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Frontotemporal Dementia and Psychiatric Diagnosis

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EDITORIAL

The changes of DSM 5 with regard to frontotemporal dementia (FTD) (essentially frontotemporal lobar degeneration/ frontotemporal neurocognitive disorder) are among developments leading psychiatry toward the use of biomarkers (American Psychiatric Association, 2013; Kelleher, 2018). This condition was previously classified as Pick's Disease, an Axis III disorder. FTD has broader criteria. In addition, with the dissolution of the axial system (Fukuda & Hattori, 2014), FTD is in a less nuanced position in psychiatric diagnosis. These developments should gradually promote enhanced assessment of more patients using advanced tools.

The incidence of FTD is 1.6-4.1 per 100,000 people annually (Coyle-Gilchrist et al., 2016; Knopman & Roberts, 2011; Olney, Spina & Miller, 2017). In the United States 20,000-30,000 people are affected (Knopman & Roberts, 2011; Olney, Spina & Miller, 2017). Pathologically, FTD involves synapse loss, gliosis, and neuronal loss, which lead to gross atrophy within the frontal and anterior temporal lobes, basal ganglia, and thalamus (Brun, Liu & Erikson, 1995; Ljubenkov & Miller, 2016). About 40% of patients with patients with FTD have a family history of dementia in a first-degree relative. In about 15% of cases, family history is suggestive of an autosomal-dominant mutation (Rosso et al, 2003; Goldman, JS., Farmer et al.,2005; Le bert, Stekke, Hasenbroekx & Pasquier, 2004).

The spectrum of FTD syndromes includes nonfluent/agrammatic variant primary progressive aphasia, semantic variant primary progressive aphasia, and behavioral variant frontotemporal dementia (bvFTD) (Ljubenkov & Miller, 2016). bvFTD is the most common of these, accounting for 60% of FTD, and is characterized clinically by progressive disturbances in personality, emotion, and behavior (Olney, Spina & Miller, 2017; Onyike & Diehl-Schmid, 2013). More than the aphasic FTD conditions, bvFTD has the greatest potential to change clinical perspectives on patients otherwise diagnosed with mood, psychotic, and anxiety disorders. Previous research shows six percent (46/751) of selected FTD cases published between 1950 and 2007 presented with schizophrenia, schizoaffective disorder, bipolar disorder (BPD), psychotic depression, or unspecified psychotic states (Lanata & Miller, 2016; Velakoulis, Walterfang, Mocellin, Pantelis & McLean, 2009). Obsessive–compulsive behaviors are also seen early in bvFTD (Lanata & Miller, 2016; Tonkonogy, Smith & Barreira, 1994).

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DSM 5 distinguishes possible and probable bvFTD. Criteria for possible bvFTD are: (1) a prominent decline in social cognition and/or executive function with relative sparing of memory and perceptual-motor function; and (2) at least 3 of the following -- behavioral disinhibition, apathy/inertia, loss of sympathy/empathy, perseverative, stereotyped or compulsive/ritualistic behavior, hyperorality and dietary changes. Criteria for probable bvFTD are: those of possible bvFTD plus either an FTD pathogenic mutation or disproportionate involvement of frontal or temporal lobe on neuroimaging (American Psychiatric Association, 2013).

Treatment options for FTD are limited. Nonpharmacologic approaches include caregiver education and environmental intervention, evaluation of swallowing (since many patients with bvFTD eventually die of aspiration pneumonia), exercise and diet (Brun, Liu & Erikson, 1995). Pharmacologically, the best evidence of efficacy is shown by selective serotonin reuptake inhibitors and trazodone (Le bert, F., Stekke, W., Hasenbroekx, C., & Pasquier, 2004; Swartz, Miller, Lesser & Darby, 1997).

These changes in nosology are still being assimilated into clinical practice. Over time, the nominal prevalence of this condition may increase. This could be attributable in some cases to revised diagnoses. Treatment advances may also follow. All of these developments will be related to neuroimaging or other objective pathologic assessment. For a variety of reasons therefore, the diagnostic changes leading to current concepts of frontotemporal dementia represent incremental changes in psychiatric precision.

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