



POSTER PRESENTATION

Neuropsychiatric symptoms in frontotemporal dementia

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Abstract

Introduction: Frontotemporal dementia (FTD) comprises a heterogeneous group of clinical and pathological syndromes, with presenile onset and variable combinations of behavioural, executive, language or motor symptoms. FTD includes three main subtypes: behavioural variant, progressive non-fluent aphasia and semantic dementia.

Objectives: We aim to review and summarize the neuropsychiatric symptoms in behavioural variant.

Methods: Literature review up to 13th March 2015, using MeSH term frontotemporal dementia.

Results: Behavioural variant is the most common phenotype accounting for 50% of cases. Common symptoms can be either positive (disinhibition, hyperorality, stereotypies, compulsive and ritualistic behaviours) and negative (apathy, loss of empathy, social withdrawal and low self-care). These translate in to major personality changes from which we highlight social behaviour – patients lack tact and manners, use unacceptable physical contact, improper verbal or physical acts and are socially awkward. Compulsive and ritualistic behaviours may mimic obsessive-compulsive disorder. Disinhibition and mood elation can mimic a manic state. Depression, as in other dementias, is common. However, its diagnosis is complicated by the negative symptoms overlap.

Suicide attempts are not rare and are more likely in FTD patients as compared with controls. Prefrontal cortex malfunction and related impulsiveness may explain the increased risk of suicide. Curiously, risk is higher in patients with previous history of depression. Regarding the increased impulsiveness, there are at least five reported cases presenting as pathological gambling. One-third of the patients also exhibit excessive somatic complaints as headache and gastrointestinal, urogenital or musculoskeletal pain. The association between depression and somatic complaints is not well established in FTD. Sleep disturbances have also been reported with increased nocturnal activity and decreased morning activity, suggesting phase delay. Psychotic symptoms may occur in one third of FTD patients some time during the course of dementia: paranoid delusions and visual hallucinations are the most common, but auditory hallucinations may also occur. There seems to be a strong correlation between psychotic symptoms and predominantly right-sided degeneration.

Discussion and Conclusions: Neuropsychiatric symptoms in FTD may lead to misdiagnosis, most commonly with other neurodegenerative dementias, psychotic disorders or depression. We believe that if physicians are aware of their existence, diagnosis delay can be avoided.

Supplementary material: Complete presentation available at <http://ijcnmh.arc-publishing.org>

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