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Frontotemporal dementia and psychosis: Literature review

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Introduction Frontotemporal dementia (FTD) is a progressive neurodegenerative disease especially sporadic. About 30–40% have positive family history, with an identifiable genetic mutation in a percentage of cases increasing. Although the FTD psychosis has been recognized for many years, it is not included in the clinical criteria.
Objectives To assess the prevalence and characteristics of psychotic symptoms in FTD, compare the presence of psychosis in FTD $C9^+$ versus $C9^-$ and analyze the occurrence of wrong diagnoses in FTD with psychosis.
Methods Literature review, using computerized databases (Pubmed®). Articles were selected based on the content of their abstract and their relevance.
Results It is frequently the presence of psychotic symptoms in FTD associated with $C9^+$ versus $C9^-$. These may arise as initial symptom often leading to a psychiatric diagnosis years before obtaining diagnosis of FTD. There is no conclusive evidence about the anatomical correlation of psychotic features in the FTD, although there is the possible association with the right brain degeneration.
Conclusions The existence of psychotic symptoms do not argues against the diagnosis of FTD verifying a high frequency of psychosis in FTD – $C9^+$. As can be the first symptom in FTD is critical to differentiate psychiatric disorders. Further studies are needed in order to obtain a better characterization of psychotic symptoms in FTD – $C9^+$.
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Relationship between emotional intelligence and neurocognition in severe mental disorders

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Introduction The severe mental disorders are the subject of growing research in the area of emotional intelligence because of his relationship with psychosocial functionality loss. Despite treatment advances, patients continue to experience high levels of social, professional and personal disabilities, related to the presence of deficits in cognition. These changes are manifested in two areas: the neurocognitive and social cognition.
Objectives To better understand the relationship between neuro- and sociocognition in schizophrenia and bipolar disorder.
Aims The aim of this research is to study the factors related to emotional intelligence, with particular interest in neurocognitive deficits.
Methods A total of 75 adult patients with schizophrenia and bipolar disorder type I were evaluated. The assessment protocol consisted of a questionnaire on socio-demographic and clinical-care data, and a battery of clinical and cognitive scales, including MSCEIT, WAIS-IV, TMT and Rey Figure.
Results MSCEIT was negatively correlated with age, the severity of the clinical symptoms (BPRS, CGI-S), the TMT-A and the Test of Complex Figure, and positively with the intelligence quotient.
Conclusions The deficits in emotional intelligence are part of a set of cognitive, social and non-social skills, which are altered in these severe mental disorders. Emotional intelligence worsens with the deterioration of cognitive functioning, executive dysfunction and severity of psychiatric disorder.
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Are we able to influence cognitive dysfunction in multiple sclerosis?

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Introduction Multiple sclerosis (MS) is the most common chronic neurologic disease affecting young people. Cognitive dysfunction is an important part of disability, interfering with quality of life (QoL). Disease modifying therapies (DMT) are gold standard of long-term treatment in MS.
Objectives Assessment of DMT impact on evolution of cognitive dysfunction.
Aims To analyze the cognitive status in a lot of 74 patients with MS, with a mean age of 40.4 years, treated with different DMT in the National Health Program.
Methods Testing patients during 2014–2015 for cognitive dysfunction, by applying MMSE, Sunderland Clock Test, Beck Depression Inventory, Fatigue Impact Scale and QoL Short form-36 scores every 6 months; analyzing demographic, clinical and magnetic resonance imagery (MRI) data.
Results Thirty-six percent of lot showed memory and concentration changes (12 patients with secondary progressive MS, 15 with relapsing-remitting MS); mean age of these patients was 46.29 years, with a mean period of evolution of the disease of 9.8 years before starting DMT; cortical atrophy was present on MRI in 37% of these patients. Mean age of those who didn't present cognitive disturbances was 37.01 years, with a mean period of evolution of 6.2 years before starting DMT. Disturbances appeared independently of the presence of cortical atrophy, as this marker appeared in 5% of patients with no cognitive dysfunction.
Conclusions When starting DMT, age and time of evolution of the disease are essential for further developing of cognitive dysfunction. Mood and anxiety disturbances can be a prodromal marker of neurocognitive troubles. DMT have neuroprotective outcome in MS.
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The effect of interpersonal multisensory stimulation on the self-face recognition in adults with autistic syndrome disorder

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