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Supplementary appendix

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A worldwide cohort study of age at symptom onset and death and disease duration in genetic

frontotemporal dementia

Moore et al.

Supplementary Appendix

Section 1) GRN and MAPT pathogenic variants included in the study

Supplementary Figure 1: Flow chart for inclusion of *GRN* **and** *MAPT* **variants in the study.**

The 35 GRN and 18 MAPT variants included in the study from the Pubmed search are shown with references in Supplementary Tables 1 (GRN) and 2 (MAPT) below. It was noted that the AD&FTD Mutation Database had not been updated for some time. Novel mutations described in the study are shown in Supplementary Tables 3 and 4.

Inclusion/exclusion criteria

All mutations were reviewed by two geneticists (RG/JB) to examine pathogenicity (as not all *GRN* and *MAPT* variants are pathogenic), and were only included if both agreed on their likely pathogenic nature. For *GRN,* mutations causing haploinsufficiency, due to a frameshift mutation or insertion of a stop codon, were all included as likely pathogenic. The literature on *GRN* missense mutations is less clear as to whether these are likely to be pathogenic or represent risk factors (apart from A9D which affects the signal peptide and is therefore likely to be pathogenic). We only included missense mutations where there was evidence in the literature of a) low progranulin levels (in blood or CSF) similar to those causing haploinsufficiency (rather than intermediate levels as seen in some missense mutations), or b) functional evidence of pathogenicity, and c) no contrary evidence that the mutation was not pathogenic (e.g. the C139R variant has been shown to be associated with Alzheimer's disease (AD) pathology rather than TDP-43 inclusions as would be expected for *GRN* mutations⁴³).^{6,24,44} *C9orf72* families with intermediate length expansions (<30 repeats) were not included in the study. Lastly, we did not include in the analysis families with dual mutations e.g. the combination of a *C9orf72* expansion and a pathogenic *GRN* or *MAPT* mutation.

Supplementary Table 1: *GRN* **mutations found in Pubmed search.**

Supplementary Table 3: Novel *GRN* **mutations reported in this study.**

Supplementary Table 4: Novel *MAPT* **mutations reported in this study.**

Of note, the majority of the *GRN* mutations found either via a Pubmed search or newly described here are expected to cause haploinsufficiency. We also included two missense mutations: C105Y has been studied functionally and shown to affect both progranulin secretion and cleavage by elastase suggesting it is pathogenic (ref 6), whilst P373S has been shown to be associated with very low progranulin levels in CSF (ref 24).

In total therefore we report 130 mutations in *GRN* and 67 mutations in *MAPT*, a much larger number than previously described, either in previous reviews or current online databases. The majority of these mutations are reported in 5 or fewer families, with only 50 mutations in *GRN* and 23 mutations in *MAPT* reported in more than 5 families. A complete table of mutations included in the study is shown below in Supplementary Table 5 with number of participants and means for age at onset (AAO), age at death (AAD) and disease duration (DD).

Supplementary Table 5. Individual genetic mutations included within the *GRN* **and** *MAPT* **mutation groups, with mean age at onset (AAO), age at death (AAD) and disease duration (DD). N = number: for AAO, AAD and DD this is the number of participants with available data.**

Data from published studies was included if individual-level data was available rather than group-level data only.

All mutations described in the literature are included here even when no individual clinical data was available for analysis within the study – these mutations are shown here by a 0 in the 'N total' column: 11 *GRN* mutations and 1 *MAPT* mutation.

Of note, data was included from both confirmed mutation carriers and from some family members who were assumed to be mutation carriers based on their clinical phenotype – this was the case for data from sites in the study as well as the data taken from publications. However, there is a potential that some untested family members could be phenocopies and not true mutation carriers.

Data on individual mutations is also affected by the extent to which families have been investigated – it is likely that some families have been studied in more detail than others which may affect the observed frequencies.

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Section 2) Detailed statistical methods

The different statistical methods used in each part of the Results section are detailed below. Age at Onset = AAO, Age at Death = AAD, Disease Duration = DD.

Sex distribution

A chi-squared test was used to compare sex distribution in each of the genetic groups.

Age at Onset, Age at Death and Disease Duration

i) Differences between genetic groups (GRN, MAPT and *C9orf72*), *and ii) within a genetic group (GRN and MAPT)* We used mixed effects models to examine whether there were differences in AAO, AAD and DD between genetic groups (*C9orf72, MAPT* and *GRN*) and between the common mutations in the *GRN* and *MAPT* groups. Due to the skewed distribution of DD, this was log transformed before analysis. To compare the mean AAO, AAD and DD between the *C9orf72, MAPT* and *GRN* groups we included a fixed effect of group in the model (g = *GRN*, *MAPT,* or *C9orf72*) and used Wald tests for hypothesis testing. The model allowed for relatedness by including a random effect for family membership. The model can be written as:

 $y_{ijg} = \alpha_g + \mu_{jg} + \varepsilon_{ijg}$ (Equation 1)

where,

 y_{ija} is the AAO or AAD for the ith participant in the jth family within mutation group g α_a is the mean for mutation group g μ_{jq} is the random deviation for the jth family away from the mean in group g ε_{ijg} is the residual error

The random effects and residual variance were assumed to follow a normal distribution and we assessed this assumption through plots of the residuals from the model. To allow variability in AAO, AAD or DD to differ by genetic group the model included three variance terms for the family random effects and three residual variance terms, one for each of the mutation carrier groups:

 $\mu_{jg} \sim N(0, \sigma_{\mu,g}^2)$ ε_{ijg} ~ $N(0, \sigma_{\varepsilon,g}^2)$

Within the *GRN* and *MAPT* groups we used a mixed model to examine whether there were differences in mean AAO, AAD or DD between the common mutations. This model included fixed effects for the individual mutation and a random effect for family. Wald tests were used for comparisons between the mutations.

It is important to note that age at death was known for 59% of those with data on age at onset (57% in the *GRN* group, 65% in the *MAPT* group and 57% in the *C9orf72* group). For those with missing data of age at death, no information was available on disease duration or reasons for censoring so it was not possible to take account of this in the analysis (e.g. through survival models). This means the reported disease durations, and extent of variability in disease durations, may be underestimates of the true values.

It is also important to note that we did not account for the particular geographical site where a participant was from within the mixed models as there was no a priori hypothesis about this affecting age at onset or death, but if geography did have an effect then this could have introduced bias.

Lastly, AAO, AAD and DD data were captured in two methods, via a standardized form from the FTD Prevention Initiative sites, and via data taken from Pubmed articles. There is a possibility that AAO, AAD and DD data is differently interpreted when captured via these two methods.

iii) Generational analysis

In order to investigate potential anticipation and differences in AAO between generations we performed a subanalysis investigating families with two generations of AAO data (insufficient data being unavailable to explore three or more generations). Within each genetic group (*GRN*, *MAPT,* and *C9orf72)* we used a mixed effect model in which generation was included as a fixed effect and used a Wald test to examine whether there was evidence of a difference in AAO. Family membership was included as a random effect.

Analysis of differences within group of iv) sex and v) phenotype

We used mixed effects models including random effects for family to examine whether within each mutation carrier group there were differences in AAO, AAD and DD by sex and clinical phenotype. Due to the skewed distribution of DD, this was log transformed before analysis. In each model we included fixed effects for sex or clinical phenotype and used Wald tests for hypothesis testing on these variables.

vi) Disease duration analysis in MAPT mutation carriers

In the *MAPT* group we used the same mixed effect modelling approach to examine whether there were systematic differences in DD between those carrying mutations categorised by their functional consequences and underlying pathology into five groups: group 1 (exons 1,2 and 9); group 2 (exon/intron 10 affecting splicing); group 3 (exon 10 not affecting splicing); group 4 (exons 11-13 with non-PHF-tau pathology) and group 5 (exon 11-13 with PHF-tau pathology group).

Correlation of individual AAO (or AAD) with parental and mean family AAO (or AAD)

The Pearson correlation coefficient was calculated between a) an individual's AAO (or AAD) and the AAO (or AAD) of their affected parent, and b) an individual's AAO (or AAD) and the average AAO (or AAD) of other members of the same family.

Modelling variability in age at onset and age at death

We used mixed effects models to explore the extent to which variability in AAO and AAD were explained by *family membership* and the *specific mutation* carried, and how this differed between the genetic groups.

Firstly, to explore the variability in AAO (and AAD) by *family membership* in all mutation carriers we fitted the two level linear mixed effects model given in equation 1 using the *mixed* command in Stata. This includes a fixed effect for genetic group (g = *GRN*, *MAPT,* or *C9orf72*) and a random effect for family membership. It allows for variability in AAO (and AAD) to differ by genetic group by including three variance terms for the family random effects and three residual variance terms, one for each of the mutation carrier groups (g = *GRN, MAPT,* or *C9orf72*):

 $\mu_{jg} \sim N(0, \sigma_{\mu,g}^2)$ ε_{ijg} ~ $N(0, \sigma_{\varepsilon,g}^2)$

To test for heterogeneity in the *within* family variability we used a likelihood ratio test to compare the above model to a simpler model that allowed for different distribution of the family random effect for each mutation carrier group but had one common residual variance for all carriers:

 $\mu_{jg} \sim N(0, \sigma_{\mu,g}^2)$

$$
\varepsilon_{ijg} \sim N(0, \sigma_{\varepsilon}^2)
$$

i.e.
$$
\sigma_{\varepsilon,GRN}^2 = \sigma_{\varepsilon,MAPT}^2 = \sigma_{\varepsilon, C9 or f72}^2
$$

To test whether there was heterogeneity in the *between* family variability we used a likelihood ratio test to compare the more complex model to a simpler model that allowed for different residual variance in each mutation carrier group but had one common variance for the family random effect:

$$
\mu_{jg} \sim N(0, \sigma_{\mu}^{2})
$$

\n
$$
\varepsilon_{ijg} \sim N(0, \sigma_{\varepsilon,g}^{2})
$$

\ni.e.
$$
\sigma_{\mu,GRN}^{2} = \sigma_{\mu,MAPT}^{2} = \sigma_{\mu,C9orf72}^{2}
$$

Secondly, for *GRN* and *MAPT* groups only we explored the extent to which variability in AAO (or AAD) was explained by the specific mutation by fitting a three level model with a fixed effect for genetic group (g = *GRN* and *MAPT*), and random effects of family membership nested within mutation carried.

$$
y_{ijkg} = \alpha_g + \delta_{kg} + \mu_{jkg} + \varepsilon_{ijkg}
$$

Where,

 y_{ijkg} is the AAO or AAD for the ith participant in the jth family with specific mutation k, within mutation

group g

 α_a is the mean for mutation group g

 μ_{jkg} is the random deviation for the jth family with specific mutation k away from the mean in group g δ_{ka} is the random deviation for those carrying specific mutation k away from the mean in group g ε_{ijkg} is the residual error

As before, to allow variability in AAO (and AAD) to differ by genetic group we allowed for different variance of the family random effect and residual variance for each of the mutation carrier groups (g = *GRN, MAPT*). In addition, we also allowed variability of the specific mutation random effect to differ by carrier group (g = *GRN, MAPT*)

$$
\delta_{kg} \sim N(0, \sigma_{\delta,g}^2)
$$

$$
\mu_{jkg} \sim N(0, \sigma_{\mu,g}^2)
$$

$$
\varepsilon_{ijkg} \sim N(0, \sigma_{\varepsilon,g}^2)
$$

To test whether *GRN* and *MAPT* groups differed in the extent to which the variability in AAO (and AAD) was due to the *specific mutation* we used a likelihood ratio test to compare the above model to a simpler model with one common variance for the specific mutation random effect, but still allowing for different family variance and residual variance terms for each mutation carrier group:

$$
\delta_{kg} \sim N(0, \sigma_{\delta}^{2})
$$

\n
$$
\mu_{jkg} \sim N(0, \sigma_{\mu,g}^{2})
$$

\n
$$
\varepsilon_{ijkg} \sim N(0, \sigma_{\varepsilon,g}^{2})
$$

\ni.e.
$$
\sigma_{\delta,GRN}^{2} = \sigma_{\delta,MAPT}^{2} = \sigma_{\delta,C9orf72}^{2}
$$

For the best fitting model, the intraclass correlation was used to quantify the degree of variability explained by family and by the specific mutation. Confidence intervals for the ICC were calculated in Stata using the *estat icc* command.

For a model which included only family random effect (e.g. in *C9orf72* carriers) the ICC for family was:

$$
ICC(family) = \frac{\sigma_{\mu,g}^2}{\sigma_{\mu,g}^2 + \sigma_{\varepsilon,g}^2}
$$

For a model which included random effects for both family and specific mutation random effect the ICC for specific mutation was:

$$
ICC(mutation) = \frac{\sigma_{\delta,g}^2}{\sigma_{\delta,g}^2 + \sigma_{\mu,g}^2 + \sigma_{\varepsilon,g}^2}
$$

And the ICC for family was:

$$
ICC(family) = \frac{\sigma_{\delta,g}^2 + \sigma_{\mu,g}^2}{\sigma_{\delta,g}^2 + \sigma_{\mu,g}^2 + \sigma_{\varepsilon,g}^2}
$$

The ICC for family includes both the family and specific mutation variance components in the numerator because members of the same family also share the same mutation.

Section 3) Geographical distribution

Geographical variability in the prevalence of the different genetic groups is shown in the main text and in Figure

1. Data from the following countries was included in the study:

Discussion

The study supports previous work suggesting that the most common genetic form of FTD overall across the world is due to pathogenic expansions of the *C9orf72* gene^{45,46}. However, there is geographical variability: in Italy, *GRN* mutations are the most common cause of genetic FTD⁴⁷, mainly due to a large founder family with the T272fs variant⁴⁸, the most common *GRN* mutation in our study. Similarly, there are large *GRN* founder families in Spain (IVS7-1G>A49,50, in the Basque country) as well as in Belgium (IVS1+5G>C51,52). *MAPT* mutations are the least common form of genetic FTD overall, although they are more common in some countries than others: in the Netherlands, this is due to a variety of mutations, whilst in the US, although different mutations contribute, there are a number of large families e.g. the pallido-ponto-nigral-degeneration (PPND) family with the N279K mutation53-55; similarly, in the UK, *MAPT* mutations are almost as common as *C9orf72* mutations due to a large founder family from the North Wales area of the UK with the IVS10+16C>T mutation⁵⁶. In contrast, some of the most common mutations are seen across the world in a wider distribution e.g. the *GRN R493X⁵⁷* and *MAPT*

P301L58-61 mutations. Whilst *C9orf72* expansions are seen across the world, they are more common in North America and Europe (particularly the Nordic countries) than Asia⁶²⁻⁶⁶. One limitation of this study was our focus on age at onset and death data rather than ascertaining all families reported in the literature (i.e. those without any data were not included), and so the data may be an underrepresentation of some mutations, given the emphasis was not specifically on geographical variability.

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Section 4) Clinical phenotype

Many family members in previous generations did not have a specific diagnosis beyond 'dementia' and here they are categorized as 'Dementia-not otherwise specified' (Table 2 in main text, Supplementary Table 6). *Excluding these cases from a phenotypic analysis*, most patients in each group had a clinical diagnosis within the FTD spectrum (82% in *GRN*, 85% in *MAPT*, 87% in *C9orf72*). The most common phenotype was bvFTD across all three genetic groups: 55% of patients with *GRN* mutations, 66% of those in the *MAPT* mutation group and 42% of those with *C9orf72* expansions. Beyond bvFTD, there was variability across the mutations: PPA was a more common diagnosis in *GRN* mutation carriers (20%) with the specific variant usually being nfvPPA or PPA-NOS, compared with *MAPT* (6%) or *C9orf72* (4%). ALS (or FTD-ALS) was only a very rare occurrence in *GRN* (2%) or *MAPT* mutation carriers (1%) whereas 40% of *C9orf72* expansion carriers had either pure ALS (26%) or an FTD-ALS overlap (15%). CBS was seen not uncommonly in the *GRN* group (6%) and more rarely in the *MAPT* group (3%) but only in 2 patients in the *C9orf72* group. In comparison, a PSP syndrome (Richardson's syndrome) was seen in 6% of *MAPT* mutation carriers but not in the *GRN* group and in only 1 *C9orf72* expansion carrier. In each of the groups, clinical diagnoses outside of the FTD spectrum were seen in a sizeable minority: AD in 12% of *GRN*, 4% of *MAPT* and 8% of *C9orf72*; and Parkinson's disease (PD) had been diagnosed in 2% of *GRN*, 7% of *MAPT* and 1% of *C9orf72*.

Looking at the common mutations individually (Supplementary Table 6), the majority of *GRN* mutations had a similar pattern, with bvFTD being the most common phenotype and a substantial minority having PPA: T272fs 47% bvFTD, 18% PPA; R493X 49% bvFTD, 30% PPA; IVS7-1G>A 61% bvFTD, 18% PPA; C31fs 44% bvFTD, 25% PPA; and G35fs 49% bvFTD, 31% PPA. However, the A9D mutation was predominantly associated with bvFTD, found in 84% of patients. In the common *MAPT* mutations, P301L and R406W were associated mainly with bvFTD: 91% in both mutations. In comparison, the N279K mutation was associated mainly with a primary parkinsonian phenotype (94% with a primary diagnosis of PSP, CBS or PD). The IVS10+16C>T mutation was associated mainly with bvFTD (67%) but with a significant minority having a primary parkinsonian phenotype (17%).

Supplementary Table 6: Individual primary clinical diagnoses in each of the mutations. Diagnoses within the frontotemporal dementia (FTD) spectrum include behavioural variant FTD (bvFTD), the primary progressive aphasia (PPA) subtypes [nfv = nonfluent variant, sv = semantic variant, lv = logopenic variant, PPA-NOS = PPA not otherwise specific i.e. does not meet criteria for a specific subtype], FTD with amyotrophic lateral sclerosis (ALS), ALS, corticobasal syndrome (CBS) and progressive supranuclear palsy (PSP). Diagnoses outside the FTD spectrum include Alzheimer's disease (AD), Huntington's disease (HD), Parkinson's disease (PD), Dementia with Lewy Bodies (DLB), VaD (vascular dementia) and a dementia diagnosis not otherwise specific (Dementia-NOS).

Discussion

The study further supports the clinical heterogeneity of genetic FTD, identifying multiple phenotypes both within and outside the FTD spectrum in each of the mutations. Whilst bvFTD is the most common phenotype in all three genetic groups, each group has particular associations with other primary phenotypes: ALS in *C9orf72* expansions, PPA in *GRN* mutations, and parkinsonism in *MAPT* mutations. Expansions in *C9orf72* are the commonest cause of familial ALS, and exemplify the spectrum of disease across FTD/ALS with pure FTD (46% of cases here with bvFTD or PPA) and ALS (26%) at either end, and the overlapping condition of FTD-ALS (15%) in the middle – of note, the frequencies here represent the primary phenotype, and it may well have been that many patients presenting with 'pure' ALS or FTD went on to develop the other condition later in time. The PPA phenotype in *GRN* mutations has not been explored in detail, but this study suggests two major phenotypes, nfvPPA fitting consensus Gorno-Tempini criteria⁶⁷, and a PPA syndrome not meeting criteria for any of the three major variants (PPA-NOS) – this 'mixed' aphasia pattern has been previously described as potentially distinctive for those with GRN mutations⁶⁸. Whilst parkinsonism is most common in *MAPT* mutations, the phenotype is variable, often being diagnosed as either 'PD^{'69} (suggesting the presence of an asymmetrical akinetic-rigid syndrome), or PSP (Richardson's syndrome)⁷⁰, more commonly than CBS, a condition that was also seen in a substantial minority of people with GRN mutations⁷¹⁻⁷³. The phenotypic heterogeneity does not seem to be particularly related to the individual mutation in the *GRN* group (apart from perhaps the A9D variant), but there was a clear distinction between the majority of the common *MAPT* mutations in which bvFTD was the most frequent syndrome, and the N279K variant where a primary parkinsonian disorder predominated.

Outside of the FTD spectrum, a number of patients were given the clinical diagnosis of Alzheimer's disease, a diagnosis more commonly given when the AAO was older in each genetic group – this is likely to represent a number of factors including misdiagnosis (particularly in prior generations), a true amnestic presentation, which has been described in all three genetic groups⁷⁴⁻⁷⁷, and potentially in older patients, a number of 'true' cases of neuropathological Alzheimer's disease occurring coincidentally. Less common phenotypes were also seen: Huntington's disease (HD) in 4 people with *C9orf72* expansions⁷⁸, Dementia with Lewy Bodies (DLB) in 4 people with *GRN* mutations and 5 people with *C9orf72* expansions (likely related to the combination of visual hallucinations and parkinsonism that can be seen in these conditions), and vascular dementia (VaD) in 9 people with *GRN* mutations (potentially related to the presence of white matter hyperintensities in a subset of people in this group79) and 7 people with *C9orf72* expansions.

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Section 5) Sex distribution

Sex distribution is shown in the text and in Table 1. Comparisons are shown in Supplementary Table 7.

Supplementary Table 7: Chi-squared tests comparing sex distribution across the genetic groups

Discussion

In terms of sex distribution we replicate the results of a recent meta-analysis which found an increased female:male ratio in GRN mutations⁸⁰. One suggestion has been that this increase is due to the fact that in most populations women live longer than men and given the known age-related penetrance in *GRN*81, female mutation carriers are therefore more likely to reach an age where they develop symptoms than men. Supportive of this theory is the finding that the mean age at onset (and age at death) was significantly older in the female *GRN* group, suggesting the presence of more women developing symptoms at an older age [See Section 9 below]. Survival does not seem to be a major factor in the increased female:male ratio as there was no significant difference between men and women in disease duration in the *GRN* group. There is also age-related penetrance in *C9orf72* mutation carriers⁸², and this may account for the significantly older age at onset (and older age at death) in females in this group (although, unlike in *GRN* mutation carriers, we did not find any difference in frequency between the sexes). These findings in the *C9orf72* group replicate those of recent studies which showed an earlier onset in males^{82,83}. One of these studies highlighted that bulbar onset ALS (which is more common in women) had an older AAO compared with spinal onset ALS⁸³; however, we did not have data on the specific ALS type to investigate that further in this study.

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Section 6) Ranges of age at onset, age at death and disease duration in each genetic group and in the individual mutations

The mean AAO, AAD and DD in each individual mutation is shown in Supplementary Table 5 above. Supplementary Figure 2 shows the mean (black rectangle) and ranges for each of ages at onset and death, and disease duration i.e. the left-hand end of the bar is the youngest AAO and AAD, and the shortest DD, whilst the right-hand end of the bar is the oldest AAO and AAD, and the longest DD in each mutation.

Supplementary Figure 2: Mean and range of a) ages at onset, b) ages at death, and c) disease durations for the individual *GRN* **and** *MAPT* **mutations.** Means are shown as whole numbers, either rounded up if >.5 or rounded down if <.5.

a)

b)

A472

Q503
R535

 $\frac{1}{6271}$

 $IVSS-10G$

 $L2841$ $rac{5285}{6201}$

 $\frac{K298}{P30}$

Section 7) Cumulative percentage probability of symptom onset in the genetic groups.

Data is shown within the main text and in Figure 3 showing the cumulative proportion of people with symptom onset by each year of age within each genetic group (*GRN, MAPT* and *C9orf72*) and in the common mutations (for *GRN* and *MAPT*). Data is shown in Supplementary Table 8. Comparisons of AAO as well as AAD and DD across the common mutations are shown in Supplementary Table 9.

Supplementary Table 8: Cumulative percentage probability of symptom onset in *GRN, MAPT* **and** *C9orf72* **groups overall and the common** *GRN* **and** *MAPT* **mutations [in 5 year intervals]. Mean (standard deviation) AAO for the common mutations is shown in the last row of the table.**

Supplementary Table 9: Adjusted mean differences (with 95% confidence intervals) in age at onset (AAO), age at death (AAD) and disease duration (DD – natural log differences) comparing the common individual *GRN* **and** *MAPT* **mutations.**

Section 8) Generational analysis

In order to investigate potential anticipation and differences in AAO between generations, we used a mixed effect model to perform a subanalysis investigating families with two generations of AAO data (insufficient data being unavailable to explore three or more generations). Results are shown in the main text, in Supplementary Table 10 and in Supplementary Figure 3.

Supplementary Table 10: Cumulative percentage probability of symptom onset in *GRN, MAPT* **and** *C9orf72* **group generational analysis – generation 1 (earlier), generation 2 (later). N is the number of people in each group. In the bottom row adjusted mean differences between generation 1 and 2 are shown with 95% confidence intervals.**

Supplementary Figure 3: Generational analysis of age at onset in a) *GRN***, b)** *MAPT* **and c)** *C9orf72* **groups – generation 1 (earlier), generation 2 (later).**

c) *C9orf72* **mutation carriers**

Section 9) Sex analysis

Analyses were performed *within* genetic groups comparing male and female sex. Data is shown in the main text and in Supplementary Table 11.

Supplementary Table 11: Age at onset (AAO), age at death (AAD) and disease duration (DD) in each genetic group by sex. In the bottom row adjusted mean differences (natural log differences for DD) between female and male sex are shown with 95% confidence intervals.

Section 10) Phenotype analysis

Analyses were performed *within* groups comparing the main phenotypes. Data is shown in the main text and in Supplementary Table 12.

Supplementary Table 12: Age at onset (AAO), age at death (AAD) and disease duration (DD) in each genetic group by phenotype [where sufficient data was available; N/A = not applicable, when not enough data]. Atypical parkinsonism (AP) = CBS for *GRN* **mutation carriers and a combined CBS/PSP cohort for** *MAPT* **mutation carriers. In the bottom row adjusted mean differences between phenotypes are shown with 95% confidence intervals.**

Age at symptom onset subanalysis in C9orf72 expansions carriers

A further AAO analysis was performed within the *C9orf72* group comparing those with a 'cognitive' presentation (combining clinical phenotypes of bvFTD, PPA, AD as well as DLB, VaD, and Dementia-NOS) with those with an ALS presentation:

- Mean (standard deviation) AAO in cognitive *C9orf72* group = 58.6 (10.2)
- Mean (standard deviation) AAO in cognitive *C9orf72* group = 57.0 (9.0)
- Using a mixed models analysis as described above, adjusted mean difference = -1.81 (95% confidence intervals -3.38, -0.24), p=0.0241

In other words, the cognitive *C9orf72* group had a significantly older AAO than the ALS group.

Section 11: Disease duration analysis in MAPT mutation carriers

A mixed effect modelling approach was used to examine whether there were systematic differences in DD between those carrying *MAPT* mutations categorised by their functional consequences and underlying pathology into five groups:

- ϵ group 1 mutations in exons 1.2 and 9;
- group 2 mutations in exon/intron 10 affecting splicing;
- group 3 mutations in exon 10 not affecting splicing;
- group 4 mutations in exons 11-13 with non-paired helical filament (PHF)-tau pathology;
- group 5 mutations in exon 11-13 with PHF-tau pathology group.

Results are shown in Supplementary Figure 4 and Supplementary Table 13.

Supplementary Figure 4: Disease duration in patients with *MAPT* **mutations grouped by type of mutation and pathology (median and interquartile range).**

Group 1: *R5H, R5L, G55R, K257T, I260V, L226V, G272V, IVS9-5T>C, IVS9-11G>C, IVS9-10G>C, IVS9-10G>T;* **Group 2:** *N279K, deltaK280, L284L, L284R, S285R, C291R, N296N, K298E, IVS10+3G>A, IVS10+4A>C, IVS10+11T>C, IVS10+12C>T, IVS10+12C>A, IVS10+13A>G, IVS10+14C>T, IVS10+15A>C, IVS10+16C>T, G303V, G304S, S305N, S305I, S305S;* **Group 3:** *P301T, P301S, P301L;* **Group 4:** *L315R, L315L, K317M, S320F, P332S, G335S, G335V, Q336H, E342V, S352L, S356T, V363A, P364S, G336R, K369I, E372G, G389R (2170G>A), G389R (2170G>C), T427M;* **Group 5:** *V337M, R406W.*

Supplementary Table 13: Adjusted mean (natural log) differences with 95% confidence intervals in disease duration between the *MAPT* **groups.**

In summary, group 5 (i.e. the exon 11-13 with PHF-tau pathology group incorporating V337M and R406W mutations) had a significantly longer disease duration compared with all the other groups.

Section 12: Modelling variability in age at onset and age at death

Supplementary Table 14: Variability in age at onset associated with family membership and with presence of a specific mutation. AAO: age at onset (years); CI: confidence interval; SD: standard deviation; N/A: not applicable (for *C9orf72* **as only a single mutation).**

Supplementary Table 15: Variability in age at death associated with family membership and with presence of a specific mutation. AAD: age at death (years); CI: confidence interval; SD: standard deviation; N/A: not applicable (for *C9orf72* **as only a single mutation).**

Discussion

Little is known about either genetic or environmental factors modifying AAO, AAD or DD in people with *MAPT*, *GRN* or *C9orf72* mutations.

MAPT

One recent study identified that the presence of the *APOE* e4 genotype lowered AAO in those with FTD and tau pathology, including those with *MAPT* mutations⁸⁴ (although it did not look at *MAPT* mutation carriers separately to other tauopathies). However studies have yet to identify other modifying factors.

GRN

Genetic factors affecting AAO in *GRN* mutation carriers include a polymorphism in *TMEM106B*85, with a lower AAO related to carrying the risk allele, and homozygous carriers of the protective allele rarely found in symptomatic GRN mutation carriers⁸⁶. In the Basque IVS7-1G>A families one study has shown an earlier AAO in MM homozygous carriers at PRNP codon 129 compared with MV or VV carriers⁸⁷. A number of studies have now identified inflammation as a key player in *GRN*-associated FTD pathogenesis^{88,89}, and symptomatic patients with *GRN* mutations have a higher risk of also having a co-existent autoimmune disease⁹⁰. It may be therefore that there are environmental factors related to an altered neuroinflammatory response (e.g. traumatic brain injury 91 or systemic inflammation) that modify AAO, that are currently poorly understood.

C9orf72

A number of factors have now been studied as modifiers of AAO in *C9orf72* expansion carriers. There is contradictory evidence in terms of the relationship of expansion length to $AAO⁹²⁻⁹⁵$, with one recent study suggesting that the association was driven by age at blood sample collection⁹⁴ (implying that expansion length in blood may increase with age, although there is no evidence for this at present). Other studies have found that hypermethylation of the *C9orf72* 5'CpG island is a modifier^{95,96}, with longer DD and later AAD⁹⁶. Another study showed that DNA methylation age-acceleration is associated with a decrease in AAO and a shorter DD⁹⁷. More recently, a study of *C9orf72* expansion carriers identified a locus on chromosome 6 containing two overlapping genes (LOC101929163 and *C6orf10*) in which a polymorphism at rs9357140 was associated with a median AAO six years earlier in GG compared with AA carriers⁹⁸. Lastly, a study of parental-offspring relationships in *C9orf72* revealed a significant correlation in AAO only in the mother-son relationship⁹⁹, which they suggest may be related to unknown X-linked genetic modifiers. Environmental or lifestyle factors affecting AAO in *C9orf72* expansion carriers are currently unknown but may be revealed by large prospective cohort studies such as those underway in the FTD Prevention Initiative.

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