina Lombardi	Department of Neurology, University of Ulm, Ulm
Sarah Anderl-Straub	Department of Neurology, University of Ulm, Ulm, Germany
Adeline Rollin	CHU, CNR-MAJ, Labex Distalz, LiCEND Lille, France
Gregory Kuchcinski	Univ Lille, France; Inserm 1172, Lille, France; CHU, CNR-MAJ, Labex Distalz, LiCEND Lille, France
Maxime Bertoux	Inserm 1172, Lille, France; CHU, CNR-MAJ, Labex Distalz, LiCEND Lille, France
Thibaud Lebouvier	Univ Lille, France; Inserm 1172, Lille, France; CHU, CNR-MAJ, Labex Distalz, LiCEND Lille, France
Vincent Deramecourt	Univ Lille, France; Inserm 1172, Lille, France; CHU, CNR-MAJ, Labex Distalz, LiCEND Lille, France
Beatriz Santiago	Neurology Department, Centro Hospitalar e Universitario de Coimbra, Coimbra, Portugal
Diana Duro	Faculty of Medicine, University of Coimbra, Coimbra, Portugal
Maria João Leitão	Centre of Neurosciences and Cell Biology, Universidade de Coimbra, Coimbra, Portugal
Maria Rosario Almeida	Faculty of Medicine, University of Coimbra, Coimbra, Portugal
Miguel Tábua-Pereira	Neurology Department, Centro Hospitalar e Universitario de Coimbra, Coimbra, Portugal
Sónia Afonso	Instituto Ciências Nucleares Aplicadas a Saude, Universidade de Coimbra, Coimbra, Portugal

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.jns.2023.120711>.

## References

- [1] Sharon Ash, Naomi Nevler, Jeffrey Phillips, David J. Irwin, Corey T. McMillan, Katya Rascovsky, Murray Grossman, A longitudinal study of speech production in primary progressive aphasia and behavioral variant frontotemporal dementia, *Brain Lang.* 194 (2019) 46–57.
- [2] M. Bocchetta, M. Malpetti, E.G. Todd, J.B. Rowe, J.D. Rohrer, Looking beneath the surface: the importance of subcortical structures in frontotemporal dementia, *Brain Commun.* 3 (2021) fcab158.
- [3] Martina Bocchetta, Juan Eugenio Iglesias, Marzia A. Scelsi, David M. Cash, M. Jorge Cardoso, Marc Modat, Andre Altmann, Sebastien Ourselin, Jason D. Warren, Jonathan D. Rohrer, Hippocampal subfield volumetry: differential pattern of atrophy in different forms of genetic frontotemporal dementia, *J. Alzheimers Dis.* 64 (2018) 497–504.
- [4] Martina Bocchetta, Emily G. Todd, Georgia Peakman, David M. Cash, Rhian S. Convery, Lucy L. Russell, David L. Thomas, Juan Eugenio Iglesias, John C. van Swieten, Lize C. Jiskoot, Differential early subcortical involvement in genetic FTD within the GENFI cohort, *NeuroImage: Clin.* 30 (2021), 102646.
- [5] A. Bouzigues, L.L. Russell, G. Peakman, M. Bocchetta, C.V. Greaves, R.S. Convery, E. Todd, J.B. Rowe, B. Borroni, D. Galimberti, P. Tiraboschi, M. Masellis, M. C. Tartaglia, E. Finger, J.C. van Swieten, H. Seelaar, L. Jiskoot, S. Sorbi, C.R. Butler, C. Graff, A. Gerhard, T. Langheinrich, R. Laforce, R. Sanchez-Valle, A. de Mendonça, F. Moreno, M. Synofzik, R. Vandenberghe, S. Ducharme, I. Le Ber, J. Levin, A. Daneš, M. Otto, F. Pasquier, I. Santana, J.D. Rohrer, Anomia is present pre-symptomatically in frontotemporal dementia due to MAPT mutations, *J. Neurol.* 269 (2022) 4322–4332.
- [6] M. Jorge Cardoso, Marc Modat, Robin Wolz, Andrew Melbourne, David Cash, Daniel Rueckert, Sebastien Ourselin, Geodesic information flows: spatially-variant graphs and their application to segmentation and fusion, *IEEE Trans. Med. Imaging* 34 (2015) 1976–1988.
- [7] Gayathri Cheran, Wu Liwen, Seonjoo Lee, Masood Manoochehri, Sarah Cines, Emer Fallon, Timothy Lynch, Judith Heidebrink, Henry Paulson, Jill Goldman, Cognitive indicators of preclinical behavioral variant frontotemporal dementia in MAPT carriers, *J. Int. Neuropsychol. Soc.* 25 (2019) 184–194.
- [8] E. Fedorenko, S.L. Thompson-Schill, Reworking the language network, *Trends Cogn. Sci.* 18 (2014) 120–126.
- [9] Sian Fitzpatrick, Sam Gilbert, Lucy Serpell, Systematic review: are overweight and obese individuals impaired on behavioural tasks of executive functioning? *Neuropsychol. Rev.* 23 (2013) 138–156.
- [10] A. Geraudie, P. Battista, A.M. García, I.E. Allen, Z.A. Miller, M.L. Gorno-Tempini, M. Montembeault, Speech and language impairments in behavioral variant frontotemporal dementia: a systematic review, *Neurosci. Biobehav. Rev.* 131 (2021) 1076–1095.
- [11] Ilse Gijssels, Tim Van Langenhove, Julie van der Zee, Kristel Slegers, Stéphanie Philtjens, Gernot Kleinberger, Jonathan Janssens, Karolien Bettens, Caroline Van Cauwenbergh, Sandra Pereson, A C9orf72 promoter repeat expansion in a Flanders-Belgian cohort with disorders of the frontotemporal lobar degeneration-amyotrophic lateral sclerosis spectrum: a gene identification study, *Lancet Neurol.* 11 (2012) 54–65.
- [12] R.E. Graves, S.C. Bezeau, J. Fogarty, R. Blair, Boston naming test short forms: a comparison of previous forms with new item response theory based forms, *J. Clin. Exp. Neuropsychol.* 26 (2004) 891–902.
- [13] Chris J.D. Hardy, Aisling H. Buckley, Laura E. Downey, Manja Lehmann, Vitor C. Zimmerer, Rosemary A. Varley, Sebastian J. Crutch, Jonathan D. Rohrer, Elizabeth K. Warrington, Jason D. Warren, The language profile of behavioral variant frontotemporal dementia, *J. Alzheimers Dis.* 50 (2016) 359–371.
- [14] Julie D. Henry, John R. Crawford, Verbal fluency deficits in Parkinson's disease: a meta-analysis, *J. Int. Neuropsychol. Soc.* 10 (2004) 608–622.
- [15] G. Hickok, The dual stream model of speech and language processing, *Handb. Clin. Neurol.* 185 (2022) 57–69.
- [16] David B. Hogan, Nathalie Jetté, Kirsten M. Fiest, Jodie I. Roberts, Dawn Pearson, Eric E. Smith, Pamela Roach, Andrew Kirk, Tamara Pringsheim, Colleen J. Maxwell, The prevalence and incidence of frontotemporal dementia: a systematic review, *Can. J. Neurol. Sci.* 43 (2016) S96–S109.
- [17] Ging-Yuek R. Hsiung, Mariely DeJesus-Hernandez, Howard H. Feldman, Pheth Sengdy, Phoenix Bouchard-Kerr, Emily Dwosh, Rachel Butler, Bonnie Leung, Alice Fok, Nicola J. Rutherford, Clinical and pathological features of familial frontotemporal dementia caused by C9ORF72 mutation on chromosome 9p, *Brain* 135 (2012) 709–722.
- [18] Muireann Irish, Elucidating a core semantic network in the brain—implications for disorders of semantic cognition, *J. Neurosci.* 36 (2016) 6144–6146.
- [19] Takanori Ishizuka, Masayuki Nakamura, Mio Ichiba, Akira Sano, Familial semantic dementia with P301L mutation in the tau gene, *Dement. Geriatr. Cogn. Disord.* 31 (2011) 334–340.
- [20] Rebecca L. Jackson, Paul Hoffman, Gorana Pobric, Matthew A. Lambon, Ralph., The semantic network at work and rest: differential connectivity of anterior temporal lobe subregions, *J. Neurosci.* 36 (2016) 1490–1501.
- [21] J. Kim, M. Kim, J.H. Yoon, The tip-of-the-tongue phenomenon in older adults with subjective memory complaints, *PLoS One* 15 (2020), e0239327.
- [22] Le Ber, Agnès Camuzat Isabelle, Didier Hannequin, Florence Pasquier, Eric Guedj, Anne Rovelet-Lecrux, Valérie Hahn-Barma, Julie Van Der Zee, Fabienne Clot, Serge Bakchine, Phenotype variability in progranulin mutation carriers: a clinical, neuropsychological, imaging and genetic study, *Brain* 131 (2008) 732–746.
- [23] Wendy J. Mack, David M. Freed, Betsy White Williams, Victor W. Henderson, Boston naming test: shortened versions for use in Alzheimer's disease, *J. Gerontol.* 47 (1992) P154–P158.
- [24] Ian B. Malone, Kelvin K. Leung, Shona Clegg, Josephine Barnes, Jennifer L. Whitwell, John Ashburner, Nick C. Fox, Gerard R. Ridgway, Accurate automatic estimation of total intracranial volume: a nuisance variable with less nuisance, *Neuroimage* 104 (2015) 366–372.
- [25] I.P. Martins, I. Mares, P.A. Stilwell, How subjective are subjective language complaints, *Eur. J. Neurol.* 19 (2012) 666–671.
- [26] Toji Miyagawa, Danielle Brushaber, Jeremy Syrjanen, Walter Kremers, Julie Fields, Leah K. Forsberg, Hilary W. Heuer, David Knopman, John Kornak, Adam Boxer, Use of the CDR® plus NACC FTLD in mild FTLD: data from the ARTFL/LEFFTDS consortium, *Alzheimers Dement.* 16 (2020) 79–90.
- [27] Michie Miyoshi, Hitoshi Shinotoh, Zbigniew K. Wszolek, Audrey J. Strongosky, Hitoshi Shimada, Ryoosuke Arakawa, Makoto Higuchi, Yoko Ikoma, Fumihiko Yasuno, Kiyoshi Fukushi, In vivo detection of neuropathologic changes in presymptomatic MAPT mutation carriers: a PET and MRI study, *Parkinsonism Relat. Disord.* 16 (2010) 404–408.
- [28] Katrina Moore, Rhian Convery, Martina Bocchetta, Mollie Neason, David M. Cash, Caroline Greaves, Lucy L. Russell, Mica T.M. Clarke, Georgia Peakman, John van Swieten, A Modified camel and cactus test detects presymptomatic semantic impairment in genetic frontotemporal dementia within the GENFI cohort, *Appl. Neuropsychol.: Adult.* (2021) 1–8.
- [29] Stuart M. Pickering-Brown, Sara Rollinson, Daniel Du Plessis, Karen E. Morrison, Anoop Varma, Anna M.T. Richardson, David Neary, Julie S. Snowden, David M. A. Mann, Frequency and clinical characteristics of progranulin mutation carriers in the Manchester frontotemporal lobar degeneration cohort: comparison with patients with MAPT and no known mutations, *Brain* 131 (2008) 721–731.
- [30] S.M. Pickering-Brown, A.M.T. Richardson, J.S. Snowden, A.M. McDonagh, A. Burns, W. Braude, M. Baker, W.-K. Liu, S.-H. Yen, J. Hardy, Inherited frontotemporal dementia in nine British families associated with intronic mutations in the tau gene, *Brain* 125 (2002) 732–751.
- [31] Jackie M. Poos, Amy MacDougall, Esther Van Den Berg, Lize C. Jiskoot, Janne M. Papma, Emma L. Van Der Ende, Harro Seelaar, Lucy L. Russell, Georgia Peakman, Rhian Convery, Longitudinal cognitive changes in genetic frontotemporal dementia within the GENFI cohort, *Neurology* 99 (2022) e281–e295.
- [32] Katya Rascovsky, John R. Hodges, David Knopman, Mario F. Mendez, Joel H. Kramer, John Neuhaus, John C. Van Swieten, Harro Seelaar, Elise G.P. Dopper, Chiadi U. Onyike, Sensitivity of revised diagnostic criteria for the behavioural variant of frontotemporal dementia, *Brain* 134 (2011) 2456–2477.
- [33] J.D. Rohrer, R. Guerreiro, J. Vandrovca, J. Uphill, D. Reiman, J. Beck, A. M. Isaacs, A. Authier, R. Ferrari, N.C. Fox, The heritability and genetics of frontotemporal lobar degeneration, *Neurology* 73 (2009) 1451–1456.
- [34] Jonathan D. Rohrer, Sebastian J. Crutch, Elizabeth K. Warrington, Jason D. Warren, Progranulin-associated primary progressive aphasia: a distinct phenotype? *Neuropsychologia* 48 (2010) 288–297.
- [35] Jonathan D. Rohrer, Jennifer M. Nicholas, David M. Cash, John van Swieten, Elise Dopper, Lize Jiskoot, Rick van Minkelen, Serge A. Rombouts, M. Jorge Cardoso, Shona Clegg, Presymptomatic cognitive and neuroanatomical changes in genetic frontotemporal dementia in the genetic frontotemporal dementia initiative (GENFI) study: a cross-sectional analysis, *Lancet Neurol.* 14 (2015) 253–262.
- [36] K. Samra, A.M. MacDougall, A. Bouzigues, M. Bocchetta, D.M. Cash, C.V. Greaves, R.S. Convery, J.C. van Swieten, H. Seelaar, L. Jiskoot, F. Moreno, R. Sanchez-Valle, R. Laforce, C. Graff, M. Masellis, M.C. Tartaglia, J.B. Rowe, B. Borroni, E. Finger, M. Synofzik, D. Galimberti, R. Vandenberghe, A. de Mendonça, C.R. Butler, A. Gerhard, S. Ducharme, I. Le Ber, P. Tiraboschi, I. Santana, F. Pasquier, J. Levin, M. Otto, S. Sorbi, J.D. Rohrer, L.L. Russell, Language impairment in the genetic forms of behavioural variant frontotemporal dementia, *J. Neurol.* 270 (4) (2023) 1976–1988.
- [37] D. Sapolsky, K. Domoto-Reilly, B.C. Dickerson, Use of the progressive aphasia severity scale (PASS) in monitoring speech and language status in PPA, *Aphasiology* 28 (2014) 993–1003.
- [38] D. Saracino, S. Ferrieux, M. Noguès-Lassaille, M. Houot, A. Funkiewiez, L. Sellami, V. Deramecourt, F. Pasquier, P. Couratier, J. Pariente, A. Géraudie, S. Epelbaum, D. Wallon, D. Hannequin, O. Martinaud, F. Clot, A. Camuzat, S. Bottani, D. Rinaldi, S. Auriacombe, M. Sarazin, M. Didic, C. Boutoleau-Bretonnière, C. Thauvin-Robinet, J. Lagarde, C. Roué-Jagot, F. Sellal, A. Gabelle, F. Etcharry-Bouyx, A. Morin, C. Coppola, R. Levy, B. Dubois, A. Brice, O. Colliot, M.L. Gorno-Tempini, M. Teichmann, R. Migliaccio, I. Le Ber, Primary progressive aphasia associated with GRN mutations: new insights into the nonamyloid Logopenic variant, *Neurology* 97 (2021) e88–e102.
- [39] D. Saracino, A. Géraudie, A.M. Remes, S. Ferrieux, M. Noguès-Lassaille, S. Bottani, L. Cipriano, M. Houot, A. Funkiewiez, A. Camuzat, D. Rinaldi, M. Teichmann, J. Pariente, P. Couratier, C. Boutoleau-Bretonnière, S. Auriacombe, F. Etcharry-

- Bouyx, R. Levy, R. Migliaccio, E. Solje, I. Le Ber, Primary progressive aphasia associated with C9orf72 expansions: another side of the story, *Cortex* 145 (2021) 145–159.
- [40] Sharon J. Sha, Leonel T. Takada, Katherine P. Rankin, Jennifer S. Yokoyama, Nicola J. Rutherford, Jamie C. Fong, Baber Khan, Anna Karydas, Matt C. Baker, Mariely DeJesus-Hernandez, Mochtar Pribadi, Giovanni Coppola, Daniel H. Geschwind, Rosa Rademakers, Suzee E. Lee, William Seeley, Bruce L. Miller, Adam L. Boxer, Frontotemporal dementia due to *C9ORF72* mutations, *Clin. Imag. Feat.* 79 (2012) 1002–1011.
- [41] M.A. Skeide, A.D. Friederici, The ontogeny of the cortical language network, *Nat. Rev. Neurosci.* 17 (2016) 323–332.
- [42] J.D. Warren, J.D. Rohrer, M.N. Rossor, 'Clinical review. Frontotemporal dementia, *BMJ* 347 (2013) f4827. Members Copy, Not for Commercial Sale.
- [43] Jennifer L. Whitwell, Stephen D. Weigand, Bradley F. Boeve, Matthew L. Senjem, Jeffrey L. Gunter, Mariely DeJesus-Hernandez, Nicola J. Rutherford, Matthew Baker, David S. Knopman, Zbigniew K. Wszolek, Neuroimaging signatures of frontotemporal dementia genetics: C9ORF72, tau, progranulin and sporadics, *Brain* 135 (2012) 794–806.
- [44] K. Samra, A.M. MacDougall, A. Bouzigues, et al., Genetic forms of primary progressive aphasia within the GENFI cohort – comparison with sporadic primary progressive aphasia, *Brain Commun* 5 (2) (2023) fcad036.