Pathway-specific progression of Tau pathology in the human thalamus

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Misfolded hyperphosphorylated pathological Tau proteins (pTau) define many neurodegenerative diseases including Alzheimer's disease, yet propagation within brain networks remains to be defined. Here we mapped the distribution of pTau at various stages of cortical pathology in *post-mortem* human thalamus. We found that calretinin-expressing neurons of the anterodorsal nucleus are highly vulnerable to pTau even at the earliest stage. At the subcellular level, pTau filaments were detected in cell bodies and at both postsynaptic and presynaptic sites. Moreover, pTau accumulated in large presynaptic vesicular-glutamate-transporter-2-containing terminals arising from the mammillary body, but not in small corticothalamic terminals, suggesting that Tau crosses synapses at select glutamatergic synaptic sites. These data define a subcortical route of Tau propagation that may drive pathology via the thalamus to the cortex.

One-Sentence Summary: Synaptic terminals containing vesicular glutamate transporter 2 preferentially accumulate pathological Tau proteins in the human thalamus.

Introduction

A major function of Tau is to mediate the assembly of microtubules. The accumulation and apparent 'prion-like' spread of pathological forms of Tau (pTau) are associated with a wide range of neurodegenerative diseases including Alzheimer's disease (*1-3*). The cellular and neurochemical routes of pTau spread in the human brain remains uncertain and animal models cannot exactly recapitulate it.

Early impairments in spatial navigation and episodic memory are associated with pathology in the entorhinal cortex (EC) and hippocampus (*4, 5*). These cortical areas are dependent on subcortical regions of the Papez circuit, which includes the anterior thalamic nuclei and mammillary bodies (*6, 7*) (Fig. 1A). The anterior thalamic nuclear group, located within the rostral part of the thalamus, comprises anterodorsal (ADn), anteroventral (AV), and anteromedial nuclei, which receive glutamatergic input from different regions of the mammillary bodies (Fig. 1A). Lesions impair spatial memory in rodents (*8-10*), and degeneration in humans causes memory deficits (*11*). Earlier data have shown cell loss, extracellular amyloid deposits and neurofibrillary tangles in the anterior nuclear complex (*3, 12*), indicating a potential role for specific rostral thalamic nuclei in driving Alzheimer's disease-related memory impairments. However, the exact subcellular compartments (such as axons and dendrites) containing pTau have not been determined, with descriptions typically limited to neurofibrillary tangles and neuropil threads. Compared to the vast and layered cerebral cortex, adjacent thalamic nuclei (or even subfields of the same nucleus) exhibit markedly different cortical and subcortical connectivity (*13-16*). This provides a unique opportunity for understanding the spread of pTau and the sites of vulnerability.

Strong and early vulnerability of the anterodorsal thalamic nucleus to Tau pathology

We examined the rostral thalamus at early (n=9), middle (n=5), and late (n=4) 'Braak Tau stages' of disease progression (see Methods) (*1*) and compared these with the hippocampal formation, parahippocampal gyrus, and cingulate gyrus (Fig. 1A-F, S1 and S2; Table S1, S2, S3 and S4). We quantified pTau coverage and pTau-immunoreactive (pTau+) cells using the AT8 antibody, which recognizes phosphorylated serine 202 and threonine 205 residues of Tau (*17*), in 50-µm-thick sections from perfusion-fixed human brains using a pixel classifier (Fig. 1G and H, S3; Table S1; Methods). We confirmed these data with a pTau-intensity scoring system in a larger number of samples comprising the perfusion-fixed sections and 10-µm-thick formalin-fixed paraffin-embedded (FFPE) sections (Fig. 1I and J; Table S4; n=18 cases).

We observed pTau+ cells and processes restricted to the ADn at stage 0 (n=3/4 cases; coverage=0.56%, pTau+ cells=1.29 mm^{-2}, intensity score=1; Fig. 1A, G, H and I, 2A). In contrast to the ADn, at early stages (defined here as Braak stages 0-I), other rostral thalamic nuclei, even those adjacent to the ADn such as the AV nucleus, distinctly lacked pTau (Fig. 1A and 2A; Table S3 and S4). Among the postsynaptic targets of the ADn (*18, 19*), both the EC and granular retrosplenial cortex (RSg), but not the presubiculum (PreS), exhibited sparse pTau (EC score=1, n=3 cases; RSg score=0.5, n=2 cases; Fig. 1B and J; Table S4).

At middle stages (Braak stages III-IV), the ADn contained moderate levels of pTau (coverage=8.54%, pTau+ cells=11.65 mm^{-2}, intensity score=2; Fig. 1C, G, H and I, S1; Table S3 and S4), whereas other rostral thalamic nuclei showed sparse pTau (AV: coverage=0.15%, pTau+ cells=14.49 mm^{-2}, score=0.5; paraventricular nucleus (PVT): coverage=0.96%, pTau+ cells=1.91 mm^{-2}, score=1.35; Fig. 1C, G, H and I, S1; Table S3 and S4). In the cortex, pTau was observed at moderate-to-intense levels, with the RSg, EC and prosubiculum (ProS) showing intense pTau

immunoreactivity; the PreS displayed sparse immunolabeling at this stage (RSg score=3; EC score=3; ProS score=3; PreS score=1; Fig. 1D and J; Table S4).

At late stages (Braak stages V-VI), which had Alzheimer's disease (Table S1 and S2) (*1*), intense pTau was observed in the ADn, with a high density of pTau+ cells (coverage= 36.31%, pTau+ cells=118.89 mm^{-2}, intensity score=3; Fig. 1E, G, H and I, S2; Table S3 and S4). The laterodorsal nucleus (LD) showed a high pTau density in the late stages, matching that of the ADn (Fig. 1I and S2; Table S4). The PVT had a similar pTau coverage to middle-stage ADn (11.62%, score=; Fig. 1C, E, G and I, S2; Table S3 and S4) and had the highest pTau+ cell count after the ADn (29.13 cells mm^{-2}). The reuniens nuclear complex (RE) was similarly affected (score=2). In contrast, the AV had lower coverage and pTau+ cell counts (coverage=6.28%, pTau+ cells=14.49 mm^{-2}, intensity score=2) followed by the mediodorsal nucleus (MD), which remained relatively sparse compared to the other examined nuclei (coverage=1.62%, pTau+ cells=2.84 mm^{-2}, score=1; Fig. 1E, G, H and I; Table S3 and S4). The GABAergic thalamic reticular nucleus (TRN) lacked pTau immunopositive cell bodies; only axons and axon terminals were pTau+ (coverage= 2.98%, pTau+ cells=0 mm^{-2}, score=2 Fig. 1E, G, H and I, S2, Table S3 and S4), consistent with published data (*20*). In the cortex, pTau severely affected each examined area (Fig. 1F and J; Table S4), consistent with previous studies (*1*).

In addition to neuronal pTau, we observed pTau-immunopositive (pTau+) 'coiled bodies' in the ADn (Fig. S4A). Based on their size (~10 µm) and shape, we suggest that coiled bodies are localized to oligodendrocytes, which are typically overlooked in Alzheimer's disease (*21, 22*). We also detected pTau+ astrocytes, which are associated with both ageing and Alzheimer disease (*23, 24*). Interestingly, we could find pTau+ astrocytes of varying shape and size, even within the same brain regions of the same cases (Fig. S4B, Table S2). This suggests that pTau can accumulate in a variety of different kinds of astrocytes (*23*). These results reveal that distinct nuclei of the rostral thalamus are affected early on by pTau, with the ADn consistently having the highest pTau density and pTau+ cells across all stages (Fig. 1A, C, E, G, H and I, 2A).

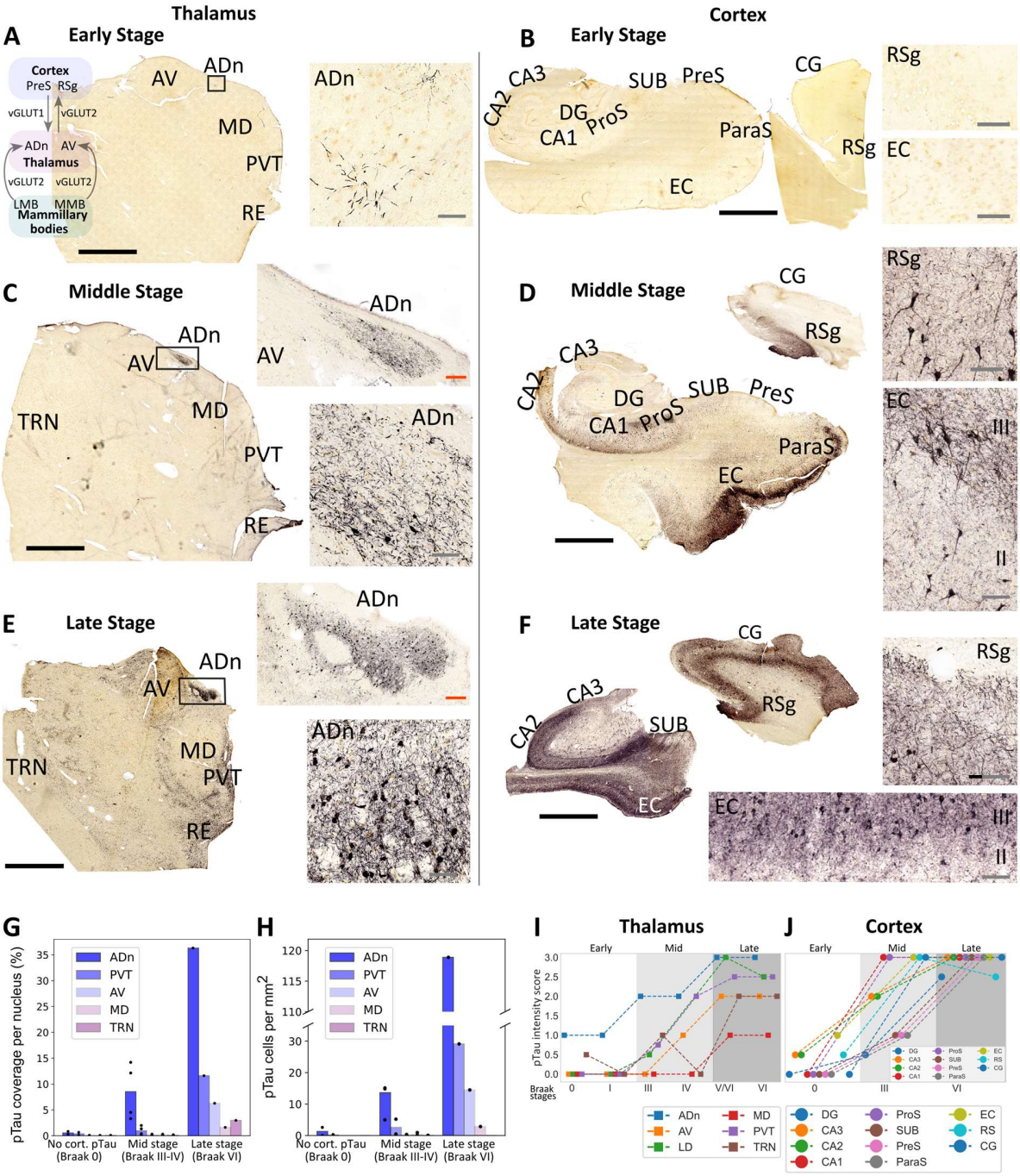


Figure 1. Progression of Tau pathology in the rostral thalamus and the cerebral cortex. (**A-F**) Brightfield images of pTau (AT8 immunoreactivity; HRP-based diaminobenzidine (DAB) end-product) in 50-µm-thick sections of rostral thalamus, hippocampal formation, parahippocampal gyrus, and cingulate gyrus. (A) Braak Stage 0, Case 5. Note pTau+ dendrites in the ADn (right). Inset, schematic of neural circuit. (B) Braak Stage 0, Case 5. Note lack of pTau immunoreactivity in the cortex. (C) Braak stage III, Case 12. (D) Braak stage III, Case 11. (E) Braak stage VI, Case 17. (F) Braak stage VI, Case 17 (cingulate gyrus) and Case 19 (hippocampal formation). (**G-H**) Quantification of pTau coverage (G) and pTau+ cells (H) for early (n=2), middle (n=3), and late (n=1) stage cases. (**I-J**) Scoring of pTau intensity across different thalamic nuclei (n=18 cases) and cortical areas (n=8 cases). Scores: undetectable pTau (0), trace inclusions

(0.5), sparse (1), moderate (2), dense (3). Median values are shown (see Table S4 for individual datapoints). Abbreviations: ADn, anterodorsal nucleus; AV, anteroventral nucleus; MD, mediodorsal thalamic nucleus; PVT, paraventricular thalamic nucleus; RE, reuniens nuclear complex; TRN, reticular thalamic nucleus; DG, dentate gyrus; ProS, prosubiculum; PrS, presubiculum; ParaS, parasubiculum; EC, entorhinal cortex; CG, cingulate gyrus; RSg, granular retrosplenial cortex; LMB, lateral mammillary nucleus; MMB, medial mammillary nucleus. Scale bars: black, 4 mm; red, 250 µm; gray, 80 µm.

Calretinin-expressing neurons accumulate pTau in the rostral thalamus

We noticed that thalamic nuclei vulnerable to pTau were in calretinin (CR)-enriched regions (Fig. 2A, S1, S2) (*25*) and hypothesized that CR+ neurons were sensitive to accumulating pTau. We performed double immunolabeling with CR and AT8 (for pTau) and observed colocalization in neurons within the ADn, PVT, and RE (Fig. 2A-D). In the TRN, CR-enriched neurons lacked pTau (Fig. 2F), consistent with the distinct lack of pTau+ TRN cell bodies (Fig. 1H). Since the ADn contained pTau+ neurons even at stage 0 (Fig. 1A and H, 2A), we tested whether CR+ neurons were affected at early, middle and/or late stages. Even at Braak stage 0, CR was detected in the majority of pTau+ neurons (64.3% CR+, n=1 case; Fig. 2A, B, and E). In the middle stage, a large proportion of pTau+ cells were CR+ (81.1%; n=3 cases; Fig. 2C and E), and in the late stage, 71.1% were CR+ (n=1 case; Fig. 2D and E). In conclusion, CR-expressing neurons were affected very early on, and at every stage, the majority of pTau immunopositive cells were CR+ in the ADn.

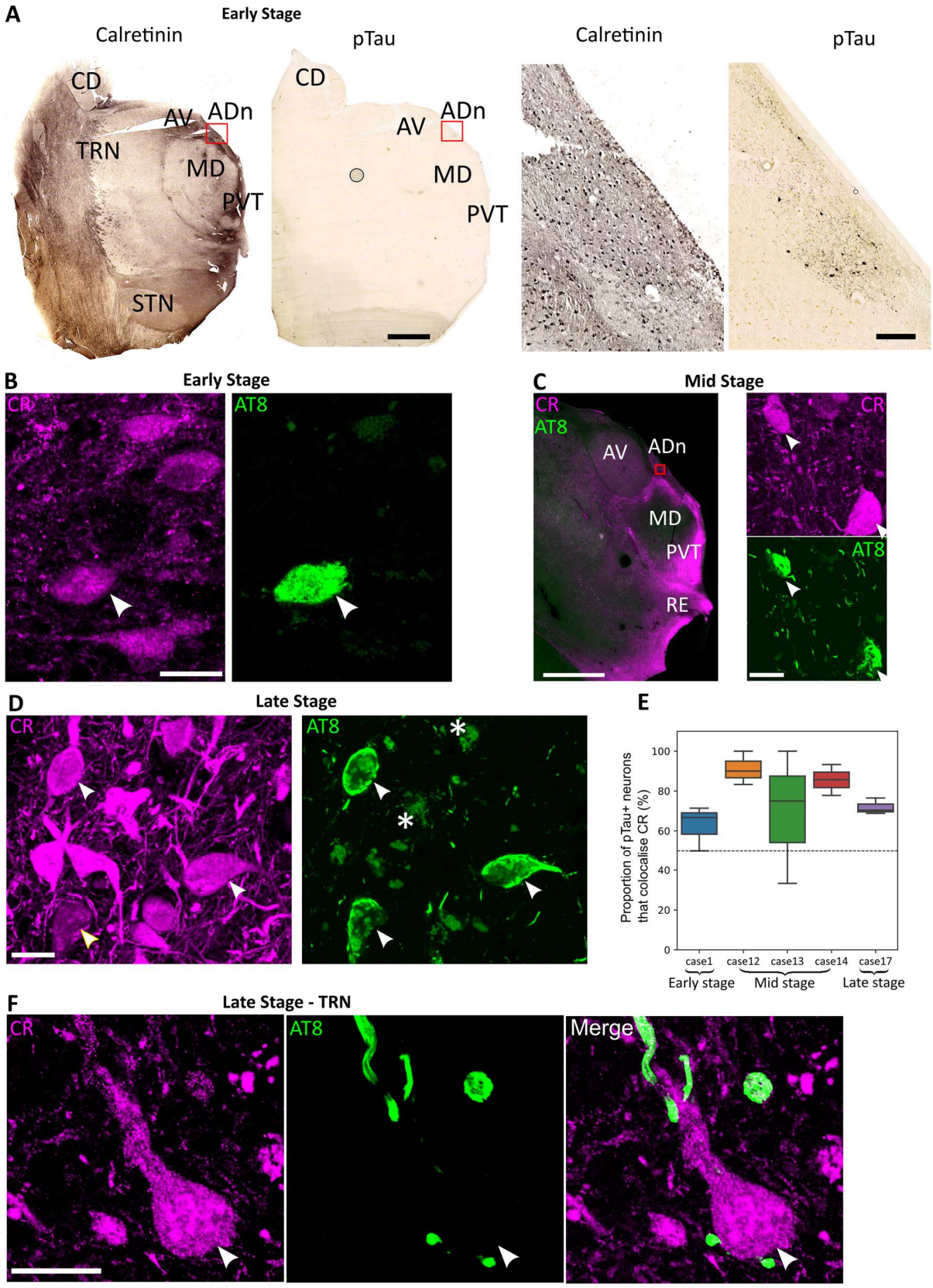
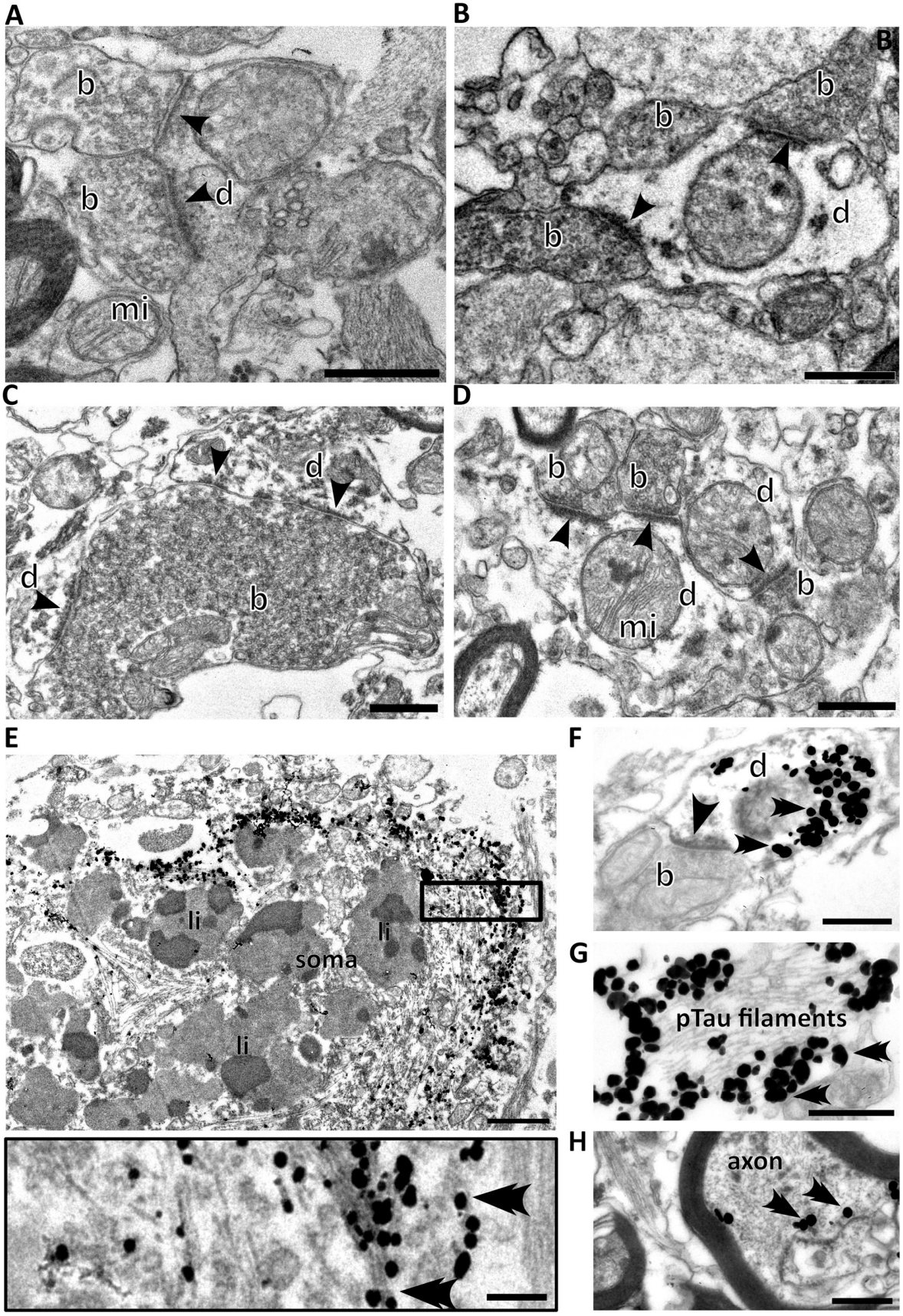

A
Early Stage
Calretinin
pTau
Calretinin
pTau
CD
AV
ADn
TRN
MD
PVT
STN
CD
AV
ADn
MD
PVT
B
Early Stage
CR
AT8
C
Mid Stage
CR
AT8
AV
ADn
MD
PVT
RE
CR
AT8
D
Late Stage
CR
AT8
E
Proportion of pTau+ neurons that colocalise CR (%)
100
80
60
40
20
0
case1
case12
case13
case14
case17
Early stage
Mid stage
Late stage
F
Late Stage - TRN
CR
AT8
Merge

Figure 2. pTau-containing neurons in the anterodorsal thalamic nucleus express calretinin. (**A**) Brightfield images of the rostral thalamus at Braak Stage 0 (Case 1, FFPE, 10-µm-thick section). Left, adjacent sections immunoreacted for calretinin (CR) and AT8 (pTau) visualized with HRP-based DAB reaction end-product. Right, enlarged view of the ADn (red boxed region) revealing CR+ and pTau+ neurons. (**B-D**) Subpopulations of calretinin (CR) immunoreactive neurons (magenta) colocalize pTau (AT8, green; white arrowheads) in the ADn. (B) Early stage (Case 1, FFPE sample), confocal z-projection (5.7 µm thick). (C) Middle stage (Case 12, perfusion-fixed, 50-µm-thick section). Left, widefield fluorescence. Right, detail CR and AT8 colocalization in the ADn from an adjacent section (red boxed region), confocal z-projection (3.7 µm thick). (D) Late stage (Case 17, perfusion-fixed, 50-µm-thick section), confocal z-projection (3.9 µm thick). Faded green signal is lipofuscin (e.g. asterisks). (**E**) Box plots of the percentage of AT8 immunoreactive cells in the ADn that were immunopositive for CR. (**F**) In the TRN, a CR+ neuron in close apposition to pTau+ boutons lack pTau (arrowhead, soma). Confocal z-projection, 2.2 µm thick (C). Scale bars: 4 mm (A left, C left); 250 µm (A right); 100 µm (C right); 20 µm (B, D, F). Abbreviations: CD, caudate nucleus; STN, subthalamic nucleus.

Subcellular distribution of pTau in the anterodorsal thalamus

After establishing that ADn neurons were especially vulnerable to pTau, we investigated the subcellular distribution of pTau in order to reveal how it spreads. To define synaptic structures at different stages of Tau pathology, we examined ultrathin (~50-70 nm) sections of the ADn. We were able to obtain electron microscopic samples from 5 cases (Cases 3, 4, 12, 17; Table S1 and S2); 3 cases were appropriately preserved for quantitative analysis (Fig. 3A-D; Braak stages 0, III, and VI). We identified two main types of synaptic boutons with asymmetric synapses: large ~1-8 µm boutons (Fig. 3C, Fig. S5A-C), consistent with presynaptic axon terminals from the mammillary body (*26*), and small <~1 µm diameter boutons (Fig. 3D, Fig. S5A-C), resembling 'classical' cortical presynaptic terminals (*27*). Some presynaptic boutons from stage 0 (n=20/70) and stage VI (n=31/103) had a highly electron opaque ('dark') appearance, ranging from a homogeneous state to others with recognisable vesicles and mitochondria, but all showing collapsed, scalloped forms (Fig. S6A). This may indicate degeneration of certain nerve terminals, and/or be a sign of selective vulnerability to *post-mortem*/fixation conditions (*28, 29*); these terminals were omitted from our quantification.

To identify subcellular pTau, we first examined cell bodies in the ADn, which contained abundant filaments (Fig. 3E). These resembled filaments previously found in the cortex of tauopathies including Alzheimer's disease (*2, 30, 31*). We visualized pTau with silver-enhanced immunogold particles, and observed that pTau was specifically associated with the intracellular filaments (Fig. 3E), thus unequivocally demonstrating the association of pTau with the originally described paired helical filaments (*32*) at the ultrastructural level. Cell bodies also contained abundant lipofuscin (Fig. 3E and 2D). Filaments immunolabeled for pTau were also localized to dendrites (Fig. 3F, S6B-D), and could be observed in large bundles (>1 µm) (Fig. 3G, S6D). Filament bundles were immunolabeled predominantly on the cytoplasmic surface, most likely due to reagents not penetrating into the bundle (Fig. 3G). We also detected pTau in myelinated axons (Fig. 3H). Given that pTau was localized to a variety of subcellular domains, we next investigated whether pTau can also be associated with axon terminals in the ADn.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li
li
soma
li
F
d
b
G
pTau filaments
H
axon

Figure 3. Electron micrographs of synaptic elements and Tau filament-bearing structures in the human anterodorsal thalamic nucleus. (**A-D**) Unlabeled synaptic boutons (b) and dendrites (d) forming synaptic junctions (arrowheads): (A, B) early stage (Braak stage 0, Cases 3 and 4); (C) middle stage (Braak stage III, Case 12); a large bouton containing a high density of synaptic vesicles forms multiple synapses with its postsynaptic partners; (D) late stage (Braak stage VI, Case 17), small terminals form junctions (arrowheads) with small caliber dendrites. (**E-H**) Immunolabeling for pTau (AT8, gold-silver particles, all from Case 17, Stage VI): (E) localization of pTau in a cell body containing lipofuscin (li); inset, detail of the boxed region showing immunolabeled pTau filaments (double arrowheads mark gold-silver particles); (F) a thin, p-Tau+ dendrite receiving an asymmetric synapse (arrowhead) from a small bouton (b); (G) high power image of paired helical filaments associated with silver intensified immunogold particles demonstrating pTau immunoreactivity; (H) pTau immunolabeling in a myelinated axon. Scale bars: 0.5 µm (A-H), 0.25 µm (E inset).

Subcortical vesicular transporter 2-expressing presynaptic terminals preferentially contain pTau

Large presynaptic terminals of subcortical origin contain vesicular glutamate transporter 2 (vGLUT2) (*16*). We observed strongly overlapping distributions of vGLUT2 and AT8 immunoreactivities at the light microscopic level, especially in the ADn, RE, PVT, and internal medullary lamina (Fig. 4A). The overlapping vGLUT2 and AT8 distributions suggested that vGLUT2 may be related to pTau. When we examined ultrathin sections immunoreacted for both vGLUT2 and AT8, we discovered that pTau was localized to vGLUT2+ boutons (Fig. 4B, S6B). Whereas some vGLUT2+ boutons showed no signs of abnormalities (Fig. 4C), others were degenerating (Fig. 4D), similar to the unlabeled material (S6A). The degenerating vGLUT2+ boutons had clumped mitochondria (Fig. 4D). Many of these boutons contained large (80-100 nm) double-walled vesicles (Fig. 4D) (*30*), consistent with autophagy or the packaging and/or potential release of different forms of Tau (*33, 34*). Not all vGLUT2-positive degenerating boutons displayed detectable pTau, at least in the sections that we examined. In some degenerating boutons which were immunoreactive for both vGLUT2 and pTau, pTau-positive bundles of filaments occupied a large proportion of the volume crowding out vesicles (Fig. 4B and E), which may cause impairments in neurotransmission. We also observed synaptic partners consisting of presynaptic vGLUT2+ boutons and postsynaptic dendrites that *both* contained pTau (Fig. 4F, S6B), suggestive of transsynaptic spread between the mammillary bodies and ADn (Fig. 1A). The size distribution of pTau-positive terminals also confirmed that large presynaptic terminals are preferentially affected by pTau-pathology (Fig. S5A-C).

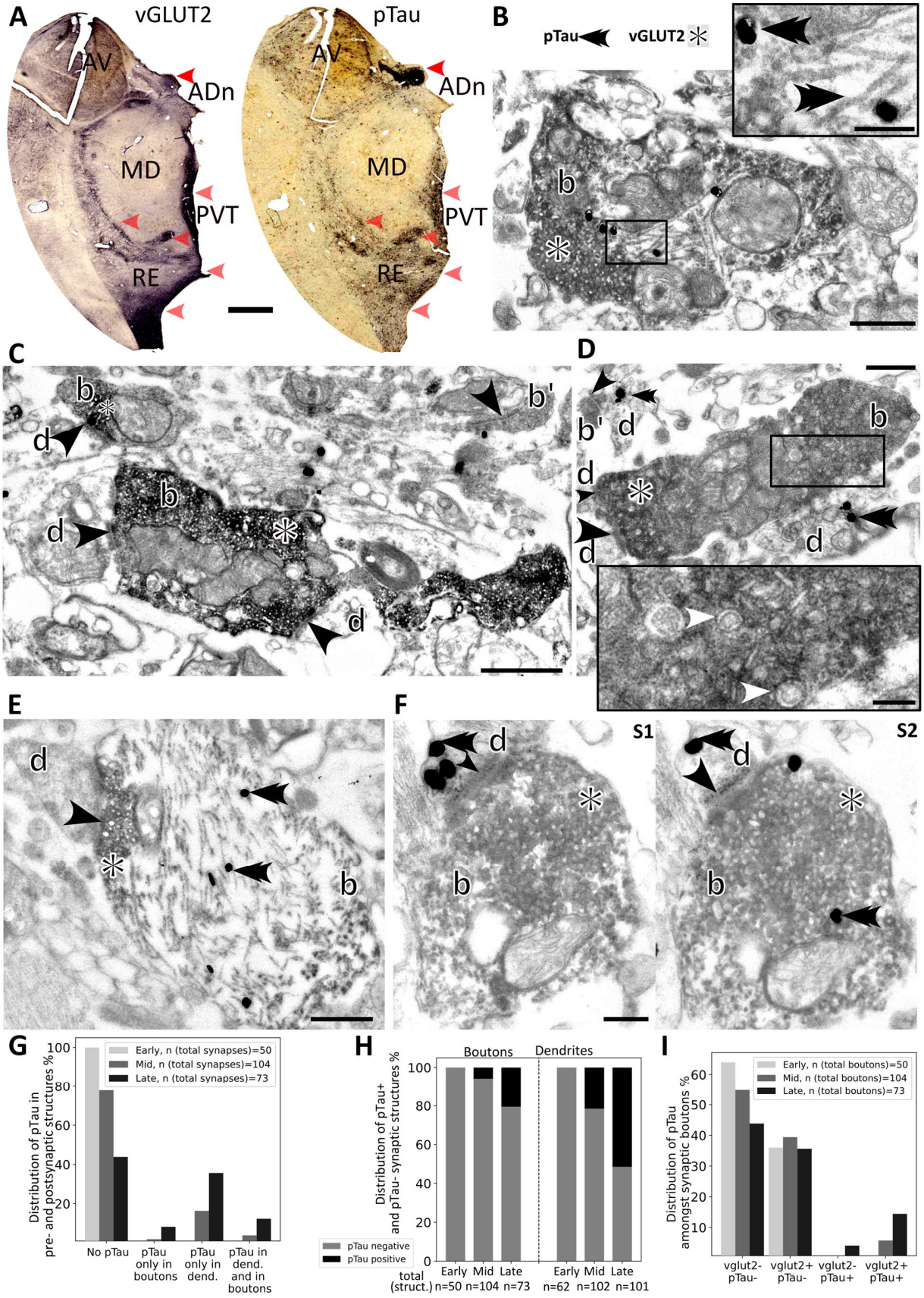
A
vGLUT2
pTau
AV
ADn
MD
PVT
RE
B
pTau
vGLUT2
b
C
b
b'
d
D
b'
d
b
E
d
b
F
S1
S2
d
b
G
Distribution of pTau in pre- and postsynaptic structures %
Early, n (total synapses)=50
Mid, n (total synapses)=104
Late, n (total synapses)=73
No pTau
pTau only in boutons
pTau only in dend.
pTau in dend. and in boutons
H
Boutons
Dendrites
Distribution of pTau+ and pTau- synaptic structures %
pTau negative
pTau positive
total (struct.)
Early n=50
Mid n=104
Late n=73
Early n=62
Mid n=102
Late n=101
I
Distribution of pTau amongst synaptic boutons %
Early, n (total boutons)=50
Mid, n (total boutons)=104
Late, n (total boutons)=73
vglut2- pTau-
vglut2+ pTau-
vglut2- pTau+
vglut2+ pTau+

Figure 4. Localization of pTau to vGLUT2-expressing presynaptic terminals. (**A**) Brightfield microscope images of rostral thalamus (serial sections, late stage, Case 17) reacted for vGLUT2 (left) and pTau (AT8, right); HRP-based diaminobenzidine end-products (DAB). The distributions correlate (red arrowheads). (**B-F**) Electron micrographs showing pTau filaments (AT8 immunolabeling, e.g. double arrowheads mark gold-silver particles) and vGLUT2-immunolabeled boutons (DAB) from the ADn of Case 17. Abbreviations: b, bouton; d, dendrite. Black arrowheads mark synaptic junctions. (B) A vGLUT2-immunopositive (vGLUT2+) bouton containing pTau filaments in the middle. Inset, higher magnification of helical pTau filaments from boxed region. (C) Two vGLUT2+ boutons (DAB) and a vGLUT2- bouton (b', top right) lacking pTau, a silver particle is adjacent to the bouton. (D) A large vGLUT2+ terminal (b) containing double-walled vesicles and clumped mitochondria. Inset, detail of boxed region showing vesicles (e.g. marked by white arrowheads). A small bouton (b', top left) forms a synapse with a pTau immunopositive dendrite. (E) A large vGLUT2+ bouton (note DAB end product on vesicles at the synapse) containing dense pTau filaments. (F) Electron micrographs of sequential sections (S1, S2) showing pTau in both the vGLUT2+ bouton and the postsynaptic dendrite. Double arrowheads mark examples of gold-silver particles; asterisks label dark DAB product around vGLUT2+ vesicles. (**G**) Proportion of synapses (%) in the ADn with or without pTau in the presynaptic bouton and/or postsynaptic dendrite in early, middle, and late Braak stages of tauopathy. (**H**) Proportions of synaptic boutons (%, left) and dendrites (right) containing pTau at the different stages. (**I**) Proportion of synaptic boutons (%) with or without vGLUT2 and pTau immunoreactivities at the different stages. Scale bars: 2mm (A), 0.5 µm (B,D,E), 1 µm (C), 0.25 µm (F), 150 nm (B and D insets).

The distribution of presynaptic and postsynaptic pTau suggests transsynaptic spread

Given the observation of pTau in both presynaptic terminals and postsynaptic dendrites (Fig. 3F, 4B, D-F, S6B-D), we quantitatively characterized how the synaptic distribution of pTau changed across different Braak stages, examining 543 presynaptic boutons and postsynaptic dendrites, each of which was followed over several serial sections. In the early stage (Braak stage 0), despite pTau being detectable at the light microscopic level (Fig. 1A and 2A), all sampled boutons and dendrites lacked pTau (n=50/50 boutons, n=62/62 dendrites; Case 4; Fig. 4G and H). In the middle stage (Braak stage III), 5.8% of boutons (n=6/104) and 21.6% of dendrites (n=22/102) were pTau+ (Case 12; Fig. 4G and H). In this stage the proportion of synapses in which *both* the presynaptic boutons and the associated postsynaptic dendrites contained pTau was 3.9% (n=4/104; Fig. 4F and G, S6B). In the late stage (Braak stage VI), the proportion of affected boutons and dendrites greatly increased: 20.6% of boutons (n=15/73) and 51.5% of dendrites (n=52/101) contained pTau (Case 17; Fig. 4B, D-H). Furthermore, 12.3% (n=9/73) of synapses consisted of *both* pTau+ boutons and pTau+ dendrites (Fig. 4F and G). These data demonstrate that the proportions of both the presynaptic and postsynaptic elements containing pTau increase with Braak stage.

Finally, we examined the relationship between presynaptic vGLUT2 and pTau across stages. In the early stage, we found vGLUT2+ boutons (Fig. S5E) but did not detect pTau (Fig. S5A). But by the middle stage, from a total of 104 synaptic boutons, 5.8% (n=6) were both vGLUT2 and pTau double immunopositive (Fig. 4I), whereas none of the vGLUT2 immunonegative boutons (n=57) were pTau+. In other words, 100% of pTau+ boutons were vGLUT2+ (n=6) and 12.8% of vGLUT2+ boutons (n=47) were pTau+, supporting the hypothesis of selective vulnerability of subcortical vGLUT2+ synaptic terminals. Filamentous contacts with postsynaptic structures, known as puncta adherentia, are associated with mammillothalamic terminals (*16*). We identified puncta adherentia between vGLUT2+ boutons and postsynaptic dendrites containing pTau (Fig. S6B). Moreover, the small corticothalamic boutons lacked pTau (Fig. S5B and E), which indicates that pTau in the ADn is unlikely to have spread anterogradely from the cortex.

In the late stage, out of a total of 73 synaptic terminals, an even higher proportion showed vGLUT2 and pTau colocalization (16.4%; n=12; Fig. 4I), i.e., ~*80%* of pTau+ boutons (n=15) were immunopositive for vGLUT2. And of all vGLUT2+ boutons (n=38), 31.5% were pTau+. The data on the colocalization of vGLUT2 and pTau is even likely to be an *underestimate*, given that large 'dark' boutons are likely to be degenerating mammillothalamic terminals (Fig. S5F, S6A), and we only sampled relatively few sections from each terminal. The above results suggest that vGLUT2+ boutons are strong candidates for the transsynaptic spread of pTau between postsynaptic ADn neurons and presynaptic mammillary body neurons (Fig. 5).

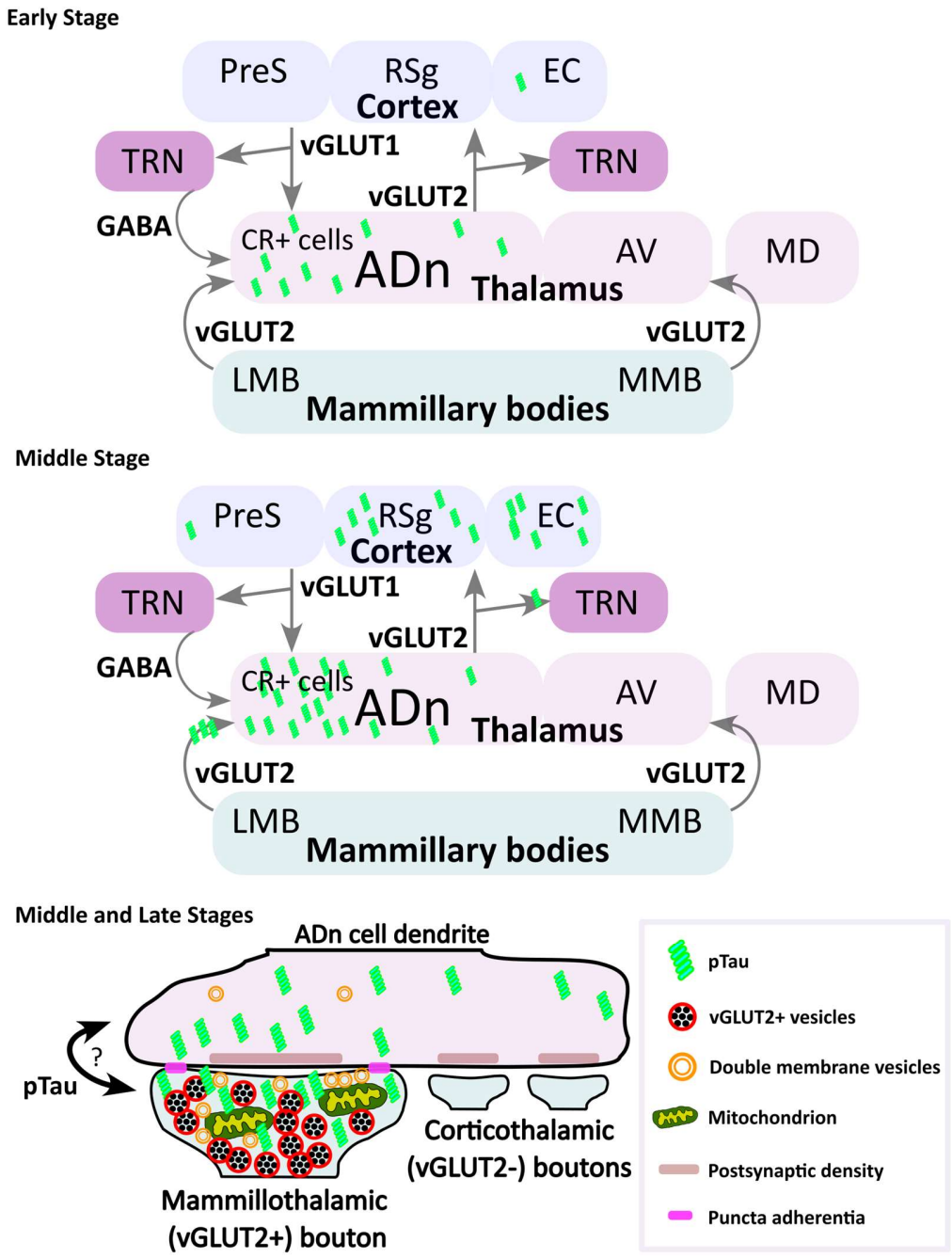

Figure 5: Schematic of pTau transsynaptic spread involving vGLUT2+ terminals in the ADn. Scheme summarizing the data. According to our hypothesis, in the early stage (top), pTau (green) initially accumulates in CR+ cells of the ADn. By the middle stage, pTau has accumulated in 2 of 3 cortical areas postsynaptic to the ADn: the EC and RSg, but not the PreS. In the thalamus, pTau is present in axons innervating the TRN and in mammillothalamic (vGLUT2+) terminals innervating the ADn. The GABAergic cells in the TRN are not invaded by pTau, nor are the corticothalamic terminals in the ADn. Bottom, detail of pTau within the ADn at the middle stage (also applies to the late stage). Transsynaptic spread between the large vGLUT2+ mammillothalamic boutons and ADn dendrites may be retrograde or anterograde, potentially mediated through puncta adherentia (see Fig. S6B). Puncta adherentia are not found between small corticothalamic boutons and postsynaptic dendrites, and pTau was not observed in these presynaptic terminals at either middle or late stages, despite pTau in presynaptic cortical areas. See Discussion for further details.

Significance of ADn Tau pathology

Untangling which brain regions are first affected in neurodegenerative diseases may facilitate earlier diagnosis and enhance treatment options. We found that the human ADn accumulated pTau very early on and we detected affected neurons even in cases lacking significant neocortical and hippocampal pathology (Braak stage 0). Calretinin-expressing neurons were vulnerable at all disease stages. Given the consistently high pTau density and pTau+ cell counts that we observed in the ADn at all stages, we suggest that the human ADn is a 'hub' for early-forming Tau pathology. Using high-quality perfusion-fixed tissue and immunogold labeling, we localized, for the first time, pTau to intact presynaptic boutons and postsynaptic dendrites, with paired helical filaments resembling those described previously in cases of Alzheimer's disease and other tauopathies (*2, 23, 30, 32, 35*). Surprisingly, despite the classical hypothesis of pTau spreading via corticocortical pathways originating in the EC, pTau was not found in corticothalamic boutons in the ADn. Instead, pTau was preferentially localized to large vGLUT2-expressing subcortical terminals. This suggests an alternative or parallel major subcortical glutamatergic pathway driving the spread of pTau in relation to the emergence of Alzheimer's disease.

The thalamic ADn, AV, and AM are commonly referred to as the anterior nuclear group; lesions impair spatial reference and working memory in rats (*8, 9, 36, 37*), and thalamic infarctions (especially those that include the mammillothalamic tract) are associated with amnesia in humans (*38*). Also, in mice, selective disruption of the ADn impairs spatial working memory (*39*). The anterior nuclear group shares cortical targets through direct projections to the RSg, PreS, and EC (*18, 19*). The AV and AM receive inputs from multiple cortical areas including the EC, yet the ADn only receives input from the dorsal part of the RS and not the EC (*40, 41*). If pTau had spread directly from the EC to the anterior nuclear group, we would have expected to find early pTau in the AV, but it was sparse even at the middle stage. Another key difference between the anterior thalamic nuclei is that the ADn receives glutamatergic input from the lateral mammillary nucleus, whereas the AV and AM receive input from the medial mammillary nucleus (*42, 43*) (Fig. 1A, Fig. 5).

The large vGLUT2-containing axon terminals arising from the lateral mammillary nucleus are thought to act as 'drivers', releasing glutamate in response to dynamic changes in the pattern of sensorimotor inputs evoked by stimuli, such as changes in head direction or shifts in gravity (*16, 44-46*). Postsynaptically, ADn neurons will be strongly depolarized leading to high-frequency firing within the receptive field (*45*). The lateral mammillary nucleus and ADn are more severely affected by Tau pathology compared to the medial mammillary nucleus, AV, and AM (*3, 47, 48*). It is likely that pTau accumulating within axon terminals and neurons in the ADn will disrupt

receptive fields (eg. head direction tuning, angular velocity) and firing rates, thereby decreasing the information content provided to postsynaptic neurons in the RSg, PreS, and EC (*18, 19*). This might cause early and progressive deficits in the awareness of orientation and a resulting increase in the probability of losing balance. Our findings may explain the early impairments in spatial navigation, memory deficits, and an increased number of falls in people that go on to develop Alzheimer's disease (*49-51*).

Propagation of pTau involving vGLUT2-containing terminals

Nuclei adjacent to the ADn such as the AV and MD were relatively resistant to pTau, even in late stages, suggesting that in the thalamus, propagation of pTau is facilitated via specific synapses rather than geometrical proximity. Our data are consistent with the following hypothesis (Fig. 5): pTau first accumulates in CR-expressing ADn neurons. Next, pTau spreads to mammillothalamic vGLUT2+ terminals from ADn neuron dendrites. Myelinated axons of the ADn neurons transfer pTau to vGLUT2+ terminals in the TRN and to cortical target areas. A lack of pTau+ cell bodies in the TRN (*20*) at any stage suggests that the predominantly GABAergic cell population is 'resistant' to the spread of pTau from vGLUT2+ boutons, whereas cortical neurons postsynaptic to ADn neurons are likely to be vulnerable. Note we cannot currently rule out pTau spreading retrogradely from the cortex into ADn vGLUT2+ terminals, then from ADn dendrites to mammillothalamic terminals at early stages (Fig. 5). However, the very early appearance of pTau+ neurons in the ADn prior to cortical neurons makes this route unlikely. Anterograde spread of pTau from the cortex to the ADn is also unlikely due to the lack of pTau in small corticothalamic terminals at the middle stage (Braak stage III, prior to Alzheimer's disease) or even in the late stage (Alzheimer's disease). The vGLUT2+ mammillothalamic terminals are especially vulnerable due to a nearly 3-fold increase of pTau in these boutons from the middle stage to late stage. These boutons are unusual due to the accumulation of double-walled vesicles that may represent a type of autophagic/secretory organelle, and the presence of puncta adherentia, which contain intercellular adhesion proteins such as nectins. The puncta adherentia may even be required for the transfer of pTau (Fig. 5), and are located at other sites of potential pTau propagation including between mossy fibers of dentate granule cells and CA3 pyramidal neurons (*52, 53*). In contrast, puncta adherentia are lacking in the corticothalamic terminals in the ADn, which did not contain pTau.

Data supporting the transsynaptic spread of Tau has been obtained in animal models (*54-57*) and humans (*58, 59*), with presynaptic glutamate release inducing a rise in extracellular Tau (*60*). However, transsynaptic spread has not been previously demonstrated in the human brain at the subcellular level in well-preserved tissue. As well as 'prion-like' spread (*61*), Tau may also be released extracellularly (e.g. in vesicles) under certain conditions (*62, 63*). The large vGLUT2+ terminals packed with double-walled vesicles resemble those found at a lower density in the cortex of Alzheimer's disease cases (*30, 35*). Due to their prime position within the terminal, we suggest these vesicles are candidates for the transport and/or release of Tau. Alternatively, or in addition, pTau may be directly associated with vGLUT2-containing vesicles, consistent with a previous report of Tau being associated with the cytosolic surface of vGLUT2+ synaptic vesicles (*64*).

Selective vulnerability of different cell types

Identification of affected cell types in different neurodegenerative diseases is crucial for the understanding of biochemical factors that cause susceptibility and for therapy development, as is the case for dopaminergic neuronal loss in Parkinson's disease (*65*). Specific cell types may be

more or less vulnerable due to their connectivity, metabolic demands, or a combination. Noradrenergic locus coeruleus neurons are thought to be vulnerable due to their dense cytoarchitecture and long-range axonal projections (*66*), which could also apply to the ADn. Wolframin-expressing neurons are susceptible to pTau in human EC, and in mice pTau propagates from Wolframin+ EC cells to CA1, which is linked to memory impairments (*54*). We found that the calcium-binding protein CR was associated with pTau in the thalamus as early as Braak stage 0. This may represent a vulnerable subpopulation having specific connectivity with the cortex (e.g. with the RSg or EC) and mammillothalamic tract, with specific conditions for propagation (e.g. via puncta adherentia). Future immunohistochemical and RNA sequencing studies may shed light on the specific molecular identity of this subpopulation. Finally, it is recognized that glial cells also accumulate pTau (*21, 23, 67*), which can originate from pTau+ cortical pyramidal cell axons (*22*). We observed a range of pTau+ astrocyte profiles even within the same case, and 'coiled bodies' that are likely oligodendrocytes. Future studies will establish the contribution of different glial cell types to pTau propagation, neurodegeneration, and their association with a disrupted neurogliovascular unit (*68*), which may be one of the underlying triggers for Tau pathology in highly vulnerable brain regions such as the ADn. In summary, our results demonstrate that the connectivity, synaptic specificity, and molecular profile of subpopulations of glutamatergic rostral thalamic neurons potentially drive progression of Tau pathology in the human brain.

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Competing interests

Authors declare that they have no competing interests.

Data and materials availability

All data, code, and materials used in the analysis will be made available. Human brain tissue is governed by materials transfer agreements with the Brain Banks and the Human Brain Research Laboratory.

Supplementary Materials

Materials and Methods

Figs. S1 to S6

Tables S1 to S7