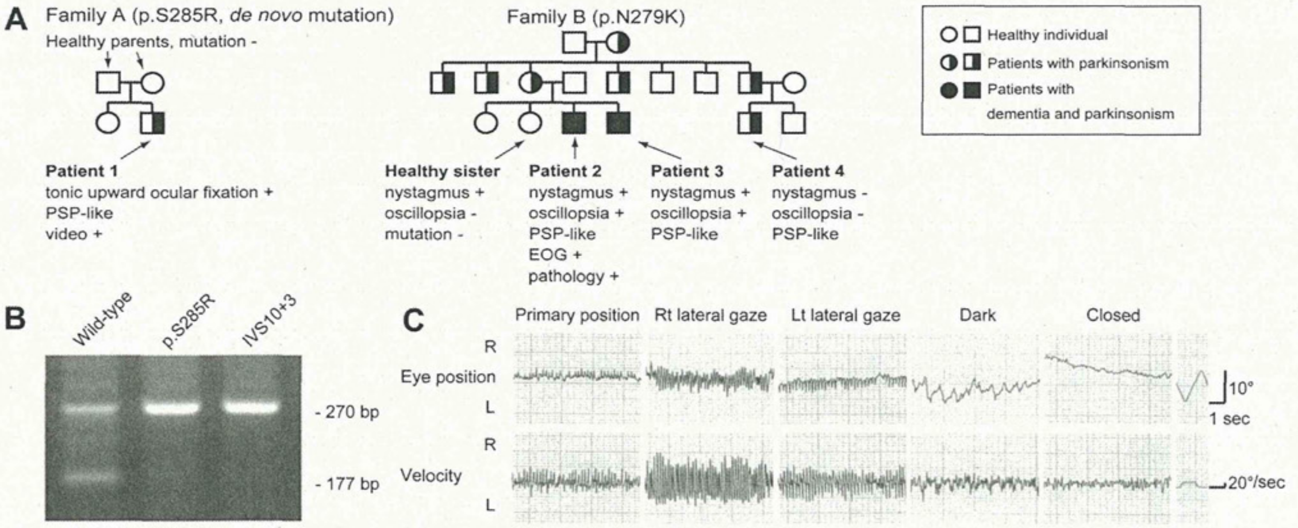

Fig. 1. (A) The pedigrees of families A and B. (B) Exon-trapping analysis for the effects of the *MAPT* p.S285R mutation on exon 10 splicing. (C) Horizontal electro-oculogram recordings in Patient 2.

3.1.2. *Clinical presentations of MAPT-positive patients with the abnormal eye movements that are generally not observed in patients with sporadic PSP*

3.1.2.1. Patient 1 (MAPT p.S285R). This patient was a 46-year-old man who presented with difficulty speaking and breathing. The patient had no family history of dementia or movement disorders (Fig. 1A). A physical examination revealed gait disturbance, limb bradykinesia, and frequent falling. At age 47, the patient exhibited palilalia and a mild obsession with eating. The patient's Mini-Mental State Examination (MMSE) score was 28/30, but his Frontal Assessment Battery score was 12/18. The patient exhibited a slowing of saccadic eye movements with a relative preservation of smooth pursuit, vertical supranuclear gaze palsy, and tonic upward ocular fixation (see Video Supplement); when the patient's eyes opened after closing, they remained fixated upward and could not be moved voluntarily to the primary position (i.e., Bell's phenomenon remained). To overcome this disability, the patient extended his neck, which resulted in a reflex downward movement of the eyes (the vestibulo-ocular reflex), and next he slightly flexed his neck to a neutral position with his eyes in the primary position. Later, the patient developed bradykinesia and postural instability with frequent falling. L-dopa/benserazide (up to 900 mg/day) was ineffective. The patient's condition gradually deteriorated, and he developed dementia, retrocollis, vertical and horizontal supranuclear palsy, and bradykinesia. At age 49, the patient died of suffocation from the aspiration of food material. No autopsy was performed. The clinical diagnosis was probable PSP.

3.1.2.2. Patient 2 (MAPT p.N279K). This patient was the older brother of Patient 3 (Fig. 1A). Patient 2 was a 42-year-old man who exhibited oscillopsia, micrographia, and a shuffling gait. This patient reported having had nystagmus without oscillopsia since childhood. A neurological examination revealed marked horizontal nystagmus. The patient's pupils were isocoric, and his visual acuity was normal. The patient presented with rigidity, bradykinesia, and postural tremor in the upper limbs. Electro-oculography revealed horizontal pendular nystagmus in the primary position and in all gaze directions (Fig. 1C). L-dopa/benserazide at 200 mg/day mildly alleviated his parkinsonism. Two years later, the patient developed prominent postural instability and became prone to falling. Upward and downward gaze palsy and apraxia of eyelid opening were also noted. At that time, the clinical diagnosis was possible PSP with a family history of dementia and parkinsonism. The patient's cognitive function deteriorated gradually. At age 52, he was bedridden and required a gastrostomy. The patient died of pneumonia at age 54. A postmortem pathological examination of the brain revealed mild atrophy of the frontal lobe and the tegmentum of the midbrain and pons. Microscopic analysis showed severe degenerative changes in the substantia nigra and the subcortical nuclei. Immunohistochemistry using anti-phosphorylated tau (p-tau) antibodies revealed numerous tau-positive neuronal and glial inclusions in the frontotemporal cortex, white matter, and the subcortical nuclei (see Supplementary Fig. 4). These p-tau deposits reacted with anti-4-repeat tau antibodies but not with anti-3-repeat tau antibodies.

3.1.2.3. Patient 3 (MAPT p.N279K). This patient was the younger brother of Patient 2 (Fig. 1A). At age 44, Patient 3 noticed clumsiness in his right hand and oscillopsia. The patient reported having nystagmus since childhood. A neurological examination revealed large, horizontal pendular nystagmus in the primary position and in all gaze directions. The patient's visual acuity, pupils, and light reflexes were all normal. Mild bradykinesia and rigidity in the neck and the right upper limb were noted. Postural tremor in both hands and the tongue and postural instability were observed. Treatment with 600 mg/day of L-dopa/carbidopa was not effective. The patient's oscillopsia gradually worsened, and eventually he was unable to read printed materials. At age 47, the patient developed upward and downward gaze palsy, slowing of saccades, and apraxia of eyelid opening. The patient had prominent postural instability and was prone to falling. The patient's first clinical diagnosis was possible PSP with a family history of dementia and parkinsonism. The patient died at age 56. An autopsy was not performed.

3.1.2.4. Patients 5, 6, and 7 (MAPT p.N279K). The clinical presentations of these three patients have been described previously [19]. All three patients had clinical diagnoses of possible PSP (Table 2) and visual grasping [19,20].

3.2. *Results of PGRN analysis*

3.2.1. *Genetic Analyses of PGRN*

We identified one patient with a *PGRN* mutation (Table 2, Supplementary Fig. 3). One novel heterozygous deletion/insertion

Table 2
Clinical features of patients with *MAPT* and *PGRN* mutations.

Family	A	B			C	D		E	F	G
Patient	1	2	3	4	5	6	7	8	9	10
Gene	*MAPT*									*PGRN*
Genotyping	Heterozygous									
Nucleotide change	c.853A > C	c.837T > G	c.837T > G	c.837T > G	c.837T > G	c.837T > G	c.837T > G	c.796C > G	c.888T > C	c.1012_1013delGGinsC
Amino acid change	p.S285R	p.N279K	p.N279K	p.N279K	p.N279K	p.N279K	p.N279K	p.L266V	p.N296N	p.G338RfsX23
Exon	10	10	10	10	10	10	10	9	10	9
Mode of inheritance	*de novo*	AD	AD	AD	NA	AD	AD	AD	AD	AD
Age at onset, years	46	42	44	46	41	42	43	37	44	59
Age at evaluation, years	47	47	45	50	44	44	45	38	49	61
Age at death, years	49	54	56	alive	51	54	51	alive	alive	alive
Sex	M	M	M	M	F	F	F	F	M	F
Clinical syndromes	PSP	PSP	PSP	PSP	PSP	PSP	PSP	bvFTD	PSP	PPA
Clinical features										
Initial symptoms	P	P	P	P	P	P	P	dementia	P	aphasia
Personality/behavior changes	−	+	−	−	−	−	−	+	+	−
Mini mental state examination score	28/30	NA	NA	28/30	NA	NA	NA	0	24/30	29/30
Hasegawa dementia scale-revised[a]	NA	18/30	NA	NA	21/30	28/30	30/30	0	21/30	29/30
Nonfluent spontaneous speech	−	−	−	−	−	−	−	−	−	+
Apraxia of eyelid opening	−	+	+	+	+	+	+	−	−	−
Abnormal eye movements										
Supranuclear gaze palsy	+	+	+	+	+	+	+	−	+	−
Tonic upward ocular fixation	+	−	−	−	−	−	−	−	−	−
Oscillopsia with CN	−	+	+	−	−	−	−	−	−	−
Visual grasping	−	−	−	−	+	+	+	−	−	−
Parkinsonism										
Bradykinesia	+	+	+	+	+	+	+	−	+	−
Rigidity	−	+	+	+	+	+	+	−	+	−
Tremor	−	+	+	−	−	−	−	−	−	−
Postural instability	+	+	+	+	+	+	+	−	+	−
Response to ʟ-dopa	−	partial[b]	−	partial[b]	partial[b]	partial[b]	partial[b]	NA	+	NA
Pyramidal sign	+	−	NA	−	+	−	+	+	+	−
Features of motor neuron disease	−	−	−	−	−	−	−	−	−	−
Reference					[19]	[19]	[19]			

AD = autosomal dominant.
P = parkinsonism; NA = not available.
CN = congenital nystagmus; PSP = progressive supranuclear palsy.
bvFTD = behavioral variant frontotemporal dementia; PPA = primary progressive aphasia.

[a] The Hasegawa dementia scale-revised is a brief dementia screening scale. The maximum score of the Hasegawa dementia scale-revised is 30 points. There was a significant difference in the mean score between the demented and non-demented subjects when the cut-off point was set at 20/21 [31].

[b] A partial response to ʟ-dopa indicates that ʟ-dopa was effective only in the early stages.

mutation in *PGRN*, p.G338RfsX23 (c.1012_1013delGGinsC), was detected by direct sequencing and TOPO TA cloning sequencing (Supplementary Fig. 1). None of the 182 normal Japanese controls included in this study had the *PGRN* p.G338RfsX23 (c.1012_1013delGGinsC) mutations. The age at disease onset of the patient with the heterozygous *PGRN* deletion/insertion was 59 years. Novel *PGRN* variants with unknown significance, p.R18Q and p.N118del, are listed in Table 3. MLPA analysis showed no gene dosage abnormalities in *PGRN*.

3.2.2. A clinical presentation of a novel PGRN mutation

3.2.2.1. Patient 10 (PGRN p.G338RfsX23, c.1012_1013delGGinsC). This patient, a 59-year-old woman, developed word-finding difficulties and underwent surgical clipping at age 54 for an unruptured

Table 3
Novel variants with unknown significance.

Gene	Nucleotidechange	Amino acid change	Exon	Amino acid conservation	Mean AAO (years)	Frequency		*P* value	Clinical diagnosis
						Patients *N* (%)	Controls *N* (%)		
PGRN	c.56G > A	p.R19Q	1	not conserved	66	1/69 (1.4)	0/186 (0)	0.605	PSP (*n* = 1)
PGRN	c.352_354delAAC	p.N118del	4	not conserved	53	3/69 (4.3)	3/272 (1.1)	0.187	bvFTD (*n* = 3)

AAO = age at onset.
PSP = progressive supranuclear palsy.
bvFTD = behavioral variant frontotemporal dementia.

aneurysm of the left middle cerebral artery. The patient's mother suffered from dementia, but the details of her disease were unknown. The patient substituted words for names of people and objects. Two years after the onset of symptoms, the patient became severely disfluent. However, she did not show any violent behavior, personality changes, or other behavioral abnormalities. The patient scored 29/30 on the MMSE. On the frontal assessment battery, she scored 13/18. The patient's time to complete the Trail Making Test (TMT) A was 70 s, and she could not finish the TMT B within five minutes. Her spontaneous speech production was characterized by slow and hesitant speech, frequently interrupted by long word-finding pauses. Her motor speech abilities were within the normal limits, and no apraxia of speech was noted. No parkinsonism was observed. The patient's clinical diagnosis was PPA with a family history of dementia.

3.3. Results of C9orf72 analysis

We identified no patients with expanded hexanucleotide repeats in *C9orf72* in this study. In 75 patients, the average repeat number based on fluorescent fragment-length analysis was 3.77 ± 2.56 (range 2–11 repeats). We have previously reported that an analysis of 197 Japanese healthy controls did not find any *C9orf72* mutation. The average repeat number was 3.69 ± 2.46 (range 2–14 repeats) in the 197 controls [21].

4. Discussion

We identified five *MAPT* mutations, including a novel *de novo* mutation and a novel *PGRN* mutation, and we found no *C9orf72* mutations in our 75 patients. More mutations were found in *MAPT* than in the other two genes evaluated in this study. The infrequent observation of *PGRN* and *C9orf72* mutations might be partly due to the small number of FTLD patients included ($n = 38$) because the majority of *PGRN* and *C9orf72* mutations have been described in patients with FTLD. In contrast to most other mutation screening studies, we performed MLPA analysis to ensure that exonic or larger deletions or multiplications of *MAPT* and *PGRN* would be identified. Therefore, our data also show that multiplications of *MAPT* and exonic or genomic deletions in *PGRN* are rare in Asian populations. Although mutations were detected in FTLD and PSP patients, we did not find any mutations in our CBS patients. A further larger study and investigation of the other genes are needed to clarify the genetic background of Japanese patients with CBS.

The *MAPT* p.S285R mutation, which we found in this study, is a novel *de novo* mutation. To the best of our knowledge, this report is the first description of an adult sporadic case of a *de novo MAPT* mutation associated with dementia and parkinsonism. All six patients (Patients 1, 2, 3, 5, 6, and 7) with PSP and the distinct eye movements described in the present study (such as tonic upward ocular fixation, oscillopsia with congenital nystagmus, and visual grasping) harbored *MAPT* mutations. Below, we discuss these abnormal eye movements, which are generally not observed in patients with sporadic PSP.

In Patient 1 (*MAPT* p.S285R), we observed tonic upward ocular fixation, which is a loss of downward saccades resembling an acquired ocular motor apraxia [22]. This condition is characterized by a loss of voluntary control of saccades and pursuit, whereas reflex movements—in particular, the vestibulo-ocular reflex—were preserved. Acquired ocular motor apraxia is usually the result of bilateral frontal or frontoparietal infarcts. Therefore, tonic upward ocular fixation due to a *MAPT* mutation might share "supranuclear" cerebral lesions in common with ocular motor apraxia. Brainstem functions, including the vestibulo-ocular reflex and Bell's phenomenon, were preserved in Patient 1.

In Patients 2 and 3 (*MAPT* p.N279K), pendular nystagmus was present since childhood and was suppressed with eyelid closure. These features are consistent with congenital nystagmus [23]. Most patients with congenital nystagmus do not complain of oscillopsia, despite having nearly continuous eye movement [23]. Notably, Patients 2 and 3 noticed oscillopsia when they developed parkinsonism. In these siblings, cerebral lesions caused solely by a *MAPT* mutation were unlikely to be the cause of their nystagmus; however, the co-existence of congenital nystagmus and the *MAPT* mutation might have caused the oscillopsia. This notion is supported in part because the patients had a sister who remained healthy – even in her late 60s – and did not complain of oscillopsia, despite having obvious pendular nystagmus (Fig. 1A). Thus, *MAPT* mutations might impair the visual-motion processing pathways that would normally suppress oscillopsia in patients with common congenital nystagmus. Visual grasping, which was first described by Ghika et al. [20], was observed in Patients 5, 6, and 7 (*MAPT* p.N279K) [19].

Although PSP is a rare manifestation of *MAPT* mutation [24], and the routine screening of sporadic PSP for mutations in *MAPT* is not recommended because of low yield [25], it is recommended that screening be considered for families in which there is an autosomal dominant history of a PSP syndrome, particularly when there are accompanying features suggestive of bvFTD [24]. The clinical difference from sporadic PSP might sometimes be difficult to detect, especially in patients without a family history [26–28]; however, an important case report indicated that an age at disease onset under 50 years combined with the absence of early falling may indicate a possible *MAPT* mutation in clinically diagnosed PSP, even in the absence of a positive family history [26]. Consistent with this observation, our eight *MAPT*-positive patients with PSP phenotype were younger than 50 years at disease onset (Table 2). We further suggest that it may be useful to test for *MAPT* mutations in early-onset PSP patients with the abnormal eye movements that are not typical of sporadic PSP. In fact, we identified the novel *de novo* mutation p.S285R in Patient 1 and p.N279K in Patient 5, who had no family history, after focusing on these clinical phenotypes.

To the best of our knowledge, the *PGRN* mutation has not been previously described in Asian populations [29]. We detected a novel *PGRN* mutation, p.G338RfsX23 (c.1012_1013delGGinsC), and thus showed that *PGRN* mutations may exist in Asian populations. This mutation introduces a premature termination codon at the same site as the p.G333VfsX28 (c.998delG) mutation, which was reported previously, and produced a PPA phenotype in all of the affected individuals [30]. The PPA phenotype of p.G338RfsX23 (c.1012_1013delGGinsC) in our study is remarkably similar to that of p.G333VfsX28 (c.998delG), especially in the manifestation of word-finding and object-naming difficulties and the lack of memory or personality changes during the first few years after symptom onset. We believe that the mutant RNA in both cases is most likely subjected to nonsense-mediated decay, similar to other *PGRN* mutations [2].

In summary, based on these findings, we recommend genetic testing for *MAPT* mutations not only in familial patients but also in sporadic patients, especially early-onset PSP patients with the abnormal eye movements that are generally not observed in sporadic PSP. Although *PGRN* and *C9orf72* mutations were rare in this study, we determined that the *PGRN* mutation does exist in Asian patients with FTLD (PPA). Based on the clinical information, screening for *MAPT*, *PGRN*, and *C9orf72* mutations should be further undertaken to improve the diagnosis of specific clinical entities of neurodegenerative disorders.

Conflicts of interest

None.

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Appendix A. Supplementary data

Supplementary data related to this article can be found online at http://dx.doi.org/10.1016/j.parkreldis.2012.06.019.

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Molecular analysis and biochemical classification of TDP-43 proteinopathy

Hiroshi Tsuji,[1,2] Tetsuaki Arai,[3,4] Fuyuki Kametani,[1] Takashi Nonaka,[1] Makiko Yamashita,[1] Masami Suzukake,[1] Masato Hosokawa,[3] Mari Yoshida,[5] Hiroyuki Hatsuta,[6] Masaki Takao,[6] Yuko Saito,[7] Shigeo Murayama,[6] Haruhiko Akiyama,[3] Masato Hasegawa,[1] David M. A. Mann[8] and Akira Tamaoka[2]

1 Department of Neuropathology and Cell Biology, Tokyo Metropolitan Institute of Medical Science, Tokyo 156-8585, Japan
2 Department of Neurology, Graduate School of Comprehensive Human Sciences, University of Tsukuba, Tsukuba-shi 305-8576, Japan
3 Department of Dementia and Higher Brain Function, Tokyo Metropolitan Institute of Medical Science, Tokyo 156-8585, Japan
4 Department of Psychiatry, Graduate School of Comprehensive Human Sciences, University of Tsukuba, Tsukuba-shi 305-8576, Japan
5 Department of Neuropathology, Institute for Medical Science of Aging, Aichi Medical University, Aichi 480-1195, Japan
6 Department of Neuropathology, Tokyo Metropolitan Institute of Gerontology, Tokyo 173-0015, Japan
7 Department of Pathology and Laboratory Medicine, National Center Hospital of Neurology and Psychiatry, Tokyo 187-8551, Japan
8 Mental Health and Neurodegeneration Research Group, Greater Manchester Neuroscience Centre, University of Manchester, Manchester M13 9PT, UK

Correspondence to: Masato Hasegawa,
Department of Neuropathology and Cell Biology,
Tokyo Metropolitan Institute of Medical Science,
2-1-6 Kamikitazawa,
Setagaya-ku,
Tokyo 156-8506,
Japan
E-mail: hasegawa-ms@igakuken.or.jp

Amyotrophic lateral sclerosis and frontotemporal lobar degeneration with TAR DNA-binding protein of 43 kDa pathology are progressive neurodegenerative diseases that are characterized by intracytoplasmic aggregates of hyperphosphorylated TAR DNA-binding protein of 43 kDa. These TAR DNA-binding protein 43 proteinopathies can be classified into subtypes, which are closely correlated with clinicopathological phenotypes, although the differences in the molecular species of TAR DNA-binding protein 43 in these diseases and the biological significance thereof, remain to be clarified. Here, we have shown that although the banding patterns of abnormally phosphorylated C-terminal fragments of TAR DNA-binding protein 43 differ between the neuropathological subtypes, these are indistinguishable between multiple brain regions and spinal cord in individual patients. Immunoblot analysis of protease-resistant TAR DNA-binding protein 43 demonstrated that the fragment patterns represent different conformations of TAR DNA-binding protein 43 molecular species in the diseases. These results suggest a new clinicopathological classification of TAR DNA-binding protein 43 proteinopathies based on their molecular properties.

Keywords: amyotrophic lateral sclerosis; frontotemporal lobar degeneration; TDP-43; classification

Abbreviations: ALS = amyotrophic lateral sclerosis; FTLD = frontotemporal lobar degeneration; FTLD-TDP = frontotemporal lobar degeneration with TAR DNA-binding protein of 43 kDa pathology; TDP-43 = TAR DNA-binding protein of 43 kDa

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Introduction

Amyotrophic lateral sclerosis (ALS) and frontotemporal lobar degeneration with TDP-43 pathology (FTLD-TDP) are sporadic and familial neurodegenerative diseases characterized neuropathologically by intracytoplasmic aggregates of TAR DNA-binding protein of 43 kDa (TDP-43) (Arai *et al.*, 2006; Neumann *et al.*, 2006). In ALS, upper and lower motor neurons progressively degenerate. Neuropathologically, the TDP-43-positive structures appear as rounded or skein-like inclusions in the lower motor neurons. Similar TDP-43-positive inclusions are also observed in the prefrontal gyrus that contains the upper motor neurons. Moreover, TDP-43-positive glial cytoplasmic inclusions are found close to the upper and lower motor neurons in ALS (Tan *et al.*, 2007). In FTLD-TDP, TDP-43 pathology is distinguished into four histological subtypes (types A–D) based on the predominant type of TDP-43-positive structures present (Mackenzie *et al.*, 2011). Type A is characterized by numerous short dystrophic neurites and crescentic or oval neuronal cytoplasmic inclusions; type B has moderate numbers of neuronal cytoplasmic inclusions, throughout all cortical layers, but few dystrophic neurites; type C has a predominance of elongated dystrophic neurites in upper cortical layers, with few neuronal cytoplasmic inclusions; and type D refers to the pathology associated with inclusion body myopathy with early onset Paget disease and frontotemporal dementia caused by *VCP* mutations, characterized by numerous short dystrophic neurites and frequent lentiform neuronal intranuclear inclusions. There is a relationship between subtypes of TDP-43 pathology and clinical phenotype, and many cases of ALS and frontotemporal lobar degeneration (FTLD) are readily distinguished by each clinical symptom. However, some cases have symptoms of both ALS and FTLD. ALS with dementia refers to cases initially presenting with motor neuron disease becoming demented, whereas FTLD-motor neuron disease refers to cases presenting with cognitive impairment and subsequently developing motor neuron disease.

TDP-43 pathology is also present in a subset of familial ALS and FTLD due to mutations in *TARDBP* (Kabashi *et al.*, 2008; Sreedharan *et al.*, 2008), progranulin (*GRN*; Baker *et al.*, 2006) and *C9ORF72* (DeJesus-Hernandez *et al.*, 2011; Renton *et al.*, 2011) genes. Although most patients with mutations in *TARDBP* present with ALS, some present with FTLD (Gitcho *et al.*, 2009; Kovacs *et al.*, 2009). Cases with FTLD-TDP with *GRN* mutation often show type A pathology (Mackenzie *et al.*, 2006b; Cairns *et al.*, 2007b; Josephs *et al.*, 2007). The pathology of ALS and FTLD due to mutations in *C9ORF72* is heterogeneous: TDP-43 pathology overlaps between ALS and FTLD-TDP types A and B (Murray *et al.*, 2011). One large multicentre study of sporadic and familial FTLD-TDP showed broad overlap between the TDP-43 subtyping, especially between types A and B (Armstrong *et al.*, 2010). These overlaps might occur because current pathological classification may be inadequate, as it is based solely on the morphological assessment of certain subjective cortical regions. A more objective and unbiased classification is needed.

In this study, we have investigated a wide range of patients with various TDP-43 proteinopathies to investigate whether patterns of protease-resistant TDP-43 might indicate different TDP-43 strain types, and characterize the TDP-43 C-terminal banding patterns in multiple regions of the CNS, basing our approach on the method used for demonstration of prion strain variation and the aetiology of new variant Creutzfeldt–Jakob disease (Collinge *et al.*, 1996). We show at least three C-terminal banding patterns that distinguish diseases with TDP-43 proteinopathy and report that the banding pattern in individual patients is indistinguishable in different brain regions and spinal cord. Corresponding patterns of protease-resistant phosphorylated TDP-43 are also seen between the pathological phenotypes. As with the prion diseases, the present results suggest that the different conformation of abnormal TDP-43 deposits in the CNS in patients corresponding with various subtypes of TDP-43 proteinopathy, and that the conformation state of the abnormal TDP-43 protein may determine the pathological phenotype.

Materials and methods

Patients

Human brain tissues were obtained from the Brain Donation Programme at the University of Tsukuba (Japan), Tokyo Metropolitan Institute of Gerontology (Japan), National Shimofusa Mental Hospital (Japan) and the University of Manchester (UK). This study was approved by the local Research Ethics Committee. The subjects in this study included eight patients with ALS, five patients with FTLD-TDP type A, eight patients with FTLD-TDP type B, six patients with FTLD-TDP type C and two patients with Alzheimer's disease without TDP-43 pathology. All cases with ALS met the revised El Escorial criteria for ALS (Brooks, 1994) without dementia. All cases with FTLD-TDP fulfilled clinical diagnostic criteria of FTLD (Neary *et al.*, 1998), and classifications of TDP-43 subtype were made in accordance with published guidelines (Cairns *et al.*, 2007*a*; Mackenzie *et al.*, 2011). Four patients with FTLD-TDP type A were cases of familial FTLD-U with *GRN* mutations. One familial ALS case, one with type A, and two with type B had the GGGCC repeat expansion in *C9ORF72*. The age, gender, brain regions examined and clinical diagnosis are given in Table 1.

A fresh frozen tissue sample was taken and cut into two pieces. One piece was fixed in 4% paraformaldehyde in 0.1 M phosphate buffer (pH 7.4) for 2 days and was used for immunohistochemical analysis. The other piece was homogenized and used for immunoblot analysis. In principle, we took the precentral gyrus and lumbar part of the spinal cord in the ALS cases, and the frontal lobe in the FTLD-TDP cases, because TDP-43 pathology is always known to be prevalent in these regions (Tan *et al.*, 2007; Geser *et al.*, 2008, 2009). However, the spinal cord was not available in four cases with ALS, and both motor regions in two cases were not available. In these cases, the frontal lobe was examined instead. For ALS Cases 1, 3, 5 and ALS and FTLD-TDP type C Case 22, the whole of the cerebral hemisphere and brainstem were available as fresh frozen tissues. In these four cases, we took the multiple regions, as described in Table 1. Every tissue sample was examined immunohistochemically for TDP-43-positive lesions. All samples, except some from the cerebellar cortex, showed an accumulation of abnormal TDP-43-positive structures.

Immunoblotting

Sarkosyl-insoluble, urea-soluble fractions were extracted from each region as previously described (Arai *et al.*, 2006; Hasegawa *et al.*, 2008).

Table 1 Description of the patients

Case number	Age at death (year)	Age at onset (year)	Sex	Family history	Brain weight (g)	Clinical diagnosis	Region
ALS							
1	62	61	M	N	1150	ALS	Prec, L and other regions[a]
2	72	71	F	N	1390	ALS	Prec and L
3	42	40	F	N	1140	ALS	Prec, L and other regions[a]
4	76	75	F	N	NA	ALS	Prec and L
5	62	54	M	N	1230	ALS	Prec and other regions[a]
6	77	76	F	N	NA	ALS	Prec
7	67	65	M	N	1414	ALS	Fr
8	55	53	M	Y(m*C9ORF72*)	1250	ALS	Fr
FTLD-TDP type A							
9	58	49	M	Y(m*C9ORF72*)	1050	FTD	Fr
10	67	54	F	Y(m*GRN*)	NA	FTD	Fr
11	71	63	F	Y(m*GRN*)	863	PNFA	Fr
12	66	56	F	Y(m*GRN*)	1100	FTD	Fr
13	68	60	M	Y(m*GRN*)	1210	FTD + MND	Fr
FTLD-TDP type B							
14	45	43	M	N	1260	FTD + MND	Fr
15	59	57	M	Y(m*C9ORF72*)	1210	FTD + MND	Fr
16	67	65	M	N	1280	FTD + MND	Fr
17	76	74	M	N	1215	FTD + MND	Fr
18	69	58	M	N	1166	FTD + MND	Fr
19	52	50	F	Y(m*C9ORF72*)	1050	FTD + MND	Fr
20	65	61	M	N	1530	FTD + MND	Fr
21	68	64	M	N	1213	FTD + MND	Fr
FTLD-TDP type C							
22	82	NA	M	N	1200	SD	Fr, Te and other regions[b]
23	67	65	M	N	NA	SD	Fr
24	59	53	M	N	NA	SD	Fr
25	63	58	M	N	NA	SD	Fr
26	66	55	F	N	1035	SD	Fr
27	75	60	M	N	1174	SD	Fr
AD							
28	65	56	F	N	1165	AD	Fr
29	70	NA	F	N	1126	AD	Fr

AD = Alzheimer's disease; Fr = frontal cortex; FTD = frontotemporal dementia; L = lumbar part of spinal cord; m*C9ORF72* = mutation of chromosome 9 open-reading frame 72 gene; m*GRN* = mutation of progranulin gene; MND = motor neuron disease; NA = not available; PNFA = progressive non-fluent aphasia; Prec = precentral gyrus; SD = semantic dementia; Y = yes; N = no.

a Other regions contained striatum, thalamus, hippocampus dentate gyrus, substantia nigra, pons, medulla and cerebellum cortex. In these cases, the grey and white matter of precentral gyrus were separated from each other macroscopically and examined.

b Other regions contain striatum, thalamus, hippocampus dentate gyrus, substantia nigra, pons, medulla and cerebellum cortex. FTLD-TDP type B without MND and type D are not analysed in this study.

The samples were loaded on 15% SDS–PAGE gels. Proteins in the gel were then transferred onto a polyvinylidene difluoride membrane (Millipore). After blocking with 3% gelatine in 0.01 M PBS (pH 7.4), membranes were incubated overnight with phosphorylation dependent anti-TDP-43 rabbit polyclonal antibody (pS409/410, 1:1000; Hasegawa *et al.*, 2008), phosphorylation independent TDP-43 polyclonal antibody 10782-1-AP (TDP-43 pAb, 1:3000) and TDP-43 monoclonal antibody, 60019-2-Ig (TDP-43 mAb, 1:3000) (ProteinTech Group). After incubation with the appropriate biotinylated secondary antibody, immunolabelling was detected using the VECTASTAIN® ABC system (Vector Laboratories) coupled with a 3,3′-diaminobenzidine reaction intensified with nickel chloride. The blot membranes were digitally analysed, and densitometric analyses were performed with ImageJ version 1.44p (NIH, http://rsbweb.nih.gov/ij/index.html). The densitometry data were averaged for all cases in each group to illustrate the different patterns.

Immunohistochemistry

After cryoprotection in 15% sucrose in 0.01 M PBS (pH 7.4), paraformaldehyde-fixed tissue blocks were cut on a freezing microtome at 30-μm thickness. The free-floating sections were immunostained with phosphorylation-dependent TDP-43 monoclonal antibody (pS409/410, 1:10 000) (Inukai *et al.*, 2008) for 72 h in the cold. After treatment with mouse secondary antibody, immunolabelling was detected using the VECTASTAIN ®ABC system coupled with a 3,3′-diaminobenzidine reaction to yield a brown precipitate. Sections were lightly counterstained with heamatoxylin.

Protease treatment of phosphorylated TDP-43

Sarkosyl-insoluble fractions extracted from the neocortical regions of patients with ALS or FTLD-TDP were treated with final concentration of 100 μg/ml trypsin (Promega) or 10 μg/ml chymotrypsin (Sigma-Aldrich) at 37°C for 30 min. The reaction was stopped by boiling for 5 min. After centrifuging at 15 000 rpm for 1 min, the samples were analysed by immunoblotting as described earlier.

Mass spectrometry

Sarkosyl-insoluble, trypsin-resistant fractions were loaded on 15% SDS–PAGE gels. The pS409/410-positive ~16 kDa bands were dissected and digested in-gel with chymotrypsin. The digests were applied to the Paradigm MS4 high-performance liquid chromatography system (Microm BioResources). A reversed phase capillary column (Develosil ODS-HG5, 0.075 × 150 mm, Nomura Chemical) was used at a flow rate of 300 nl/min with a 4–80% linear gradient of acetonitrile in 0.1% formic acid. Eluted peptides were directly detected with an ion trap mass spectrometer, LXQ (Thermo Fisher Scientific). The obtained spectra were analysed with Mascot (Matrix Science).

Statistical analysis

The *P*-values for the description of the statistical significance of differences were calculated by means of the paired, two-tailed *t*-test using Prism 5.04 software (GraphPad Software, Inc).

Results

Banding patterns of phosphorylated C-terminal TDP-43 in ALS and FTLD with TDP-43 pathology

Immunoblot analysis using an antibody specific for abnormal TDP-43, pS409/410, showed high-molecular-weight smearing substances, phosphorylated full-length TDP-43 at 45 kDa and several C-terminal fragments at 18–26 kDa to be present in affected brain regions in all cases (Fig. 1). Three major bands at 23, 24 and 26 kDa, and two minor bands at 18 and 19 kDa were seen in the precentral gyrus and frontal cortex of cases with ALS, with the 24 kDa band being the most intense (Fig. 1A and F). In the lumbar spinal cord, the two minor bands at 18 and 19 kDa were barely present, but the banding pattern of the three major bands at 23, 24 and 26 kDa was similar to that in the cerebral cortex (Fig. 1A). No such pS409/410-positive TDP-43 bands were detected in control cases with Alzheimer's disease with no TDP-43 pathology (Fig. 1B). In the FTLD-TDP cases, the banding pattern could be distinguished into three types according to the FTLD-TDP histological subtype (Fig. 1C–E). In FTLD-TDP type A, three major bands at 23, 24 and 26 kDa, and two minor bands at 18 and 19 kDa were detected, with the 23 kDa band being the most intense (Fig. 1C and F). In FTLD-type B cases, the banding pattern was the same as that in the ALS cases (Fig. 1D and F). In FTLD-TDP type C cases, two major bands at 23 and 24 kDa, and two minor bands at 18 and 19 kDa were detected, with the 24 kDa band being the most intense, and the band at 26 kDa being hardly detectable (Fig. 1E and F). Densitometric analyses of the immunoblots for all cases are shown in Supplementary Fig. 1. Each component of the C-terminal fragments was significantly different (Fig. 1F).

Immunoblot analysis using phosphorylation independent TDP-43 polyclonal and monoclonal antibodies detected phosphorylated full-length TDP-43 at 45 kDa, two bands ~25 kDa and high-molecular-weight smears, in addition to the normal TDP-43 band at 43 kDa in ALS and various subtypes of FTLD-TDP. The banding patterns between ALS and various subtypes of FTLD-TDP could not be distinguished with these antibodies. In the cases with Alzheimer's disease, the normal TDP-43 band at 43 kDa was detected, but neither the phosphorylated 45 kDa band nor the ~25 kDa fragments were observed (Supplementary Fig. 2). Immunoblot analysis of α-tubulin in Tris saline-soluble fractions from cases with types A, B and C pathology showed no correlation between the banding pattern of α-tubulin and that of TDP-43 (Supplementary Fig. 3), indicating that the differences in the banding patterns are not because of protein degradation caused by a long post-mortem interval or unfavourable agonal status.

Immunohistochemistry and immunoblot analyses of phosphorylated TDP-43 in multiple regions of ALS and FTLD with TDP-43 pathology

In ALS cases, the neuronal cytoplasmic pathology, which included skein-like inclusions, irregularly shaped TDP-immunoreactive neuronal cytoplasmic inclusions and densely staining granules, was confirmed in multiple regions by immunohistochemistry analysis using pS409/410 (Fig. 2A–G). Glial cytoplasmic inclusions were also present in many regions. Glial cytoplasmic inclusions were more frequent in the white matter than in the grey matter (Fig. 2H). A few neuronal cytoplasmic inclusions were found in the cerebellar cortex granule cells (Fig. 2G). In FTLD-TDP type C, dystrophic neurites were seen in multiple regions except for the cerebellar cortex (Fig. 2I–O), whereas neuronal cytoplasmic inclusions were also present in the striatum and hippocampus dentate gyrus granule cells (Fig. 2J and L). No abnormal structures were found in the cerebellar cortex (data not shown). These observations show that pathological TDP-43 is present throughout many CNS areas in ALS, suggesting that ALS does not selectively affect only the motor system, but it is rather a multisystem neurodegenerative TDP-43 proteinopathy.

Immunoblot analyses of three ALS cases confirmed that phosphorylated TDP-43 and the C-terminal fragments are deposited in multiple brain regions in ALS (Fig. 3A). Relatively strong immunoreactivities were detected in the striatum (in Cases 3 and 5) and substantia nigra (in Cases 1 and 5), although this varied between cases (Fig. 3A). Importantly, the banding pattern for the TDP-43 C-terminal fragments in these three cases was basically the same in all brain regions examined (Fig. 3A). In FTLD-TDP type C, a C-terminal banding pattern, clearly distinct from that

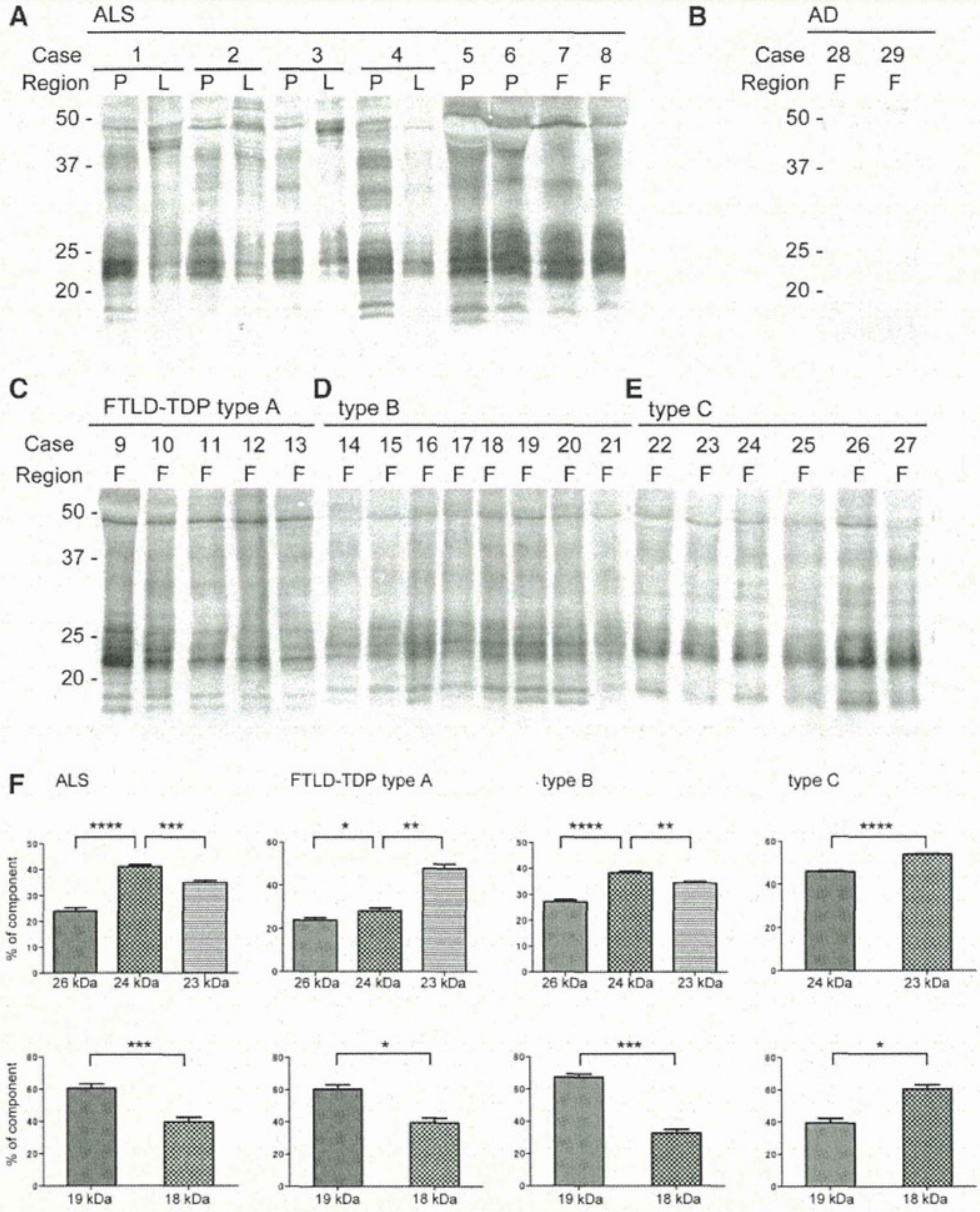

Figure 1 Immunoblot analyses of sarkosyl-insoluble TDP-43 in the brains or spinal cords of ALS (Cases 1–8) (**A**), Alzheimer's disease (Cases 28–29) (**B**), FTLD-TDP type A (Cases 9–13) (**C**), FTLD-TDP type B (Cases 14–21) (**D**) and FTLD-TDP type C (Cases 22–27) (**E**), using a phosphorylation-dependent anti-TDP-43 antibody (pS409/410). In all cases, high-molecular-weight smearing substances, phosphorylated full-length TDP-43 at 45 kDa and several C-terminal fragments at 18–26 kDa are detected. In ALS (**A**) and FTLD-TDP type B (**D**) cases, three major bands at 23, 24 and 26 kDa and two minor bands at 18 and 19 kDa are detected, whereas in the FTLD-TDP Type C (**E**) cases, two major bands at 23 and 24 and two minor bands at 18 and 19 kDa. A 24 kDa band is the most intense in ALS (**A**) and FTLD-TDP type B (**E**), whereas a 23 kDa band is the most intense in FTLD-TDP type C (**D**). The band pattern of the cases with type A (**C**) is an intermediate between FTLD-TDP type B (**D**) and FTLD-TDP type C (**E**). In spinal cords of cases with ALS, the 18 and 19 kDa bands are hardly detectable, but the same banding pattern of the 23–26 kDa bands as in precentral gyrus is detected. No such TDP-43 fragments are detected in brains of patients with Alzheimer's disease (AD) (**B**). The intensity of each C-terminal band was analysed using the ImageJ software and each component was statistically analysed by Student's *t*-test (**F**). Data indicate mean (SEM). $^{****}P < 0.0001$, $^{***}P < 0.001$, $^{**}P < 0.01$, $^{*}P < 0.05$. F = frontal cortex; L = lumbar part of spinal cord; P = precentral cortex.

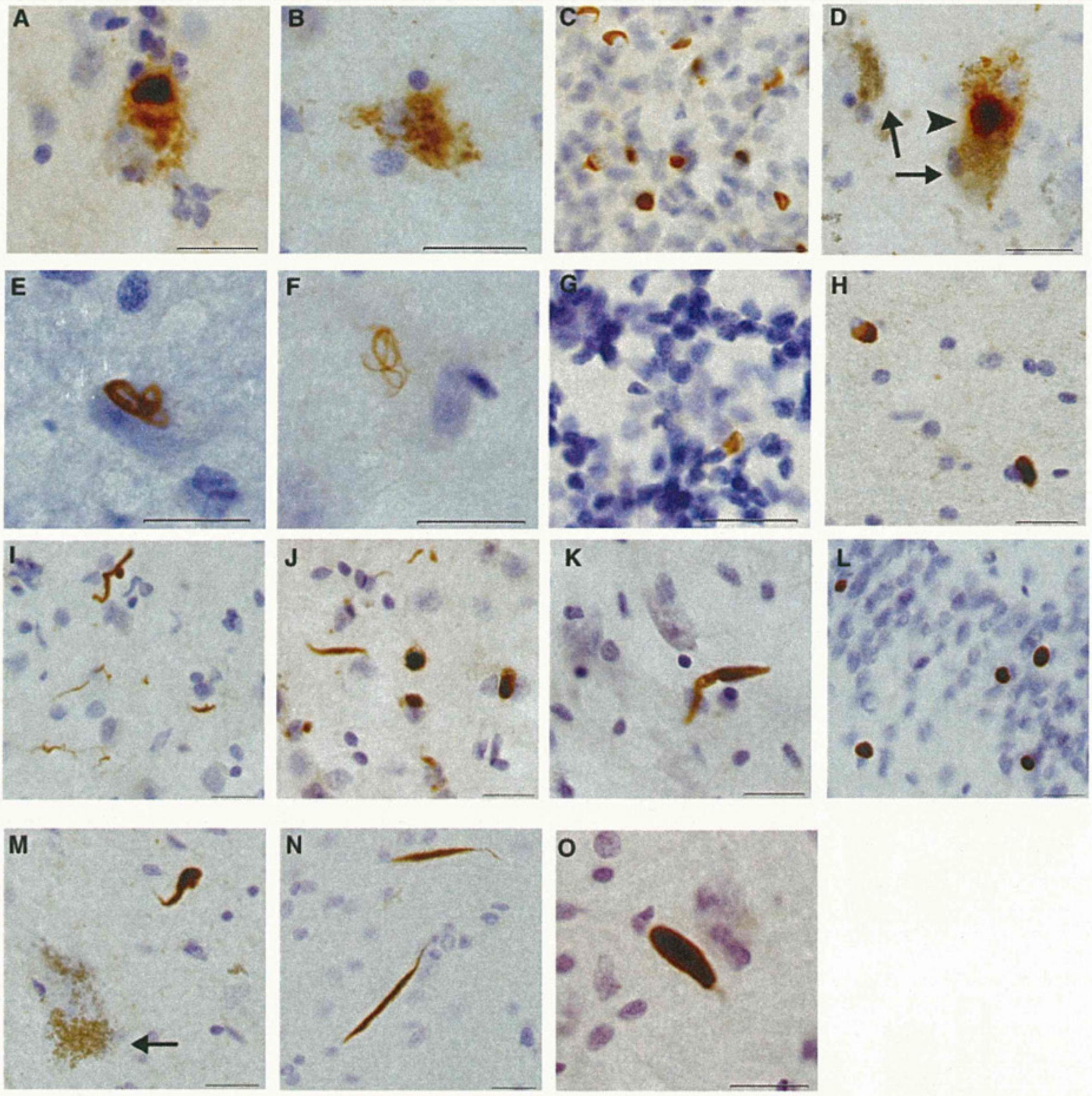

Figure 2 Phosphorylated TDP-43-positive structures observed in different brain regions and spinal cords of ALS (**A–H**) and FTLD-type C (**I–O**) using a phosphorylation-dependent anti-TDP-43 antibody (pS409/410). (**A**) Lewy body-like inclusion in the striatum neuron. (**B**) Cytoplasmic granular staining in the thalamus. (**C**) Neuronal cytoplasmic inclusions in the granular cells of hippocampus. (**D**) Irregularly shaped TDP-immunoreactive neuronal cytoplasmic inclusion in the substantia nigra (arrowhead). The arrows denote neuromelanin granules. (**E**) Skein-like inclusion in the motor nucleus of trigeminal nerve of pons. (**F**) Skein-like inclusion in the inferior olivary nucleus of medulla. (**G**) Neuronal cytoplasmic inclusion in the granular cells of cerebellar cortex. (**H**) Glial cytoplasmic inclusions in the white matter of precentral cortex. (**I**) Dystrophic neurites in the temporal cortex, (**J**) dystrophic neurites and neuronal cytoplasmic inclusions in the striatum. (**K**) Dystrophic neurites in the thalamus. (**L**) Neuronal cytoplasmic inclusions in the granular cells of hippocampus. (**M**) Dystrophic neurites in the substantia nigra. The arrow denotes neuromelanin granules. (**N**) Dystrophic neurites in the pons. (**O**) Dystrophic neurites in the medullary reticular formation. Scale bars = 20 μm.

of ALS, was detected in the temporal cortex, striatum and hippocampus, but was barely detected in the thalamus, substantia nigra, pons and medulla, and not at all in the cerebellar cortex (Fig. 3B). The banding pattern observed in these brain regions was indistinguishable (Fig. 3B). These results suggest that the same abnormal TDP-43 molecular species is deposited in different brain regions and different cell types, although the morphology of the TDP-43 inclusions may be different in the brain regions. Densitometric analyses of the immunoblots for all cases are shown in Supplementary Fig. 4.