Letter to the Editor

Frontotemporal Dementia—A Chameleon?

To the Editor: Frontotemporal dementia (FTD) is a pathologically heterogeneous illness characterized by progressive atrophy of the frontal and anterior temporal cortex. Some cases are familial, but the etiology is more often idiopathic.[1] There is no known treatment, and the illness progresses inexorably to death, with a mean survival of about 8 years.[1]

FTD is often misdiagnosed because of its confusing initial presentation.[2–4] A variety of psychiatric symptoms may be seen during the course of illness. We describe a patient with FTD who presented initially with mood and psychotic symptoms.

Case report. Ms A, a 45-year-old woman, was in good health until May 2008. Her initial symptoms were depressed mood, crying spells, decreased energy, anhedonia, and poor appetite and sleep and were attributed to her father's death. She also reported that the police were keeping her under surveillance and that a neighbor was "messing with my head" and trying to harm her children, leading to homicidal threats. After accosting the neighbor, she was admitted with a diagnosis of bipolar disorder, mixed, with psychotic features (*DSM-IV* criteria). Results of routine laboratory work, urine drug screen, and computed tomography scan were unremarkable. After 3 weeks of inpatient treatment, she was discharged with improvement of symptoms and resolution of the homicidal ideation.

Within 1 month, a change in her behavior was noticed; she became loud and aggressive, started making obscene calls to her mother, and developed pressured speech. She quickly deteriorated, becoming dependent in activities of daily living. She was readmitted in December 2008; this admission lasted for about 3 months. Results from full medical and neurologic evaluation, including magnetic resonance imaging scan, electroencephalogram, and lumbar puncture, were unrevealing. Neuropsychological testing revealed prominent executive dysfunction, and positron emission tomography scan revealed severe frontal and temporal hypometabolism. The *DSM-IV* criteria for dementia were used and, furthermore, were also correlated with the Consensus Clinical Diagnostic Criteria for frontotemporal dementia.[5]

On presentation to our Memory Disorder Clinic in November 2009, she was mute, minimally interactive, and markedly apathetic; there was also some evidence of dysphagia. The family reported trials of numerous psychotropic medications, all with minimal effect. She had an unsteady gait, swaying from side to side and magnetic in nature. She was restless, repeatedly rising from her seat, but was easily redirected. Her mood could not be assessed, but her affect was flat. It did not appear that she was responding to internal stimuli. She died in January 2010.

Frontotemporal dementia is the second most common dementia in younger individuals.[6] A young person presenting with psychotic and mood symptoms may suggest a primary psychiatric diagnosis, but the clinician must consider a neuropsychiatric syndrome such as FTD. Often, the clinical picture will evolve over time. Importantly, the consensus criteria for diagnosis of FTD do not emphasize psychiatric features.[3]

For our patient, the onset of what appeared to be a typical depressive illness after her father's death proved to be a "red herring." While she clearly presented with symptoms of a delusional depression, the clinical picture quickly evolved with increasing dependence in activities of daily living and mutism, and death soon followed. A review of the literature reveals cases in which the initial presentation of FTD was suggestive of a primary psychotic illness or a mood disorder.[4,7]

A greater index of suspicion for FTD in younger patients with new-onset psychiatric symptoms, and a longitudinal view as the disease progresses, will lead to better clinical diagnosis.

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Inyene E. Umoren, MD
iumoren@gmail.com
Jean M. Fils, MD
Jonathan T. Stewart, MD

Author affiliations: Psychiatry and Geriatric Medicine Department, James A Haley VA Hospital, University of South Florida College of Medicine, Tampa.

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