The multidimensional neurocognitive geometry in Alzheimer's disease and posterior cortical atrophy

Running head: Graded phenotypes in Alzheimer's disease

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Abstract

Alzheimer's disease spans a heterogeneous collection of typical and atypical phenotypes. Posterior cortical atrophy represents one of the most striking examples, characterised by prominent impairment in visual and other posterior functions in contrast to typical, predominantly amnestic Alzheimer's disease. Whilst putative posterior cortical atrophy subtypes include dorsal, ventral, caudal and dominant parietal presentations, investigations of posterior cortical atrophy subtypes are rare. The current study establishes how the similarities and differences of cognition and neural integrity within posterior cortical atrophy and typical Alzheimer's disease (and by extension other Alzheimer's disease variants), can be conceptualised as systematic variations across a unified transdiagnostic, graded multidimensional space.

Principal component analysis was applied to detailed neuropsychological cognitive and visual data from a large cohort of posterior cortical atrophy (N=93) and typical Alzheimer's disease patients (N=58). Voxel-based morphometry was then used to explore neural correlates of the emergent transdiagnostic PCA phenotype dimensions. The principal component analysis for posterior cortical atrophy extracted three dimensions, reflecting general cognitive, visuoperceptual and visuospatial impairments. Projecting typical Alzheimer's disease cases into the posterior cortical atrophy-derived multidimensional space, and vice versa, revealed graded, overlapping variations between cases along these dimensions, with no evidence for categorical-like clustering of the patients. Likewise, the relationship between neural integrity and scores on the extracted dimensions was overlapping for PCA and tAD.

The results are consistent with phenotypic continua spanning posterior cortical atrophy and typical Alzheimer's disease, arising from systematic graded variations within a transdiagnostic, multidimensional neurocognitive geometry.

Introduction

Alzheimer's disease (AD) underlies heterogeneous neuropsychological phenotypes [1,2], conceptualised in the latest consensus diagnostic system as typical (amnestic) and atypical AD variants. The latter are characterised by predominant non-amnestic impairment, including visual, logopenic, behavioural, and dysexecutive presentations [3]. However, these categorical classifications do not fully capture the graded variation within and between variants, or mixed phenotypes [2,4-6]. This contributes to the challenge of diagnosing AD variants, with implications for selecting appropriate therapeutics and/or rehabilitation pathways, and recruitment for research [4,7]. Utilising detailed neuropsychological and neuroimaging data from 93 PCA and 58 tAD patients, the current study tackled these important challenges by establishing and mapping the graded neuropsychological and neuroimaging dimensions that underpin the patient variations. The resultant transdiagnostic, multidimensional neurocognitive geometry systematically captures the variations within and between PCA and tAD subtypes as well as patients with a more "mixed" presentation.

Phenotypic variation within and between typical AD (tAD) and posterior cortical atrophy (PCA; "visual-spatial AD" [7]) illustrates the challenge of diagnosing AD variants. Characteristic symptoms of PCA include space and object perception deficits, constructional apraxia, environmental agnosia, and alexia [6,8,9]. PCA is alternately conceptualised as a discrete nosological entity [10], an atypical variant of AD [11], or an extreme point in an AD phenotypic continuum [12]. Most studies of tAD and PCA aim to characterise the key differences in these forms of AD, typically to aid differential diagnosis. A meta-analysis found that PCA and tAD differ in delayed auditory/verbal memory (more impaired in tAD) and both immediate visuospatial memory as well as visuoperceptive and visuospatial abilities (more impaired in PCA) [13]. However, these groups did not differ significantly on a range of other cognitive domains, including working memory, language (naming, comprehension, semantic and phonemic fluency), and ideomotor praxis. This highlights the overlapping nature of cognitive variation in these forms of dementia, which may be missed in studies which employ a categorical diagnostic classification system to define their groups. For example, some studies exploring the relations between tAD and PCA have reported on the similarities in grey matter atrophy patterns [14-16], and cognitive impairments [14,17]. Furthermore, in tAD, mild impairments in atypical (non-amnestic) domains including visuospatial processing have been found [2,12,18]. Thus, the overlapping relationship between these presentations of AD could be conceptualised as comprising one or more graded phenotypic spectra.

There is also a growing body of evidence suggesting that heterogeneity in Alzheimer's disease clinical phenotypes could be due to the spreading pattern of tau along functional brain networks [19,20]. As such, it could be expected that individuals with symptoms of tAD and PCA would show variations in the distribution of neurodegeneration that underpin their graded differences in cognitive profiles. This study therefore employed an approach which situates participants with tAD and PCA in the same graded multidimensional space to capture the patterns of overlapping and/or non-overlapping cognitive

performance, and then relates the transdiagnostic phenotype dimensions to the pattern of atrophy across the whole brain, to understand how shared cognitive variation may reflect common patterns in the distribution of atrophy in these forms of dementia.

Additionally, heterogeneity within PCA has led to proposed dorsal/spatial and ventral/perceptual subtypes [21], associated with changes in occipito-parietal or occipito-temporal cortices, respectively [22,23]. However, this heterogeneity might also represent graded variations along spectra of visual impairment, instead of discrete subtypes [6,24]. This may be supported by evidence of neural correlates for the proposed subtypes, showing a graded relationship between integrity of certain areas and degree of impairment leaning towards spatial or perceptual domains.

Traditional categorical classification systems fail to account for these heterogenous clinical presentations and potential phenotypic spectra. Reconceptualising variants/subtypes as subregions within a graded multidimensional space offers an alternative approach [2,12,14,16], which has been successfully applied to post-stroke aphasia [25,26], primary progressive aphasia [27], semantic dementia [28], fronto-temporal lobar degeneration [29] and logopenic progressive aphasia [30]. The current study employed a similar approach to explore the hypothesis that both cognitive and neuroanatomical variation within and between PCA and tAD can be captured in an overarching, graded multidimensional geometry. This was achieved through the application of principal component analysis to a large-scale, detailed neuropsychological database followed by grey matter voxel-based morphometry, allowing a data-driven exploration of (a) the presence and cognitive nature of phenotypic continua in each group; and (b) the extent of intragroup and intergroup graded variation in cognition and grey matter volume in the multidimensional space defined by these dimensions.

Methods

Patients

Ninety-three people with posterior cortical atrophy were recruited from the Specialist Cognitive Disorders Clinic at the National Hospital for Neurology and Neurosurgery, London, UK. All PCA patients met both Tang-Wai *et al*. [9] and Mendez *et al*. [8] criteria based on available information at baseline and expert retrospective clinical review. Exclusion criteria included evidence of non-Alzheimer's disease dementia (e.g., dementia with Lewy bodies, or cortico-basal degeneration) in clinical assessment and investigation; thus all patients included fulfilled consensus criteria for PCA-pure [6].

Fifty-eight people with typical Alzheimer's disease were recruited from the same Specialist Cognitive Disorders Clinic on the basis of meeting the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association (NINCDS-ADRDA) criteria for probable AD with recently proposed revisions [31].

All available molecular or pathological evidence (34 PCA; 39 typical Alzheimer's disease) supported underlying Alzheimer's disease pathology (63 had a CSF profile compatible with Alzheimer's disease [32,33]), 3 had positive amyloid PET scans; 10 had autopsy-proven Alzheimer's disease.

The posterior cortical atrophy and typical Alzheimer's disease cases have been included in previous publications [15,16,24,34-38]. All patients provided informed consent under approval from NRES Committee London, Queen Square. Demographic details are summarised in Table 1. There were no significant differences between tAD and PCA groups in either age ($t_{(137)} = .569$, $p = .571$) or symptom duration ($t_{(115)} = 1.907$, $p = .059$). There were more females than males in the PCA group, and more males than females in the tAD group ($\chi^2_{(1)} = 9.35$, p = .002). MMSE [39] scores were not significantly different between tAD and PCA ($t_{(141)} = -1.73$, $p = .085$).

Table 1 – Demographic details for each diagnostic group. Age at onset, symptom duration and MMSE score are presented as mean (SD).

Diagnosis	Total N (F)	Age (years)	Symptom duration (years)	MMSE
tAD	58 (22)	57.1 (6.4)	6.2 (3.0)	19.7 (4.9)
PCA	93 (59)	59.9 (8.1)	5.2 (2.6)	21.2 (5.1)

Neuropsychological assessments

Both groups completed the same neuropsychological battery, thus allowing direct comparisons. The tests included in the principal component analysis are shown in **Error! Reference source not found.** and most are described in Lehmann *et al.* [24], with the addition of letter "A" Cancellation [40], recognition memory for faces [41], and tests of early visual processing. The latter included: hue discrimination (CORVIST [42]), shape discrimination [43], figure/ground separation (VOSP – Visual Object and Space Perception battery [44]), and crowding. Assessments measuring time to complete or number of errors, where a lower value indicates less impaired performance, were inverted so that lower values across all tests indicated worse performance.

Cognitive analysis

All raw cognitive scores were converted to percentages. For time-based measures without a fixed maximum score (letter 'A' cancellation (time); Crowding (time); VOSP dot count (time)), scores were converted to a percentage of the maximum time taken within each cohort. The adequacy of the sample size for each principal component analysis was determined using the Kaiser-Meyer-Olkin measure of sampling adequacy and Bartlett's test of sphericity.

Imputation and component selection

To retain as much information (patients and tests) as possible, missing data were imputed using probabilistic principal component analysis (PPCA) [45], which was also used to select the optimal number of

components for subsequent principal component analysis using the imputed dataset (as described in Ingram *et al.* [27]).

Principal component analysis

We applied separate principal component analyses to the tAD and PCA cohorts to establish the multidimensional space of each presentation independently (this avoids the possible danger of creating false overlaps by fusing the two groups into an unrepresentative single homogenous space). We applied varimax rotation in order to promote cognitive interpretation of the emergent dimensions (as well as comparisons across the two multidimensional spaces). Normalised factor scores were obtained for each patient, for subsequent neuroimaging analyses and creation of the scatterplots.

Having established the multidimensional spaces for tAD and PCA independently, in order to evaluate the degree and nature of any overlap between the two groups we explored whether there were any regions of this multidimensional space which would also be occupied by the other group. This was achieved by projecting the neuropsychological scores from one group through the coefficient matrix of the other group (as both cohorts underwent the same cognitive test battery). The results obtained by projecting PCA patients into the tAD-derived multidimensional space are presented in the supplement. Finally, we calculated Pearson correlation coefficients between scores on all extracted factors and (a) age, (b) symptom duration, and (c) MMSE scores to explore the relationship with disease severity (correcting for multiple comparisons).

Image Acquisition

T1-weighted volumetric MR scans were acquired for 71 healthy controls, 70 PCA patients and 14 tAD patients over a 10-year period from 2005 – 2015. Seven PCA and 5 tAD scans were excluded after image quality assurance due to motion and ghosting artifacts, yielding a total number of 71 healthy control, 63 PCA and 9 tAD scans that were included in the final analyses. The majority of scans (controls: 39; PCA: 44; tAD: 8) were acquired on a Siemens Prisma 3T scanner using a magnetisation prepared rapid acquisition gradient echo sequence (MPRAGE) with a 256x256 acquisition matrix, 282mm field of view and the following acquisition parameters: TE=2.9ms, TR=2200ms and TI=900ms. The remaining images (controls: 32; PCA: 14; tAD: 1) were acquired on a 1.5T Sigma MRI scanner using a spoiled gradient echo (SPGR) sequence with a 256x256 image matrix, a 240mm field of view and the following acquisition parameters: TE=6.3ms; TR=14.2ms and TI=650ms.

Image Pre-processing

Image pre-processing involved the following steps: (1) image format conversion from DICOM to NIFTI; (2) tissue segmentation using SPM's unified model [46] (3) the creation of a study-specific grey matter (GM) segment template using SHOOT; (4) normalisation of the segments to the study specific template that generally matches standard space (MNI) in orientation using SHOOT transformations; (5) modulation to account for local volume changes; and (6) smoothing using a 6 mm full-width at half- maximum Gaussian

kernel to compensate for inaccuracies in spatial alignment and between-subject differences in anatomy. The smoothed, normalised and modulated SHOOT-imported GM segments were then used for analysis. Image pre-processing steps (3)-(6) were performed for the different analyses separately to ensure that the GM segment template only included analysis-specific participant scans.

Voxel-based morphometry

We used whole-brain voxel-based morphometry (VBM) to explore the neuroanatomical substrates (brain atrophy) of the graded variation in cognitive performance in PCA and tAD. VBM analysis was performed using Statistical Non-Parametric mapping (SnPM - [47] – a toolbox within Statistical Parametric Mapping software (SPM12.1 - [48] which allows for pseudo t-statistic images to be assessed for significance using a standard non-parametric multiple comparisons procedure based on permutation testing. Prior to performing the analyses, a whole-brain GM mask was defined to include only voxels for which the intensity was at least 0.2 in at least 80% of the images to circumvent exclusion of voxels most vulnerable to brain atrophy [49].

Correlations Between Grey Matter Volume and Principal Component-Derived Factor Scores

Two VBM regression analyses were performed using factor scores from the PCA-derived multidimensional space, a PCA-only (N=63) and a PCA/tAD combined (N=71) analysis to explore PCA-specific and shared PCA/tAD associations between GM volume and neuropsychological deficits, respectively. Prior to the PCA/tAD combined analysis tAD patients were projected through the PCA-derived coefficient matrix to situate the tAD and PCA cases within the same multidimensional space. A tAD-only analysis (i.e., relating GM volume to factor scores from the tAD-derived multidimensional space with projected scores for PCA cases) was not performed due to the limited number of available tAD scans. Both regression models included smoothed, modulated, and warped GM volume as the dependent variable, the three principal component-generated factor scores as the independent variables, and age at assessment (mean-centred), total intracranial volume (mean-centered) [50], gender and scanner (3T or 1.5T) as covariates. The PCA/tAD combined analysis included group as an additional covariate.

Statistical significance was determined by permutation testing (10,000 permutations) based on peak-voxel inference and set at $p<.05$ (family-wise error corrected). Scatterplots were created to visualise the relationship between GM volume and factor scores.

Grey Matter Volume Changes in posterior cortical atrophy and typical Alzheimer's disease

To aid interpretation of correlation analyses, we assessed differences in voxel-wise GM volume in PCA and tAD relative to healthy controls separately using independent t-tests. Age at assessment (mean-centred), total intracranial volume (mean-centered), gender, group, and scanner (3T or 1.5T) were included as covariates. Effect size maps are presented in Supplementary Materials.

Results

Scores on all neuropsychological tests for tAD and PCA participants are summarised in Table 2.

Table 2 - Neuropsychology test scores and missing data. Neuropsychology test scores shown as percentage of maximum score per group (higher percentage corresponds to less impairment (less errors, faster time to complete). Missing data is shown as percentage missing per group. Significant differences between diagnostic groups on each test assessed through one-way ANOVA; * Welch's W statistic reported due to heterogeneity of variance. Abbreviations: SD – standard deviation; VOSP – Visual Object and Space Perception; CORVIST – Cortical Vision Screening Test.; N correct – number of items correct.

		Posterior cortical atrophy		**Typical Alzheimer's disease**		
Domain	Test	Mean (SD) [min - max]	Missing data %	Mean (SD) [min - max]	Missing data %	Sig.
Visuoperceptual	Usual views	63.5 (30.8) [0.0 - 100.0]	22.6	91.8 (10.4) [65.0 - 100.0]	13.8	* p < .001
	Unusual views	21.7 (23.6) [0.0 - 95.0]	22.6	55.4 (25.5) [5.0 - 95.0]	13.8	p < .001
	VOSP object decision	54.3 (22.1) [25.0 - 100.0]	0.0	81.6 (11.8) [55.0 - 100.0]	1.7	* p < .001
	VOSP fragmented letters	26.3 (27.8) [0.0 - 100.0]	11.8	71.1 (30.6) [0.0 - 100.0]	3.4	p < .001
Early visual	CORVIST hue discrimination	69.1 (32.7) [0.0 - 100.0]	8.6	81.8 (25.2) [0.0 - 100.0]	5.2	* p = .011
	Crowding (time)	80.2 (21.7) [0.0 – 95.3]	26.9	85.1 (13.4) [0.0 – 93.0]	10.3	* p = .127
	VOSP figure/ground	81.3 (15.2) [50.0 - 100.0]	4.3	91.8 (8.2) [70.0 - 100.0]	3.4	* p < .001
	Efron shape discrimination	74.2 (17.1) [50.0 - 100.0]	4.3	88.6 (15.3) [50.0 - 100.0]	5.2	p < .001
Episodic memory	Recognition (words)	74.4 (16.8) [48.0 - 100.0]	29.0	74.9 (18.8) [48.0 - 100.0]	36.2	p = .891
	Recognition (faces)	81.9 (13.1) [48.0 - 100.0]	1.1	64.2 (13.3) [48.0 - 100.0]	34.5	p < .001
Language	Graded difficulty naming	70.5 (27.5) [0.0 - 100.0]	0.0	64.4 (29.6) [0.0 - 100.0]	0.0	p = .197
	Concrete synonyms	82.1 (15.7) [0.0 - 100.0]	11.8	82.7 (12.4) [48.0 - 100.0]	15.5	p = .821
	Baxter spelling	51.7 (31.9) [0.0 - 100.0]	6.5	58.5 (29.7) [0.0 - 100.0]	10.3	p = .219
'Dominant parietal'	Graded difficulty arithmetic	45.3 (18.3) [0.0 - 88.5]	9.7	54.0 (19.3) [0.0 - 88.5]	44.8	p = .027
	Digit span (forwards)	55.5 (21.3) [8.3 - 100.0]	23.7	52.7 (17.4) [16.7 - 100.0]	3.4	p = .411
	Digit span (backwards)	28.3 (14.9) [0.0 - 100.0]	24.7	33.0 (19.9) [0.0 - 100.0]	1.7	* p = .130
	Cognitive estimates	35.2 (22.4) [0.0 - 90.0]	4.3	34.8 (20.8) [0.0 - 90.0]	3.4	p = .910
Visuospatial	Cancellation (N correct)	76.8 (25.7) [0.0 - 100.0]	3.2	95.6 (7.4) [68.4 - 100.0]	5.2	* p < .001
	Cancellation (time)	63.9 (13.9) [0.0 – 89.3]	5.4	52.1 (22.8) [0.0 – 82.2]	5.2	* p = .001
	VOSP number location	30.4 (30.3) [0.0 - 100.0]	4.3	53.5 (40.2) [0.0 - 100.0]	5.2	* p < .001
	VOSP dot count (N correct)	49.2 (33.3) [0.0 - 100.0]	2.2	82.9 (26.3) [0.0 - 100.0]	5.2	* p < .001

	VOSP dot count (time)	74.7 (16.0) [0.0 – 95.7]	49.5	72.2 (18.6) [0.0 – 88.7]	36.2	p = .523

Posterior cortical atrophy

The principal component analysis for the posterior cortical atrophy group was robust (Kaiser-Meyer-Olkin = 0.865) and Bartlett's test of sphericity was significant (approximate $\chi^2 = 1242.972$, d.f. = 231, $p < 0.001$). The 3-factor varimax rotated solution accounted for 61.0% of the total variation in the patients' performance. The variance explained per factor is as follows: Factor 1 (visuoperceptual-early) = 23.0%; Factor 2 (cognitive) = 21.4%; Factor 3 (visuospatial-early) = 16.6%. The factor loadings are shown in Table 3.

Table 3 - Principal components analysis results for posterior cortical atrophy. Factor loadings larger than 0.5 are shaded in grey. Abbreviations: VOSP – Visual Object and Space Perception; CORVIST – Cortical Vision Screening Test.; N correct – number of items correct.

Domain	Test	Factor 1 (visuoperceptual-early)	Factor 2 (cognitive)	Factor 3 (visuospatial-early)
Visuo-perceptual	Usual views	0.894	0.070	0.244
	Unusual views	0.871	-0.037	-0.021
	VOSP object decision	0.857	0.017	0.135
	VOSP fragmented letters	0.648	0.115	0.464
Early visual	CORVIST hue discrimination	0.627	0.198	0.246
	Crowding (time)	0.655	0.222	0.429
	VOSP figure/ground	0.526	0.021	0.460
	Efron shape discrimination	0.454	0.125	0.413
Episodic memory	Recognition (words)	0.770	0.131	0.206
	Recognition (faces)	-0.098	0.548	0.258
Language	Graded Difficulty Naming	0.193	0.781	-0.036
	Concrete synonyms	0.135	0.773	0.103
	Baxter spelling	0.113	0.795	0.165
'Dominant parietal'	Graded Difficulty Arithmetic	0.011	0.743	0.342
	Digit span (forwards)	0.128	0.702	0.077
	Digit span (backwards)	-0.052	0.803	0.042
	Cognitive estimates	-0.202	-0.684	-0.225
Visuo-spatial	Cancellation (N correct)	0.365	0.305	0.589
	Cancellation (time)	0.252	0.220	0.542
	VOSP number location	0.237	0.147	0.814
	VOSP dot count (N correct)	0.163	0.037	0.823
	VOSP dot count (time)	0.186	0.318	0.648

Measures that loaded heavily onto the first factor were tests of visuoperceptual function (usual/unusual views, object decision and fragmented letters), early visual processing (crowding, hue discrimination, shape discrimination and figure/ground discrimination), and recognition memory for words. A common feature of these tests is the identification of stimuli based on their perceptual features; hence we called this factor 'visuoperceptual-early'. This component was not significantly correlated with MMSE (r = .094, p = .377), or age (r = -0.201, p = .057).

The second factor comprised high loadings from tests of recognition memory for faces, language abilities (synonym judgement, naming, spelling), and attention/executive tasks (digit span forwards and backwards, arithmetic, and cognitive estimates). This component was significantly correlated with MMSE (r = 0.603, p < .001) and age (r = .334, p = .001). Given the nature of the test loadings and the correlation with MMSE, we termed this factor 'cognitive'.

The final factor was associated with tests of visuospatial processing (dot counting and number location) and letter cancellation. Moderate loadings were also found for tests of early visual processing and identifying fragmented letters. This component had a significant correlation with MMSE (r = 0.398, p < .001) but not age (r = .039, p = .712). These tests overall require scanning of the visual field/visual search, and abstraction of visuospatial relationships between stimuli. Furthermore, variance associated with early visuoperceptual aspects of some of these visual tasks was already accounted for by the first factor. Accordingly, we called Factor 3 'visuospatial-early'.

To visualise variation along these dimensions, all PCA-patient factor scores were plotted (blue diamonds in Figure 1A-C). These scatterplots demonstrate various important findings: (i) within the PCA group there were three main dimensions of variation; (ii) for all three dimensions, the patients varied in graded ways – i.e., there was no evidence of clusters implicating mutually-exclusive subtypes of PCA; (iii) the analyses added evidence to previous suggestions that there are both visuospatial and visuoperceptual presentations of PCA (i.e., some patients presented with greater impairment in one aspect of visual processing than the other, as well as many cases with dual visual deficits); (iv) there are concurrent, varying levels of generalised cognitive impairment in PCA (Figure 1B&C), consistent with it being commonly associated with underlying AD.

Phenotypic continua in typical Alzheimer's disease and posterior cortical atrophy

We explored whether PCA and typical AD cases overlapped with each other in their respective multidimensional spaces, by projecting factor scores of one group into the multidimensional space of the other. Figure 1A-C show the typical AD cases (red squares) projected into the PCA-defined space. Results showing projection of PCA cases into the tAD-defined multidimensional space are shown in **Error! Reference source not found.**.

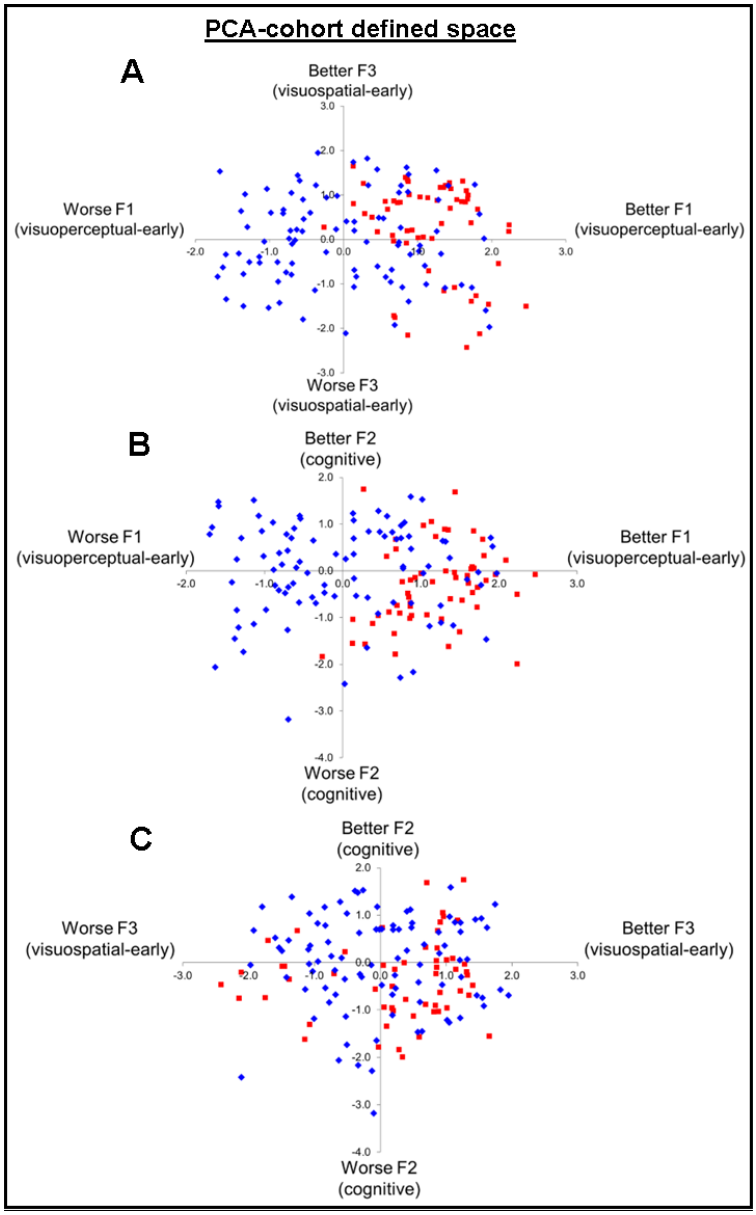

Figure 1 – Graded intergroup phenotypic variation in posterior cortical atrophy and typical Alzheimer's disease. Panels A-C: Typical Alzheimer's disease (tAD) cases projected into posterior cortical atrophy (PCA) multidimensional space. Key: tAD – red squares; PCA - blue diamonds.

These comparative plots illustrate some key observations: (i) there are graded variations along all dimensions in both patient groups; (ii) there is considerable overlap between the tAD and PCA groups on the general cognitive impairment dimension; (iii) the tAD also overlap with the PCA group in terms of the visuospatial and visuoperceptual dimensions (upper-right quadrants of Figure 1A; and the right halves of Figure 1B&C) – again pointing to the observation that the symptomatology of the two groups overlap; (iv) whilst a subset of the PCA cases overlap with the tAD cases, as one would expect, there are PCA cases

with much more pronounced visuospatial and/or visuoperceptual impairment than tAD at the same level of generalised cognitive impairment.

Neural correlates of posterior cortical atrophy multidimensional space

Regional reductions in GM volume in PCA and tAD relative to control groups were consistent with previous investigations (**Error! Reference source not found.**). A detailed summary of the PCA VBM results can be found in Table 4. Lower scores on the visuo-perceptual-early factor (suggesting worse visuo-perceptual function) were associated with decreased GM volume predominantly in right occipital regions. The largest cluster was located in the cuneal cortex and extended inferiorly into the occipital fusiform gyrus and lingual gyrus. Smaller clusters were also found in the occipital pole, lateral occipital cortex, and medial and inferior temporal gyrus. Occipital and occipito-temporal correlates are consistent with the interpretation of this principal component as capturing early visual and visuoperceptual processes.

Lower scores on the cognitive factor were associated with decreased GM volume across a distributed network of left-hemispheric parietal, temporal and frontal regions. The largest cluster within this network was located in the left supramarginal gyrus. The distributed regions associated with performance on this component have been previously associated with higher cognitive functions relating to attention, working memory and phonological processing (refs), implying higher cognitive demands on the tests loading particularly onto this component.

Lower scores on the visuo-spatial-early factor were associated with decreased GM volume predominantly in the right parietal lobe. The largest cluster was located in the right supramarginal gyrus and a smaller cluster located in the superior parietal lobule. These correlates are consistent with the interpretation that this component is capturing variation in spatial and visuomotor processes, both of which place demands on the tests loading particularly onto this component.

Table 4 - VBM results showing brain regions in which GM volume reductions were associated with lower visuoperceptual-early, visuospatial-early and cognitive factor scores in PCA. Rt: right; Lt: left; k: cluster size; P_{FWE}: Family-wise error corrected p-value p<.05 ; x, y ,z: peak-voxel MNI coordinates.

	k	P_{FWE}	T	x	y	z	Brain Region
Visuoperceptual-early Factor	2096	.0001	7.15	14	-75	21	Rt Cuneal Cortex
		.0003	6.58	21	-69	-4	Rt Occipital Fusiform Gyrus
		.0006	6.38	9	-76	0	Rt Lingual Gyrus
	109	.0006	6.40	-12	-42	-39	Rt Occipital Pole
		.0135	5.46	16	-78	-32	Rt Occipital Pole
	24	.0031	5.91	15	-40	-40	Rt Inferior Temporal Gyrus
	81	.0201	5.31	27	-44	-34	Rt Medial Temporal Gyrus
	12	.0231	5.27	-27	-46	-33	Rt Occipital Fusiform Gyrus
	4	.0256	5.23	-20	-39	-33	Rt Lateral Occipital Cortex
Visuospatial-early Factor	124	.0068	5.77	40	-36	34	Rt Supramarginal Gyrus
	69	.0095	5.67	32	-52	44	Rt Superior Parietal Lobule
Cognitive Factor	32	.0092	5.53	-42	-45	38	Lt Supramarginal Gyrus
	21	.0250	5.18	-42	-48	-15	Lt Inferior Temporal Gyrus
	15	.0187	5.28	-56	-44	22	Lt Supramarginal Gyrus
	15	.0200	5.26	-57	-12	-15	Lt Middle Temporal Gyrus
	14	.0107	5.46	-48	4	21	Lt Precentral Gyrus
	14	.0217	5.23	-44	-30	14	Lt Parietal Operculum
	6	.0226	5.21	-48	-40	33	Lt Supramarginal Gyrus
	4	.0215	5.23	-6	-69	44	Lt Precuneus
	2	.0285	5.13	-46	-44	-9	Lt Inferior Temporal Gyrus
	1	.0309	5.02	-36	-9	6	Lt Insula Cortex
	1	.0437	4.97	-62	-27	21	Lt Parietal Operculum

Shared neural correlates of cognition across phenotypes

Overall, plotting tAD within the PCA-defined principal component analysis multidimensional space shows overlapping visual and cognitive profiles. To explore this further, these multidimensional profiles were related to underlying neuroanatomy using whole-brain VBM analysis incorporating a subset of tAD participants with available MRI. Figure 2 shows the results of this combined analysis including patients with PCA and tAD.

In line with the combined analysis comprising mostly PCA participant scans (PCA n=63; tAD n=9), associations between factors and regional GM volume are broadly consistent with analyses restricted to the PCA group. For the largest cluster associated with each principal component, the GM volume in the cluster is plotted against the factor score for every patient *in Figure 2Bi-iii. In* relation to the distribution of PCA factor scores, the tAD participants appear to be shifted leftwards on cognitive compared to visuospatial-early and visuoperceptual-early factors. At the individual level, several tAD participants exhibit scores on visuoperceptual-early factors and lingual gyral atrophy which are commensurate with PCA group mean scores/atrophy.

Additional correlates identified through combined analysis include lower visuospatial-early factor scores being associated with precuneal GM decreases (Table 5). These may relate to neuropsychological deficits and atrophy patterns (for example, diminished visuospatial functioning and precuneal atrophy) which are common across PCA and tAD, particularly given the relatively young age of our tAD sample.

Table 5 - VBM results showing PCA/tAD shared brain regions in which GM volume reductions were associated with lower visuo-perceptual, visuo-spatial and cognitive factor scores. Rt: right; Lt: left; k: cluster size; PFWE: Family-wise error corrected p-value p<.05 ; x, y ,z: peak-voxel MNI coordinates.

	k	P_{FWE}	T	x	y	z	Brain Region
Visuo-perceptual Factor	2038	.0003	6.66	8	-75	-2	Rt Lingual Gyrus
		.0003	6.64	10	-74	20	Rt Intracalcarine Cortex
		.0003	6.48	11	-69	-4	Rt Occipital Fusiform Gyrus
	27	.0014	5.99	42	-93	20	Rt Occipital Pole
	26	.0050	5.64	51	-80	8	Rt Lateral Occipital Cortex
	10	.0109	5.42	45	-15	-34	Rt Inferior Temporal Gyrus
	58	.0169	5.26	36	-46	6	Rt Medial Temporal Gyrus
	2	.0446	4.92	-20	-70	-8	Rt Occipital Fusiform Gyrus
Visuo-spatial Factor	120	.0035	5.78	40	-36	34	Rt Supramarginal Gyrus
	44	.0020	6.02	50	-62	24	Rt Lateral Occipital Cortex
	28	.0140	5.28	30	-54	44	Rt Superior parietal lobule
	21	.0186	5.18	46	-28	30	Rt Parietal Operculum
	17	.0139	5.28	6	-46	50	Rt Precuneus
	14	.0240	5.10	30	-44	44	Rt Superior Parietal Lobule
	4	.0385	4.94	4	-51	34	Rt Cingulate Gyrus
Cognitive Factor	69	.0051	5.56	-46	-42	33	Lt Supramarginal Gyrus
	60	.0067	5.46	-42	-48	38	Lt Angular Gyrus
	60	.0107	5.30	-56	-57	-2	Lt Medial Temporal Gyrus
	55	.0411	4.85	-45	-46	18	Lt Inferior Temporal Gyrus
	24	.0143	5.20	-39	-70	-28	Lt Lateral Occipital Cortex
	4	.0211	5.08	-4	-69	44	Lt Precuneus
	4	.0326	4.92	-54	-45	24	Lt Supramarginal Gyrus

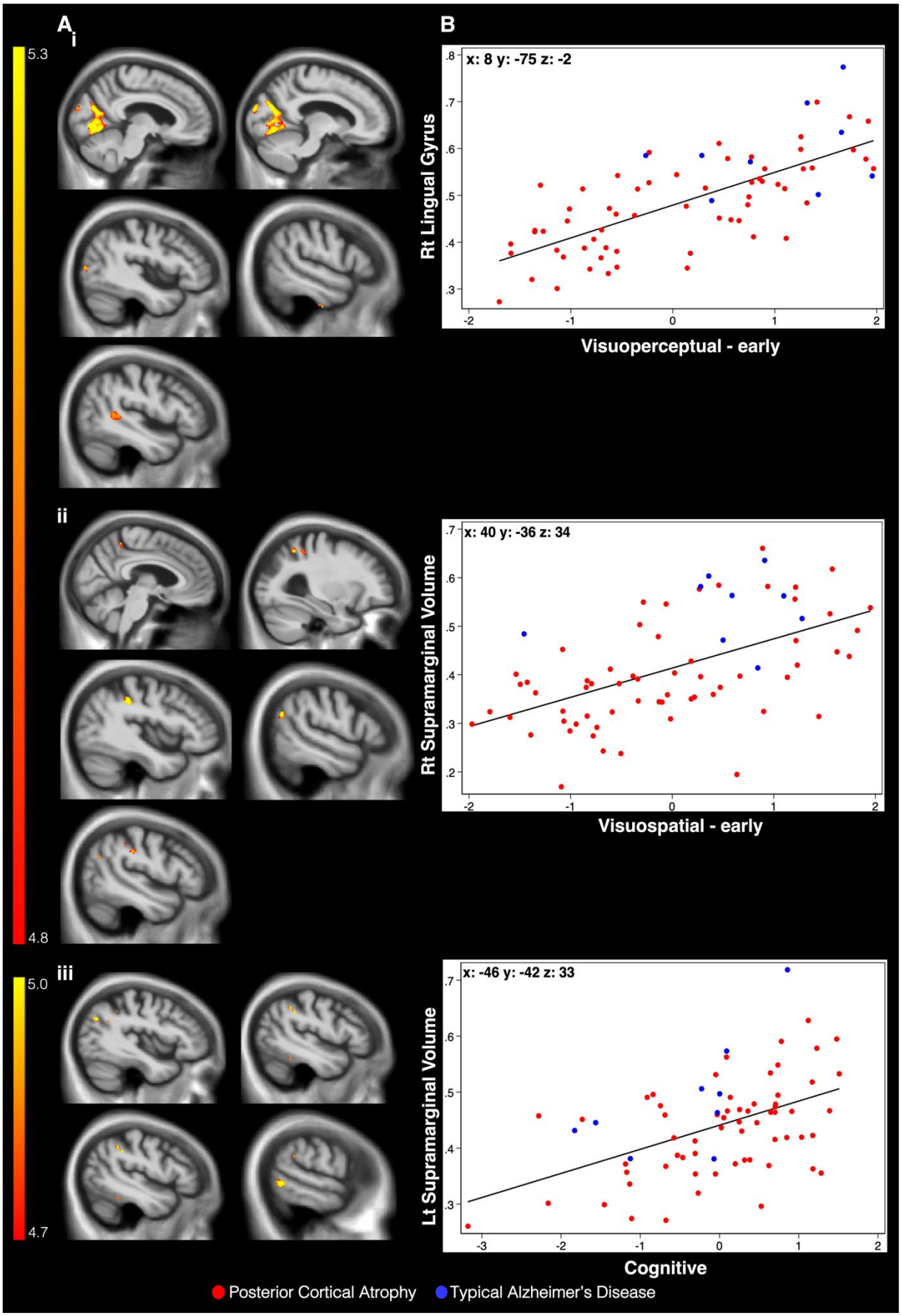
A
i
5.3
4.8
ii
iii
5.0
4.7
B
x: 8 y: -75 z: -2
Rt Lingual Gyrus
Visuoperceptual - early
x: 40 y: -36 z: 34
Rt Supramarginal Volume
Visuospatial - early
x: -46 y: -42 z: 33
Lt Supramarginal Volume
Cognitive
Posterior Cortical Atrophy
Typical Alzheimer's Disease

Figure 2 - Whole-Brain VBM Results in PCA & tAD. Presented are A) statistical parametric maps of significant positive associations between neuropsychological performance and GM volumes in PCA and tAD. FWE-corrected significant p < .05 regions, identified by permutation-based peak-voxel inference, are shown overlaid on normalised study-specific T1-weighted group templates. Colour bar represents t-values.; and B) correlations between neuropsychological scores and participant-specific mean cluster GM volume values (largest significant cluster) by group as scatterplots. MNI coordinates (mm) at peak voxel are shown in bold. Rt: right; Lt: left; i: visuoperceptual-early factor, ii: visuospatial-early factor and iii: cognitive factor.

Discussion

The presence of AD phenotypic variations poses particular challenges for correct diagnosis and clinical management [4,7]. This large scale data-driven comparison of PCA and tAD allowed us to consider to what extent varying presentations of AD are separable, mutually exclusive clinical categories or gradedly-different positions within a shared, transdiagnostic multidimensional space. We subsequently explored whether the cognitive impairments demonstrated in PCA and tAD were associated with the same neural correlates (or could be driven by atrophy in disparate brain regions). The current study provides evidence of overlapping features (visual, cognitive, and posterior cortical) in a large sample of PCA and tAD participants administered the same detailed neuropsychological battery. Findings extend separate work investigating variation within PCA [51,52] and within AD [53] to characterise clinico-radiological overlap between PCA and tAD.

Results were broadly consistent with the conceptualisation of tAD and PCA as varying continuously on a spectrum of cognitive-neuroanatomical changes: (1) both tAD and PCA data generated dimensions of graded and not clustered variation in terms of generalised cognitive and visual impairments; (2) the variation in visual impairment split into two orthogonal visual dimensions for the PCA group, contrasting predominantly visuospatial vs. visuoperceptual functions [14,17]; (3) there was considerable overlap of the two patient groups along these dimensions, (4) the relationship between cognitive impairments and underlying regions of brain atrophy in PCA persisted in tAD. In the remainder of the Discussion, we will consider the graded nature of the identified phenotypic variations and the implications for future clinical research and practice.

Continua of visual processing impairment

Plotting PCA and tAD in the respective multidimensional space from the principal component analysis demonstrated graded variation within and between these groups with respect to visual processing impairments. In terms of intragroup variation, the PCA cohort varied in a graded manner along the emergent orthogonal dimensions for visuoperceptual and visuospatial processing. This finding aligns with previous reports of overlapping clinical presentations and distributions of atrophy in the proposed dorsal/ventral subtypes of PCA [6,22,24,51,52]. We found PCA cases who scored high on one visual dimension and low on the other (top left corner and bottom right corner of Figure 1A), reflecting individual patients with a more selective impairment in visuoperceptual or visuospatial processing. However, there was no

evidence of distinct groups of cases displaying these selective presentations (there was graded variation along both dimensions). Thus, studies which seek to compare presentations of PCA by defining groups using inclusion criteria, cut-offs [24] or clustering methods [16,23] might give the impression of categorical distinctions between these forms of PCA by only sampling/comparing these 'corners' of the phenotypic 'space'.

There was also graded variation between PCA and tAD in visual processing impairment. As expected, a good proportion of the PCA patients had more severe visuospatial and/or visuoperceptual impairments than the tAD cases. However, there was a subset of tAD cases who overlapped with PCA cases on the visual processing dimensions (Figure 1C), indicating visual deficits commensurate with mild to moderate PCA. This finding aligns with previous early reports of AD cases with pronounced visual processing deficits [2,18] and recent findings suggesting a substantial proportion of tAD patients exhibit predominant visuospatial deficits [54]. Although visual processing impairments are not necessary or sufficient for diagnosis of typical AD, it is generally recognised that visuospatial deficits can be present or emerge later [55]. The profile of tAD with visual deficits commensurate with mild to moderate PCA was not confined to tAD cases with globally poor performance; some tAD cases presented with impaired visual processing even when their general cognitive status was better than most other cases (top left quadrants of Figure 1C).

Overall, these findings provide support for the core hypothesis for this PCA and tAD comparison study, namely that both within and between presentations of AD and PCA, there is evidence of graded variation along phenotypic continua. Specifically, there is evidence of a graded dimension of visual impairment that is independent of variation in general cognitive status.

Shared variation in general cognitive status

In addition to the overlap in visual processing impairments, considerable overlap of tAD and PCA on the emergent cognitive dimensions reiterates the importance of non-visual impairments in PCA [6,56,57]. Fully characterising cognitive impairments in PCA is important because these symptoms could contribute to the misdiagnosis of PCA [7,21,58]. Additionally, highlighting the extent of overlap in cognitive symptoms between typical AD and PCA (and other phenotypes associated with AD) could inform development of treatments and therapies which could be extended to and from typical and atypical AD [59,60].

Shared neurodegenerative origins of cognitive impairments

The results of the combined VBM analysis suggest that atrophy in the extracted clusters is associated with impairment along the extracted cognitive dimensions, regardless of diagnostic group. Neuroimaging findings imply that overlapping cognitive features in these forms of dementia may arise from atrophy in similar brain regions. This supports the conceptualisation of PCA and tAD as being within a shared, multidimensional phenotypic space, perhaps relating to graded neurodegeneration of functional brain networks [19], rather than as discrete subtypes caused by Alzheimer's disease pathology (for a parallel

proposal for the overlapping variations of logopenic progressive aphasia and tAD, see: Ramanan *et al.* [30]).

Implications of graded variation

Our results indicate that a simple categorical distinction between tAD and PCA based on diagnostic criteria would fail to capture the evident graded differences between these phenotypes. This raises the issue of how to relate graded, multidimensional approaches to traditional, categorical classification systems [29,61]. The latter provide a useful diagnostic short-hand for clinicians, and may be useful for contrastive group-level analysis [62]. We are not proposing that the diagnostic labels should be abandoned entirely. Rather, being able to place cases from different diagnostic categories into a shared, transdiagnostic multidimensional space can highlight key intra- and inter-subgroup variations, enhancing our understanding of the diagnostic categories themselves [25,26,29]. This approach is able to capture both graded phenotypic variation, included more atypical examples and mixed cases, as well as highlight more category-like phenotypes if they are present [27]. Thus, a comprehensive 'picture' of an individual patient could include their broad label and their nuanced multidimensional profile.

Limitations

Although the cohorts in this study met the respective neuropsychological criteria for tAD and PCA, molecular/pathological evidence of AD was only available for a subset of cases. In future work, it will be important to confirm the molecular/pathological AD status in these cases to extend these findings towards understanding the heterogeneity caused by AD pathology specifically [1]. Principal component analyses, like neuropsychological investigations more generally, are constrained by the types and coverage of the assessments included. The current study was designed to evaluate the expected neuropsychological features of PCA and thus less typical symptoms, such as motor and non-visual perceptual features [56,57,63], were omitted. When new types of assessment are included then additional dimensions can emerge if there is substantive variation of the patient group in this regard [64 65]. Finally, we note that the tAD group in this study, whilst age-matched to the PCA cases, were relatively young compared to the wider tAD population: 15/58 (25%) tAD cases younger than 60. This could mean they were more likely to have a predominant non-memory impairment [14], which could have influenced the overlap in cognitive and visual presentations in our tAD and PCA cohorts.

Further applications and future directions

The results of the current study show that this test-case exploration of phenotypic continua in tAD and PCA has promise for uncovering the nature of variation between different clinical presentations of AD. Future research could extend this beyond tAD and PCA, to explore (i) the full extent of variability in all clinical phenotypes associated with AD pathology, and (ii) variation within PCA due to different aetiologies (e.g., AD, Lewy body disease, corticobasal degeneration [6]). Establishing the underpinning multidimensional space in these samples would then provide an alternative framework in which variations along each dimension (rather than differences between groups) can be related to the underpinning

neuroimaging and neurobiological features [26,29,61]. Building from situating only tAD and PCA within the same multidimensional symptom-atrophy space, future research could extend this to canonical AD clinical phenotypes to explore the network degeneration hypothesis [1,7]. This would build on important earlier work [2,29], which has captured graded differences between subgroups of neurodegenerative disease instead of comparing groups of cases based on their diagnostic label.

This multidimensional approach could also inform clinical diagnosis and treatment/management pathways directly. By formally mapping the nature and variation of patients within an aetiology it gives a clearer picture of the patient variations that should be recognised as belonging to each diagnostic group and thus, potentially suitable for tailored interventions. This includes the frequent numbers of patients presenting to diagnostic clinics with a “mixed” clinical syndrome [5], who may in fact represent a coherent position in the graded multidimensional space. Furthermore, establishing the principal components of each aetiology might also generate transdiagnostic treatment options, as has been argued recently for the shared apathy and impulsivity symptomatology observed across different graded subtypes of frontotemporal lobar degeneration [66].

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Author contributions

RUI, GP, AH, MALR contributed to the conception and design of the study; KXXY, SC contributed to the acquisition of the data; RUI, DO, GP, AH, DC, MALR, KXXY contributed to the analysis of the data; RUI, DO, GP, AH, DC, MALR, KXXY, SC contributed to drafting the text; RUI, DO, DC, MALR, KXXY contributed to preparing the figures.

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Conflicts of interest

Nothing to report.

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