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1   [Au: We really need to reduce the number of references to ~250; accordingly, I have suggested a few
2   places in the manuscript where the number of references could be reduced. I have reduced this to
3   256]

Amyotrophic lateral sclerosis

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**Competing interests [Au: Please note I've restructured the order of the CIs here so they follow the
same order as the author list]**
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companies - we can move this into the Acknowledgements section if you wish? OK], has served on
advisory boards for Biogen, Cytokinetics, Orion, Merck and Roche and has consulted for Mitsubishi. She

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Author contributions

Introduction (O.H.); Epidemiology (G.L.); Mechanisms/pathophysiology, (W.R. and P.J.S.); Genetics, Diagnosis, screening and prevention, (O.H and L.H.B.); Management, (A.C.); Quality of life, (Z.S.); Outlook, (A.A.); Overview of Primer, (E.M.C. and O.H.).

Abstract Amyotrophic lateral sclerosis (ALS), also known as Motor Neuron Disease (MND) **[? It is synonymous.]**, is characterized by the degeneration of both upper and lower motor neurons, leading to muscle weakness and eventual paralysis. Until recently, ALS was classified primarily within the

63 neuromuscular domain, although new imaging and neuropathological data have indicated the

64 involvement of the non-motor neuraxis in disease pathology. In most patients, the mechanisms

65 underlying development of ALS are poorly understood, although a subset of patients have familial

66 disease and carry mutations in genes that have various roles in neuronal function. Two disease

67 modifying therapies which can slow disease progression, are available for the treatment of ALS, but

68 patient management is largely mediated by the use of symptomatic therapies, such as the use of muscle

69 relaxants for spasticity and speech therapy for dysarthria.

70

71

72 **[H1] Introduction**

73   Amyotrophic lateral sclerosis (ALS) is a heterogeneous neurodegenerative syndrome that is

74 characterized by the degeneration of both upper (that is, neurons that project from the cortex to the

75 brain stem and the spinal cord) and lower (that is, neurons that project from the brainstem or spinal

76 cord to the muscle) motor neurons leading to motor and extra-motor symptoms (Figure 1). The initial

77 presentation of ALS can vary between patients; some present with spinal-onset disease (that is, the

78 onset of muscle weakness of the limbs), but others can present with bulbar-onset disease (characterized

79 by dysarthria – difficulty with speech – and dysphagia – difficulty swallowing. In most patients, the cause

80 of ALS is unknown, although some individuals develop familial forms of the disease, which are

81 associated with mutations in genes that have a wide range of functions, including functions in non-

82 motor cells. In the familial forms of the disease, some of the implicated genes are incompletely

83 penetrant, and with rare exceptions, genotype does not necessarily predict phenotype [1]. Although the

84 primary symptoms of ALS are associated with motor dysfunction (such as muscle weakness, spasticity

85 and dysphagia), up to 50% of patients develop cognitive and/or behavioral impairment during the

86 course of disease and 13% of patients present with concomitant behavioral variant frontotemporal

87 dementia (bv-FTD)[2-4]. The high prevalence of cognitive and/or behavioural symptoms, coupled with the

88 finding of a hexanucleotide repeat expansion in *C9orf72* as the major genetic cause of ALS and FTD [5, 6],

89 have contributed to the re-characterization of ALS as a neurodegenerative, rather than a neuromuscular

90 disorder, and have signposted the direction of research over the coming decade.

91

92   The classification of ALS can vary depending on the criteria used. The traditional definitions of ALS

93 subgroups are based on the extent of upper and lower motor neuron involvement, although other

94 classification systems include different parameters, such as the site of onset (that is, bulbar or spinal

95 onset of disease), the level of certainty of diagnosis according to the revised El Escorial Criteria and

96 heritability (sporadic or familial disease)[7]. To date, none of these classification systems have

97 incorporated the cognitive or behavioural symptoms and within each classification system a range of

98 sub-phenotypes and clinical trajectories can be demonstrated.

99

100 This Primer will review the aspects of ALS that contribute to disease heterogeneity, and will look to the

101 future of new therapeutic trials that incorporate recent advances in our understanding of this disease

102 spectrum. For new therapies, the challenge is to define mechanisms of disease amenable to drug

103 targeting, and to define sub-cohorts of patients that are likely to respond to these new therapeutic

104 agents.

105

106

107 [H1] Epidemiology

108

109 [H2] Descriptive epidemiology

110 The majority of population based epidemiological studies for ALS have come from high quality European

111 patient Registers [8]. These European population based Registers have been combined to form the

112 European ALS Epidemiology Consortium (EURALS), which has provided data comparing the incidence of

113 ALS between European countries [9]. In Europe, the incidence ranges from 2-3 cases per 100,000

114 individuals. Defined geographical areas are ideally suited to estimate the incidence and prevalence, and

115 to support more-detailed studies of risk, clinical trajectory, outcome and utilization of services for ALS[8].

116 As ALS is a rare disease, a population-based approach with multiple sources of ascertainment is the best

117 way to describe the entire phenotypic spectrum [10] as population-based registers provide more complete

118 information about the disease than datasets from specialist clinics, which are often biased in favour of

119 younger patients and those with less severe disease **[?OK]** [10]. Similarly, clinical trial cohorts such as those

120 collected within the US-based pooled resource open-access ALS clinical trials database (**?OK]** ProACT)

121 dataset also select for patients with ALS who have better prognosis; survival within these cohorts is ~12

122 months longer than that of true population-based cohorts.

123   **[OK] [OK]** Contrary to earlier assumptions, the incidence of ALS has been shown to differ based on

124 ancestral origin; studies in populations of European origin **[]** have shown a crude incidence of >3 cases

125 per 100,000 individuals [11, 12], but incidence rates are lower in East Asia (around 0.8 per 100,00) and

126 South Asia (0.7 per 100,000).   In some regions (such as Guam and the Kii peninsula of Japan) the

127 reported incidence was very high, but dropped substantially over the past 30 years for reasons that

128 remain unclear. In areas where different ancestral populations live in close proximity (as in Northern

129 America), the incidence rates of ALS in indigenous populations is particularly low (0.63 cases per 100,000

130 individuals)[13], whereas reported incidences in regions of relatively homogeneous populations (such as

131 Ireland, Scotland and the Faroe Islands) are high (2.6 cases per 100, 000 individuals) [9, 14].

132

133 In addition, variations in the phenotype and natural history of ALS have been reported in different

134 ancestral populations; indeed reported survival of patients with ALS is much shorter in Europe (24

135 months) than in Central Asia (48 months) [15]. **[OK]** In addition, admixed populations (that is, populations

136 of mixed ancestry **OK]**) might have lower mortality rates of ALS. In a population-based study in Cuba,

137 ALS mortality rate was 0.55 per 100,000 individuals in a mixed population,**[OK]** but was about 0.9 per

138 100,000 individuals **[Au:OK?OK]** in white or black individuals [16], confirming the importance of ancestral

139 origin in disease risk. **[ok]** In Europe, most men have spinal onset disease, and women have increased

140 propensity for bulbar onset disease [9]. The percentage of individuals with bulbar onset disease is much

141 lower in Asia compared with Europe, but a North to South gradient has been described in Europe, with

142 higher percentage of individuals with spinal onset disease in Southern Europe [9]. Based on available data,

143 the age of diagnosis and first symptoms is higher in Europe compared to Asia and South America. **[OK]**

144 In Europe, the age of onset peaks at 65 [9]. **[]** The main limitation of global ALS epidemiology is that

145 almost 80% of studies have been conducted in Europe and the US, and mainly comprise patient cohorts

146 of Northern European ancestry. International consortia collecting data in areas with mixed populations

147 and in different continents will be required to fully elucidate the range of clinical presentations, and to

148 understand the roles of ancestry, genetics and environmental exposures in ALS causation.

149

150 **[H2] Causes of ALS**

151

152 **[H3] Genetics.** ALS is considered a complex genetic disorder with a Mendelian pattern of inheritance in a

153 proportion of cases, but no discernible family history in the rest. Mathematical models developed using

154 population-based registers have suggested that individuals with ALS are likely to carry a number of 'at

155 risk' variants that interact with environmental factors through a series of at least 6 notional steps

156 leading to disease manifestation. One of these steps is thought to be the genetic risk (from birth), but

157 the interplay of environmental factors that lead to the remaining steps have yet to be defined. In

158 transgenic mice, the genetic background can alter the phenotypic presentation of ALS **[OK ?]** [17, 18],

159 suggesting that human disease phenotypes could also have a genetic basis, and that genomic and

160 epigenomic "fingerprinting" could permit the clustering of different phenotypic manifestations into

161 discrete underlying causes that are amenable to therapeutic intervention.

162

163 Large combined genome-wide association studies (GWAS) of apparently sporadic ALS suggest that the

164 genetic architecture is based primarily on rare variants, in contrast to other diseases, such as

165 schizophrenia, which are associated with large numbers of common variants. GWAS in ALS are also

166 complicated as the rare variants that confer risk might be specific to individuals, families and ancestral

167 populations [19], rendering GWAS less suited for study of ALS genetics than is schizophrenia. Initiatives

168 such as the Project MinE Consortium (www.projectmine.com), which aims to undertake whole genome

169 sequencing of >16,000 patients with ALS and 6,000 control individuals, are likely to provide greater

170 clarity of the genetic architecture of ALS.

171

172 Of the known genes of major effect for the development of ALS (Table 1 **[** OK), our current knowledge

173 comes primarily from the study of ancestral European (Europe, USA, Canada and Australia) and East

174 Asian populations; within these populations, **OK**the dichotomization of ALS into 'familial' and 'sporadic'

175 subtypes is an over-simplification. Although at least 30 genes are known to confer a major risk for ALS,

176 evidence suggests a role of oligogenic inheritance (in which a phenotypic trait is determined by more

177 than one gene**? OK]**) and of genetic pleiotropy (in which a single gene **[OK]** has multiple phenotypic

178 manifestations). Within populations of European extraction, up to 20% of people with ALS have a family

179 history of either ALS or FTD (Familial ALS) , and of these 4 genes account for up to 70% of all cases of

180 familial ALS , namely *C9orf72*, *TARDBP* (also known as *TDP43*), *SOD1* and *FUS* **[?OK]** [20]. However, even in

181 the case of these known Mendelian inherited genes, familial forms of ALS are often characterized by

182 lower than 50% penetrance **[**and genetic pleiotropy, with evidence of oligogenic and polygenic

183 inheritance in individuals with apparently sporadic disease [21, 22].

184

185 **[H3] Environmental and lifestyle factors. OK].** Epidemiological case control studies have sought to

186 determine the environmental causes of ALS. Early epidemiological studies from regions with a high

187 incidence of ALS and dementia such as Guam and the Kii peninsula of Japan suggested a role for

188 neurotoxins **[Would prefer to retain neurotoxins]** contained within cycad seeds, including β-

189 methylamino-L-alanine **OK]** . Although the role of β-methylamino-L-alanine[23] has not been

190 substantiated, a possible role for related cyanotoxins has been proposed, and exposure to water

191 harbouring cyanobacterial blooms has been suggested to contribute to risk of ALS in susceptible

192 individuals [24].

193

194 ALS has been reported at a higher frequency among groups of athletes compared to the general

195 population although whether physical activity is a risk factor for ALS, or a marker of underlying athletic

196 prowess is unclear. Evidence from a UK study suggests that individuals with ALS had higher rates of pre-

197 morbid **[Pre-Morbid is ok – standard use PJS I AGREE]** physical activity, but two other European studies

198 suggested either no effect, or a protective effect [22-24]. Reasons for this discrepancy **[**might relate to study

199 design and true population-based differences. However, because ALS is a rare disease, smaller case

200 control studies are often underpowered and are subject to both bias and error in interpretation. To

201 address these problems in study design, a very large case control study **OK** has been completed as part

202 of the EuroMOTOR project (www.euromotorproject.eu*)*, which has collected >1,500 population-based

203 incident cases and 3,000 matched controls across 3 countries. Analysis is ongoing, although preliminary

204 data suggest that exposure to smoking might increase the risk of developing ALS, but type 2 diabetes

205 mellitus, high levels of circulating lipids and exposure to **[EXPOSURE is more accurate** female

206 contraceptive hormones seem to be protective [25, 26] **[(YES- OH is the senior author) PENDING** .

207

208 # [H1] Mechanisms/pathophysiology

209

210 **[H2] Histopathology [?OK]**

211 Although the fundamental pathophysiological mechanisms underlying ALS are not well understood, the

212 neuropathological hallmark of disease is the aggregation and accumulation of ubiquitinated

213 proteinaceous inclusions in motor neurons **[?YES]** . Protein inclusions occur in other neurodegenerative

214 disorders (such as amyloid plaques in Alzheimer Disease and synuclein-containing Lewy Bodies in

215 Parkinson Disease **OK]**. The biological processes leading to formation of these inclusions **OK]** has been

216 the subject of intensive research, but is poorly understood [4].

217 In most subtypes of ALS the tar DNA-binding protein 43 **OK]** (TDP-43) is the major constituent of these

218 inclusions, although mutations in *TARDBP* are a rare cause of ALS [27, 28] **OK r]** Indeed, approximately 97%

219 of patients with ALS have features of a TDP-43 proteinopathy, with depletion of TDP-43 in the nucleus,

220 but the formation of cytoplasmic aggregates with skein-like or compact morphology in residual motor

221 neurons (Figure 2A). In specific subtypes of ALS, other types of protein aggregates might be seen, such

222 as P62-positive, TDP-43 negative protein inclusions that are caused by dipeptide repeat proteins and

223 might be seen outside the motor system in patients with **'ALS associated with C9ORF72 mutations OK]**

224 (Figure 2C) and neurofilamentous hyaline conglomerate inclusions (Figure 2B) and the accumulation of

225 misfolded superoxide dismutase (SOD1) in patients with SOD1-ALS **YES]** . **[Au: green text mvoed here**

226 **from the 'impaired protein homeostasis' section for flow OK]** Although protein aggregates are the

227 hallmark of ALS, the high molecular weight **YES]** complexes that precede the formation of the

228 aggregates, rather than the aggregates themselves[29, 30], might be the toxic species. Shedding of higher

229 molecular protein complexes might mediate cell to cell propagation of disease, linking the progression

230 of ALS to a prion-like mechanism, as has also been suggested for tau and synuclein-mediated diseases [31,

231 32].

232

233 The gross pathological features of ALS comprise skeletal muscle atrophy, atrophy of the motor cortex

234 and pallor **LEAVE PALLOR –(more accurate in neuropathology)]** and sclerosis of the corticospinal and

235 corticobulbar tracts **OK]**), together with thinning of the hypoglossal nerves (which are involved in the

236 control of the muscles of the tongue) and the ventral roots of the spinal cord. Microscopic examination

237 usually reveals a depletion of at least 50% of spinal motor neurons and diffuse astrocytic gliosis and

238 microglial infiltration in the grey and white matter of the spinal cord (Figure 2D AND 2F). **OK OK NOW]**.

239 Axonal loss, gliosis and myelin pallor are seen in the corticospinal tracts, and astrocytic gliosis is usually

240 observed in the motor cortex, together with variable depletion of upper motor neurons. Skeletal muscle

241 shows features of denervation and reinnervation, with fibre type grouping and clusters of angular

242 atrophic fibres.

243

244

245 **[H2] Overview of pathophysiology OK**

246 Progress has been made in the identification of the genetic causes of ALS[21, 22] and models in rat, mouse,

247 zebrafish, flies, worms and yeast have been developed to study the mechanisms by which gene

248 mutations cause motor neuron degeneration and to model particular biological processes thought to be

249 important in disease pathobiology. All of these models have limitations and none fully recapitulates

250 human disease, which is partly because most models are based on gene overexpression (with multiple

251 copies of the human variant inserted into the transgenic model) and because the human neuro-axis

252 differs substantially. **OK]** from that of lower animals. **OK]** Nevertheless, findings from animal models

253 **OK]** can contribute to our understanding of the cell biology underlying neurodegeneration and can
254 open new avenues towards targeted drug development. In reality, the cellular disruption **?OK]** in ALS is
255 likely the result of many different interacting mechanisms that culminate in larger network disruption,
256 and the separation of different mechanisms is somewhat artificial. **[OK]** This is exemplified by the
257 finding that multiple factors can contribute to neuronal damage in models of *Sod1* **OK MODIFIED BY PJS**
258 **?]** mutations (Table 1). The relative extent by which each of these factors contributes to the overall
259 pathobiology of human disease cannot be fully ascertained, it would be erroneous to assume that all of
260 these factors are involved in all cases of ALS, as human disease is heterogeneous. Notwithstanding, each
261 of the thematic areas should be considered in detail, as they represent our current knowledge base of
262 the pathophysiology of ALS, and are the drivers of current and future therapeutic initiatives (Figure 3).
263

264 **[H2] Impaired protein homeostasis**
265 **[] OK**
266 Mutations in some genes **OK]** lead to the translation of proteins that are misfolded, have an abnormal
267 cellular localization or are aberrantly formed, and that can directly or indirectly impair the proteasome
268 or autophagy machinery of the cell, leading to impaired cellular protein turnover. Indeed, genes
269 associated with familial ALS encode proteins that can **[OK]** promote dysfunction of the ubiquitin-
270 proteasome system. For example, mutant SOD1 is associated with reduced expression of ubiquitin-
271 proteasome system components [33], valosin-containing protein (VCP) and ubiquilin-2 are involved in
272 substrate delivery to the proteasome, and this function is disrupted in the presence of ALS-associated
273 mutations **[n SENTENCE IS OK AS IT STANDS]** [34-36]. In addition, dysregulation of chaperone proteins has
274 been identified in ALS associated with *SOD1* and *TARDBP* mutations [37-40] . Mutations in *VAPB* (encoding
275 vesicle-associated membrane protein associated protein B **[Au OK:]**) can cause defective activation of
276 the unfolded protein response in disease models [41, 42].
277

278 C9orf72 **[? PROTEIN YES]** is a key regulator of autophagy initiation [43] and loss of this function might
279 contribute to the presence of ubiquitin and p62 positive, TDP-43 negative inclusions in extra-motor
280 areas of the central nervous system (CNS) in *C9orf72*-related ALS **[YES]** . **OK]** Sequestosome-1,
281 optineurin and ubiquilin-2   have a role in the early steps of autophagy [44-46], and alsin,
282 polyphosphoinositide phosphatase (FIG4), transitional endoplasmic reticulum ATPase (VCP) and charged
283 multivesicular body protein 2b (CHMP2B) have roles in the maturation of autophagosomes into
284 autophagolysosomes by regulating the fusion of autophagosomes with multivesicular bodies,

285 endosomes and lysosomes lysosomes [47-51]. Mutations in *SQSRM1* **[? OK]** might disrupt the correct

286 delivery of autophagic substrates to the autophagosome [52] and mutations in *UBQLN2* and *OPTN* **OK ?]**

287 (which both encode autophagy receptors) are also associated with ALS. The activities of sequestosome-1

288 and optineurin are regulated by serine/threonine-protein kinase **OK]** (TBK1) and [53, 54] haploinsufficiency

289 of *TBK1* **[**YES is a cause of familial ALS, which supports the hypothesis that reduced substrate delivery to

290 autophagosomes might contribute to motor neuron injury in ALS. Reduced VCP activity **YES]** has been

291 shown to decrease the maturation of autophagosomes. Other proteins implicated in ALS

292 pathophysiology, including alsin and FIG4 **YES ?]** , can affect autophagy at the stage of initiation, **OK ?]**

293 although the mechanism for this is unclear[47, 55]. Both SOD1 and TDP-43 are known substrates of

294 autophagy, suggesting that defective autophagy could contribute to the toxic accumulation of these

295 proteins in ALS. The formation of dipeptide repeat proteins through repeat-associated non-ATG (RAN)

296 translation from the expanded RNA repeat of the C9orf72 **[Au: this is quite technical - can we edit to**

297 **this to '*C9orf72* repeat expansions might cause dysproteostasis, but this remains..' for non-experts**

298 **WOULD PREFER TO KEEP ORIGINAL TEXT IF POSSIBLE ?]** gene might also result in dysproteostasis, but

299 this remains to be conclusively demonstrated and the mechanism elucidated.

300

301   **[**OK

302

303 **[H2] Aberrant RNA metabolism**

304 Alteration of mRNA processing is a key theme in ALS pathogenesis[56]. **[OK]** mRNA undergoes a complex

305 system of processing as it transits from the nucleus to cytoplasm, where it is translated into protein. In

306 neurons, mRNAs can be transported to allow local translation in the axonal compartment. Although the

307 functional consequences of RNA dysregulation that lead to age-related and selective degeneration of

308 neuronal populations **NO- other neurons also affected]** remain poorly understood **[Both actually but**

309 **the latter in this context** , analysis of the translatome of actively transcribing mRNAs will be essential in

310 elucidating the upstream molecular events contributing to neuronal injury.

311

312 **OK** The discovery of mutations in *TARDBP* and *FUS* as rare causes of **[Au: familial? NO- ok at stands** ALS

313 has identified a crucial pathogenetic role for RNA binding proteins that contain low complexity domains

314 [57]. Mutant TDP-43 or FUS proteins mislocalize from the nuclear to the cytoplasmic compartment and this

315 is hypothesised to **[OK]** result in the loss of the normal processing of their target RNAs [58, 59]. Indeed, up

316 to one third of the transcriptome is altered in models of TARDBP-related ALS **[*OK ?]** [60], and dysregulation

317   of gene expression has also been observed in relation to mutations in *C9orf72*, *SOD1*, and *FUS* **OK ?]** [61],

318   including transcription, alternative splicing of mRNA, axonal transport of mRNAs and biogenesis of

319   microRNAs [62, 63].

320

321   **[**

322   The GGGGCC repeat expansion in the noncoding region of *C9orf72* **[YES]** forms stable parallel uni- and

323   multimeric G-quadruplex structures, which avidly interact with RNA processing factors [64, 65]. **[OK]** In

324   addition, the repeat expansion gives rise to abnormal RNA species that can be identified as nuclear RNA

325   foci and the *C9orf72* mutation **[? MUTATION OK]** might induce direct RNA toxicity, by, for example,

326   sequestering RNA binding proteins [66-68] . Indeed, a large set **[No need to change – large set ok ?]** of

327   proteins that bind to the expanded repeat have been identified [69]. In addition, repeat expansions could

328   lead to the formation of R-loops **OK]** (that is, DNA-RNA hybrid structures) that increase susceptibility to

329   DNA damage and genome instability [70, 71]. Indeed, R-Loops and genome instability due to double strand

330   DNA breaks and defective serine-protein kinase ATM-mediated DNA repair have been identified as

331   important components of neuronal injury due to GGGGCC repeat expansion in C9orf72 **[OK]** [72] .

332

333   **OK?OK]** Mutations in *ANG* (encoding angiogenin, which has a role in RNA processing [73, 74]) and *SETX*

334   (encoding senataxin, which regulates the transcription of ribosomal RNA [75, 76]) **OK]** are associated with

335   ALS, and might lead to disturbances in RNA metabolism. In addition, mutations in **[OK? OK]** *ELP3*

336   (encoding elongator protein 3), *TAF15* (encoding TATA-binding protein-associated factor 2N]**OK**) and

337   *EWSR1* (encoding RNA-binding protein EWS **OK**) [77-79] have also been associated with ALS. These genes

338   encode proteins that are involved in regulation of RNA metabolism; ELP3 contributes to the regulation

339   of transcription elongation, and TAF15 and EWSR1, which are functionally and structurally related to

340   FUS, have a role in the control of transcription and alternative splicing [80, 81].

341

342   Mutations in other genes involved in RNA metabolism **[Au:** such as *TAF15*, *EWSR1*, *hnRNPA1*,

343   *hnRNPA2B1* **[Au: This gene doesn't show up on the HUGO database, does this have another name?**

344   **CORRECTED   ]** and *MATR3* have been implicated in ALS [82, 83] **[Au: Changed 'have been found' to**

345   **'implicated in ALS', OK? OK Please cite fewer refs here REFS REDUCED]**. The mislocalization of the

346   mutant proteins into the cytoplasm might result in a toxic gain-of-function, and the effect of these

347   proteins on the formation of stress granules is an area of intense research effort **[Au: why specifically**

348   **on stress granules? Do the aforementioned proteins all compose stress granules, for example? PLEASE**

349 **LEAVE AS ORIGINAL – STRESS GRANULES ARE IMPORTANT AS MOTOR NEURON INJURY IS OCCURRING**

350 **]** [84-86] .

351

352 **[H2] Nucleocytoplasmic and endosomal transport**

353 In addition to altering RNA metabolism **[OK]** , the GGGGCC repeat expansion in *C9orf72* is believed to

354 alter the intracellular localisation of C9orf72 mRNA. Dipeptide repeat proteins are generated from the

355 repeat expansion in *C9orf72* and interfere with proper nucleocytoplasmic transport and trigger

356 neurotoxicity via several mechanisms [87, 88]. **[Au: I've deleted the sentence discussing liquid phase**

357 **separation as this is quite technical. Please restrict the number of reference here to 1-2ONE OF THE**

358 **REVIEWERS SPECIFICALLY ASKED FOR INCLUSION OF DISCUSSION OF LIQID PHASE SEPARATION. ONE**

359 **REF REMOVED]** OK . For example, arginine-rich dipeptide repeat proteins isolated from **[OK]** *C9orf72*

360 expansions can induce phase separation of proteins that have a role in RNA and stress granule

361 metabolism, and produce spontaneous stress granule assembly [89]. In addition, increased binding of

362 mRNA export adaptors to expanded C9orf72 pre-mRNAs might target those pre-mRNAs for nuclear

363 export, which could allow RNA translation to occur with potential toxicity from the expression of

364 abnormal dipeptide repeat protein species **YES]** [68, 90]. Indeed, sequestration of the nuclear export

365 adaptor serine/arginine-rich splicing factor 1 (SRSF1) by the repeat expansion region of the **[Au:OK? OK]**

366 RNA, triggers nuclear RNA export factor 1 **[?OK]** (NXF1)-dependent nuclear export of C9orf72 transcripts

367 retaining the hexanucleotide repeats, allowing RAN translation to dipeptide repeats in the cytoplasm

368 **[**YES . Depletion of SRSF1 in cellular and *in vivo* models reduces the production of dipeptide repeat

369 proteins and neurotoxicity [91].

370

371 **[H2] Endosomal and vesicle transport**

372 **[OK]** TDP-43 is involved in the regulation of endosomal trafficking and TDP-43 loss-of-function

373 **[PROBABLY]** has been shown to alter dendritic endosomes **[**, which resulted in reduced **signalling of**

374 **neurotrophins [OK]** and detrimental effects on neuronal health [92]. Mutations in *ALS2* (encoding alsin)

375 and *UNC13A* can alter endosomal and vesicle transport . Indeed, alsin is a guanine nucleotide exchange

376 factor for the small GTPase Rab5, and is involved in endosome trafficking and fusion [55, 93]. UNC-13

377 homolog A **[**OK encoded by *UNC13A*, which is a risk factor for ALS), is involved in synaptic-vesicle

378 priming and neurotransmitter release [94].

379

[H2] Axon structure and function

The finding of *DCTN* (encoding dynactin) **[YES]** , *PFN1* (encoding profilin 1) and *TUBA4A* (encoding tubulin alpha-4A chain) mutations suggests that abnormalities of proteins that are essential for axonal transport are associated with ALS [95-97]. In addition, mutations in *NEFH* (**[Au: please complete this with the gene name(s) - should this be *NEFH* and *NEFL*? YES NEFH This isn't mentioned in figure 3, should this be added here under the 'axonopathy' heading? YES]** encoding neurofilament) have also been described in a small number of patients [98], although whether these mutations are pathogenetic through axonal dysfunction remains to be seen. Rare mutations in *PRPH* encoding peripherin, another cytoskeletal protein, have been suggested to have a role in ALS pathogenesis, possibly through effects on neurofilament housekeeping including protein cargo trafficking **[Au: have mutations in *PRPH* been identified in patients with ALS? THE SENTENCE HAS BEEN ALTERED]** [99, 100].

[H2] DNA repair

Impaired DNA repair was suggested to have a role in ALS pathophysiology following the identification of *FUS* mutations, although the exact role of DNA repair failure in ALS remains to be clarified[101, 102]. Mutations in *NEK1* and *C21orf2* **[**, both of which encode proteins involved in DNA repair, have recently been identified as causes for ALS [103-105] although the biological pathways associated with their their causal role awaits confirmation **[LEAVE THIS SENTENCE AS MODIFIED HERE**

[H2] Excitotoxicity

Motor neurons are very sensitive to toxicity induced by calcium entry following excessive glutamate stimulation as they have a lower calcium buffering capacity than other neuronal subtypes and α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid (AMPA) receptors that are more calcium permeable (as they contain less of the GluR2 subunit) [106]. In addition, excitatory amino acid transporter 2 (EAAT2), an astroglial **[**protein that is the main synaptic glutamate re-uptake transporter, is impaired in ALS, which is likely to result in synaptic glutamate abundance and motor neuron toxicity. The loss of EAAT2 has been observed in both rodent models and patients with familial or sporadic ALS. Excitotoxicity is thought to be a mechanism common to all forms of ALS, although the evidence for this remains indirect. One argument is that riluzole, which can attenuate disease progression and is an approved drug for neuroprotection in ALS, can inhibit glutamate release [107, 108]. However, whether this underlies the therapeutic effect of riluzole remains unclear.

[H2] Oligodendrocyte degeneration

Oligodendrocyte degeneration has been observed in ALS. In the healthy CNS, oligodendrocytes are replaced by the proliferation **[Au: and presumably differentiation NOT FULLY DIFFERENTIATED, so BEST TO LEAT TEXT AS IS ?]** of oligodendrocyte precursor cells, which are abundantly present [109, 110] . At least in animal models of ALS, and for reasons that are now clear **[Au: please expand on this in 1-2 sentences; what causes this failure to differentiate?]** CAUSES ARE NOT KNOWN , oligodendrocyte precursor cells **[Au: I've specified precursor cells here, OK?]OK** fail to go through the final stages of differentiation. Oligodendrocytes provide vital metabolic support to axons through the shuttling of lactate through monocarboxylate transporter 2 [111, 112], and accordingly, dysfunction of oligodendrocytes contributes to the motor axonal failure **[YES]** in ALS. Restoring oligodendrocytic function by transgenically deleting mutant SOD1 from these cells significantly slows disease progression and prolongs their life span [113]. In patients with ALS, abnormalities in oligodendrocytes can occur, but whether these changes contribute to the disease remains to be demonstrated.

[H2] Neuroinflammation

 [OK Neuroinflammation can be observed in imaging studies in patients with ALS, human postmortem samples and rodent models of ALS [114, 115]. **[Au: cite fewer refs here? Refs removed].** Astrocytes and microglial cells release a number of hazardous and possibly neuroprotective factors. Deleting mutant *Sod1* **OK]** from these cells in a mouse model increases survival and slows disease progression [116], indicating that inflammation is an important factor for amplifying neuronal injury and disease progression in ALS. **[**OK Microglia have dual activation phenotypes, which can be neuroprotective (the M2 phenotype) or toxic (also known as classically activated, or M1 phenotype); evidence from SOD1-transgenic mice suggests the phenotype of microglia evolves with disease progression, from a neuroprotective phenotype at disease onset to a neurotoxic phenotype, with an altered cytokine release profile, at end-stage disease [117] **OK** In addition, evidence highlights complex signalling between CNS resident immune cells and peripheral cells, including monocytes and T-lymphocytes.

[H2] Mitochondrial dysfunction

Mitochondrial function is impaired in ALS and changes in mitochondrial morphology have been shown in some patients, and in the SOD1 mouse model [118, 119]. In the SOD1 model, vacuoles containing protein aggregates containing mutant SOD1 can be observed in the mitochondrial inter-membrane space, leading to impairment of protein import [120]. In addition, oxidative damage to mitochondrial proteins leads to defects in respiratory chain function in patients with ALS and in SOD1 mouse models [121], and

444   various experimental models of ALS have defects in axonal transport of mitochondria, which could

445   contribute to the axonopathy at the neuromuscular junction [122, 123].

446

447   Many of the functions disrupted in ALS are regulated by signalling between the endoplasmic reticulum

448   and mitochondria, underpinned by tight junction associations mediated by the endoplasmic reticulum

449   protein VAPB and the outer mitochondrial protein regulator of microtubule dynamics protein [124]. These

450   associations are perturbed by *TARDBP* and *FUS* mutations[125, 126]. TDP-43 preferentially binds to mRNAs

451   encoding respiratory chain complex 1 subunits and causes complex 1 disassembly [127] and accumulates in

452   the mitochondria of patients with ALS and mutations in *TARDBP* increase the mitochondrial localization

453   of TDP-43. Suppression of TDP-43 localization to mitochondria improves mitochondrial dysfunction and

454   reduces neuronal loss in mTDP-43 cell based models. In C9orf72-related ALS models, the dipeptide

455   repeat protein poly(GR) appears to compromise mitochondrial function and causes oxidative stress and

456   DNA damage [128]. *CHCHD10* mutations, which are associated with familial ALS, can promote the loss of

457   mitochondrial cristae junctions, impair mitochondrial genome maintenance and interfere with apoptosis

458   by preventing of cytochrome-C release [129].

459

460   **[H2] Final common pathway**

461   The main mechanism involved in the pathogenesis of ALS is probably dependent on the initial cause,

462   although multiple mechanisms appear to explain the toxicity of one mutation and these mechanisms are

463   likely highly interlinked. This is clearly the case for *SOD1* mutations. In the case of C9orf72 repeat

464   expansions, multiple factors likely contribute to neuronal injury including toxic gains-of-function related

465   to RNA foci and the presence of dipeptide repeat proteins, but loss of the normal function of the

466   C9orf72 protein might also have a role.

467

468   Whatever the mechanisms of ALS, the end result is that the motor neuron cannot maintain its axonal

469   projections, leading to axonal retraction and denervation of the target cell. For lower motor neurons,

470   this results in denervation of the muscle, but for upper motor neurons results in the loss of proper

471   control of lower motor neurons, hypertonicity and weakness .. In addition, a loss of important neural

472   networks within motor and extra-motor domains is also apparent [130]. **[]OK** As many of the proteins

473   encoded by genes that are implicated in ALS are ubiquitously expressed (Table 1), it is unclear why

474   motor neurons are the most susceptible to the hazardous effects of these mutations. The large size of

475   motor neurons, and in particular the need to maintain their long axonal projections, could make these

476 cells more sensitive to metabolic abnormalities than others, but other neuronal subtypes, such as

477 sensory neurons, have even larger axonal projections. Other factors that have been suggested to have a

478 role are the high expression of EphA4 and matrix metalloprotein 9   and the low expression of

479 osteopontin and insulin-like growth factor 2 by motor neurons, which might limit axonal sprouting and

480 repair. Of particular interest is that within the motor neuron pool, neurons that establish the fast

481 fatiguable motor units die first in ALS [131, 132] , but how this relates to the other vulnerability factors needs

482 to be clarified.

483

484 ## [H1] Diagnosis, screening and prevention

485

486 ### [H2] Clinical presentations

487   [OK The clinical hallmark of ALS is the involvement of both upper and lower motor neurons (Figure 1).

488 Patients can present with symptoms of an upper motor neuron predominant onset (that is, spasticity

489 and [Au: muscle] weakness) in whom lower motor neuron involvement only becomes evident at later

490 stages of disease. [7, 133-136] [Au: cite fewer refs here? Keep these refs if possible] . Conversely, patients

491 can present with symptoms of lower motor neuron dysfunction, which includes fasciculations, cramps

492 and muscle wasting. Approximately one third of patients with ALS present with bulbar-onset disease,

493 which is characterized by progressive dysarthria, followed by difficulty swallowing and often with

494 associated emotional lability. Limb onset disease accounts for 60% of cases, is usually asymmetrical in

495 presentation and can first develop in the upper or lower limb. [Up to 5% of patients present with

496 respiratory problems and are often seen first in cardiology and pulmonology clinics prior to their referral

497 to neurology clinics [137]. In these cases, patients can also present with unexplained weight loss. Evidence

498 suggests that some patients with ALS are hypermetabolic; [138] although the pathophysiology

499 underpinning this is not well understood. Cardiovascular risk factors (such as hyperlipidemia or obesity)

500 might attenuate risk [138], but do not alter clinical outcome [139] . Patients can present with a pure motor

501 phenotype of ALS, and have normal cognition and behaviour, but some patients can present with a

502 purely cognitive or behavioural phenotype consistent with frontotemporal dementia(FTD)), or a mixed

503 phenotype with minor changes in executive impairment that progress over time. Frontotemporal

504 dementia is part of the presenting features of 13% of incident cases [2-4] and approximately 30% of all

505 incident patients have some evidence of executive dysfunction at the time of first presentation [3, 140].

506 Depending on the population and the extent of cognitive testing performed, most studies have

507 suggested that up to 50% of patients can remain cognitively normal throughout the course of the

508 disease [3] Behavioural changes are common in patients with ALS, with apathy as the most prevalent

509 symptom. Detailed examination of behavioural changes in patients with ALS, using a disease specific

510 behavioural scale (that is, the Beaumont Behavioural Index) suggests that up to 40% of incident cases

511 have new behavioural changes that can be clustered into at least 5 different groups which roughly map

512 to known neuroanatomical networks and pathways [141]. Substantial autonomic impairment (such as

513 cardiovascular, gastrointestinal and bladder dysfunction) does not occur in the majority of patients with

514 ALS.

515

516 **[H2] Diagnostic criteria**

517 No definitive test for the diagnosis of ALS is available, and diagnosis is a process of clinical investigation

518 to exclude other possible causes of the presenting symptoms, combined with evidence of disease

519 progression. However, the growing understanding of the extra-motor features of ALS, the presence of

520 phenotypic overlap with other neurodegenerative diseases and the identification of genetic and

521 pathological subtypes of ALS can confound accurate and timely diagnosis [7].

522

523 Diagnosing ALS is based on the El Escorial criteria (Box 2) [142]. Diagnosis according to these criteria

524 requires a history of progressive weakness spreading within a region or to other regions (such as bulbar

525 regions (speech and swallowing), cervical regions (upper limbs), thoracic regions (chest wall and

526 abdominal muscles) or lumbar regions (lower limbs), with evidence of lower motor neuron (through the

527 presence of specific symptoms or evidence of denervation on electromyography) and upper motor

528 neuron (through the presence of specific symptoms and brisk deep tendon reflexes) involvement In the

529 original criteria, diagnostic certainty ranged from Suspected ALS, (although this is no longer included in

530 the revised criteria), to Definite ALS (in which three body regions with mixed upper and lower motor

531 neuron findings were observed), which relates to the burden of disease. Neurophysiological findings

532 have been classified using the Awaji Criteria, which can enhance diagnostic and prognostic sensitivity [143].

533 Variants of the El Escorial criteria are used in research settings and for the purposes of clinical trial

534 enrolment, but these criteria should not be routinely used in clinical practice for routine patient

535 management, as "possible ALS" described by the criteria is almost always ALS clinically [144, 145]. Genetic

536 testing can also be included in patients with a strong family history of ALS [146] and clinical evidence of

537 disease, although this is not uniformly applied across centres [147].

538

539   **[H2] Cognitive and behavioural deficits**

540   Standard diagnostic and stratification parameters for ALS do not yet include cognitive or behavioural

541   status, which is altered in up to 50% of cases (depending on the extent of cognitive and behavioural

542   assessment [2-4]. Various screening tools have been designed to identify patients with ALS and cognitive

543   and behavioural changes in the clinic, such as the Edinburgh Cognitive and Behavioural ALS Screen

544   (ECAS), which is validated in several languages and is widely used, as it has a high degree of sensitivity

545   with lower degrees of specificity [148]. Individuals with abnormal ECAS scores (after adjustment to

546   population-based and educational norms) should be referred for a full neuropsychological evaluation [149].

547   The detection of cognitive and behavioural changes is important for patients with ALS and their

548   caregivers, as executive impairment is associated with a more-rapid disease trajectory and behavioural

549   changes are associated with higher caregiver burden [150].

550

551   **[H2] Biomarkers**

552   As ALS is a clinical syndrome with a heterogeneous phenotypic manifestation [and clinical course,

553   diagnostic and prognostic biomarkers are urgently required for the purposes of stratification. Levels of

554   neurofilament light chain (NfL) and phosphorylated neurofilament heavy chain in the cerebrospinal fluid

555   (CSF) can differentiate patients with ALS from those with mimics including cervical myelopathy,

556   multifocal motor neuropathy and inclusion body myositis, with moderate sensitivity and specificity **[Au:**

557   **could you quote some values here? 'moderate' is quite an unspecific term]**, and levels have a

558   moderate correlation with disease progression **[Au: how do they correlate? Do levels increase with**

559   **progression?]** [151-153]. However, CSF neurofilament levels are not integrated into standard clinical

560   practice. Levels of NfL in serum are sensitive and specific for separating patients with ALS from healthy

561   controls, but data on comparison with ALS mimics are not available.

562

563   MRI studies of patients with ALS have shown corticospinal tract degeneration, with extensive

564   involvement within the frontal and temporal regions and basal ganglia, compared with controls

565   Evidence suggests that selective network vulnerability of structural and functional 'connectomes' could

566   drive the clinical manifestations of ALS, such as vulnerability of the corticospinal, orbitofrontal,

567   orbitotemporal and frontostriatal circuits [154-156]. The presence of network disruption is also supported by

568   findings using spectral electroencephalogram [130], and that patients with different degrees of cognitive

569   impairment show significantly different patterns of frontal lobe metabolic impairment on ^{18}F

570   fluorodeoxyglucose PET imaging [157]. However, neither imaging nor spectral electroencephalogram can

18

571 provide individualised data that can be used as a reliable biomarker of upper motor neuron dysfunction
572 and of cognitive impairment in patients with ALS.

573

574 **[H2] Differential diagnosis**
575 The differential diagnosis in patients with pure bulbar pure upper motor neuron or pure lower motor
576 neuron presentations includes ALS variants, treatable ALS mimics and disorders with a more benign
577 prognosis [134, 158]. Other forms of motor neuron disease include progressive muscular atrophy (that is, the
578 exclusive degeneration of lower motor neurons) and primary lateral sclerosis (that is, the exclusive
579 degeneration of upper motor neurons). Some patients with progressive muscular atrophy have
580 mutations in genes associated with ALS[159]. Similarly, patients with primary lateral sclerosis may have a
581 family member with ALS and most autopsies of patients with primary lateral sclerosis show subtle signs
582 of ALS pathology in the lower motor neurons within the brain stem and spinal cord [135, 158].

583

584 Several conditions have similar initial clinical features as ALS and should be considered in the differential
585 diagnosis [145], including cervical myelopathy, multifocal motor neuropathy, myasthenia gravis, Lambert
586 Eaton myasthenic syndrome and inclusion body myositis. Features that should alert the clinician to a
587 possible mimic syndrome include presentation with of symmetrical findings; prominent extensor plantar
588 responses (which should raise suspicion of a cervical myelopathy) and the presence of sensory findings.
589 Although sensory symptoms are common in ALS, clinical evidence of sensory loss is atypical and should
590 trigger further investigations. In addition, the presence of substantial weakness in the absence of
591 wasting – which is common in multifocal motor neuropathy and myasthenia gravis – and the presence
592 of disproportionate involvement of quadriceps – which is common in inclusion body myositis – may
593 indicate the presence of an ALS mimic syndrome [160]. As ALS is a progressive disease, failure of the
594 condition to progress over months should also trigger a re-investigation [161].

595

596 **[H2] Staging and prognosis [**
597 Several different staging systems for ALS have been described (Figure 4) [162-165], including the King's
598 system, which is based on the number of affected regions of the body, and the Milano-Torino system
599 (MITOS), which is based on a clinical scale The prognosis of ALS is highly variable and prognostic
600 algorithms have been generated from population-based and clinical trial-based datasets [166, 167]. Negative
601 prognostic indicators include bulbar or respiratory onset disease, the presence of executive impairment
602 or frontotemporal dementia and weight loss. Several biochemical markers of prognosis have been

reported including serum urate, serum creatinine, serum chloride, and increased serum and CSF neurofilament levels [153, 168-170] **[Au: please cite fewer refs here. Keep if possible?]** Declining respiratory function, measured by slow vital capacity, forced vital capacity and sniff nasal inspiratory pressure also correlate with short survival [166, 167, 171, 172]. **[Au: please limit the number of references here to 1-2. Keep if possible?]**

[H2] Clinical genetics and predictive testing

Consensus guidelines recommend genetic testing of probands with ALS who have a first or second degree relative with ALS and/or frontotemporal dementia [19, 173]. As the genetic risk for ALS depends on ancestral origin, the genetic testing should be contextualized; for example, *C9orf72* variants are rare in Asia, whereas mutations in *OPTN* are more common in Asian than in European populations. Although the potential benefits of genetic testing for patients are clear and could improve knowledge about their disease, family planning and their possible inclusion in clinical trials, individuals also have a right not to know their genetic status. Pre-symptomatic testing of family members of patients with ALS remains controversial. Guidelines for genetic testing in research settings have been published [174], but most centres do not advocate routine testing outside of specialist centres [147].

[H1] Management

ALS management is best achieved by a multidisciplinary approach to care, comprising a clinical team with different specialities, including neurologists, psychologists, nutritionists, pulmonologists, physical therapists, speech therapists and specialized nurses[175, 176]. Multidisciplinary care increases survival [177-179], reduces the number of hospital admissions and shortens hospital stays [178] and increases quality of life of patients with ALS [180]. This is likely related to the optimization of pharmacological and non-pharmacological interventions and enhanced adherence to treatment guidelines.

[H2] Disease-modifying therapies

Although > 50 drugs with different mechanisms of action have been studied for the treatment of ALS, only 2 compounds (riluzole and edaravone have come to market. The negative results of these trials might include clinical and pathogenetic heterogeneity in disease, and faults in trial design [181].

Riluzole was the first FDA approved treatment for ALS, and, although the mechanism of action is poorly understood, is speculated to reduce glutamatergic neurotransmission, by blocking voltage-gated sodium

634 channels on presynaptic neurons. . In the original trial, Riluzole, increased 18-month survival of patients

635 by 3 months compared with placebo , but had no significant effect on muscle strength [182]. Riluzole is a

636 relatively safe drug, although the most common adverse effects are an increase in liver enzymes and

637 asthenia (that is, a lack of energy) and some cases of fatal hepatic failure and pancreatitis have been

638 reported. In addition to the traditional tablet form of the drug, an oral suspension has been produced

639 and marketed in some countries for patients who are unable to swallow solid forms of the drug, owing

640 to severe dysphagia [183]. Edaravone, which is thought to act as an anti-oxidant agent has a beneficial

641 effect on progression in a highly selected cohort of patients with early onset and rapidly progressive

642 disease [184], and accordingly, has been licensed by the US FDA but not by the European Medicines

643 Agency. Whether edaravone should be provided to all patients of ALS regardless of clinical

644 presentation is a matter of debate [185]

645

646 **[H2] Symptomatic treatments**

647 Other symptoms of ALS can be treated with pharmacological and non-pharmacological interventions.

648 Nuedexta may improve bulbar function [186] and is available in the US but not in Europe. However, most

649 of these therapies for the symptoms of ALS have not been tested in randomized controlled trials and

650 are based on management of other diseases.

651

652 **[H3] *Spasticity.*** Spasticity is present in most patients with ALS, but only a small proportion need

653 treatment. The most commonly used drugs are baclofen and tizanidine (both of which are muscle

654 relaxants) although no randomized controlled trials in patients with ALS have been conducted. When

655 patients have severe, disabling spasticity, baclofen can be administered through an intrathecal pump. .

656 Cannabinoids have been approved for the treatment of spasticity in patients with multiple sclerosis and

657 are also used off-label or as a self-prescribed medication in patients with ALS[187].

658

659 **[H3] *Sialorrhoea.*** Sialorrhoea (that is hypersalivation), causing drooling and the pooling of saliva within

660 the oral cavity is one of the most disturbing symptoms in patients with ALS, and is more commonly

661 observed in patients with bulbar-onset disease and during late-stages. Sialorrhoea can be treated [with

662 anticholinergic drugs, such as scopolamine, atropine, hyoscine, amitriptyline and glycopyrrolate.

663 Adverse effects associated with the use of anti-cholinergics include blurred vision, mouth dryness and

664 constipation, and these drugs are contraindicated in patients with heart conduction disturbances and

665 prostatic hypertrophy. In patients in whom pharmacological treatments are ineffective or are not

666   indicated, botulinum toxin A or B injections into the salivary glands can used to treat sialorrhoea[188, 189].

667   Salivary gland irradiation has been also proposed [190].

668

669   **[H3] Pain.** Pain is reported in 15–85% of patients with ALS, depending on the duration of the disease

670   and the setting of the study, and is more frequently of nociceptive than of neuropathic origin. [191]

671   Depending of the type of pain, pharmacological treatments include gabapentin, pregabalin and tricyclic

672   antidepressants (for neuropathic pain), and NSAIDs, opioids and cannabis for nociceptive pain), but no

673   randomized controlled trials evaluating treatment of pain in patients with ALS are available. Nociceptive

674   pain can be also treated with intra-joint injections of lidocaine or steroids, and physical therapy,

675   including assistive range-of-motion exercises.

676

677   **[H3] Muscle *cramps.*** Muscle cramps are the main cause of pain in about one-quarter of patients with

678   ALS (mainly patients with the spinal onset disease) and are caused by the instability of motor units [192].

679   Commonly used treatments for muscle cramps include quinine sulphate, levetiracetam and mexiletine.

680   Indeed, mexiletine has been shown to induce a significant dose-dependent reduction in muscle cramps

681   in a phase 2 randomized controlled trial in patients with ALS [193]. Of note, the FDA has advised against the

682   use of quinine sulphate for the treatment of cramps because it can cause cardiac arrhythmias,

683   bradycardia and prolongation of Q-T interval.

684

685   **[H3] *Dysphagia***

686   Dysphagia is reported by about 60% of patients with spinal onset ALS, within two years from onset and

687   100 % of patients with bulbar-onset disease [194]. Several strategies can be implemented to reduce the

688   effects of dysphagia in patients, including dietary changes such as modification of the consistency of the

689   diet, the use of fluid thickeners and prescription of high-protein and high-caloric supplements,

690   swallowing facilitating manoeuvers and exercises (such as oral and pharyngeal range-of-motion

691   exercises, head postures and the technique of supraglottic swallow). An option for severe difficulties

692   with swallowing is to use enteral nutrition via the insertion of a gastrostomy tube. No established

693   criteria are available for the initiation of enteral nutrition in patients with ALS, but weight loss of >5% or

694   unsafe swallowing are generally considered to be red flags that should prompt intervention. [175]. Several

695   techniques are available for minimally invasive tube insertion and open surgery is not recommended [195,

696   196]. Parenteral nutrition provided through a central venous catheter is an alternative to enteral nutrition

697   in patients with ALS who have severe respiratory insufficiency for whom PEG **[Au: Percutaneous**

698   **endoscopic gastrostomy]** or RIG **[Au: Radiologically Inserted Gastrostomy?** are contraindicated [197, 198].

699

700   **[H3]** *Dysarthria.* Dysarthria is the presenting symptom in 30% of patients and is found in > 80% of

701   patients during the course of the disease, up to complete anarthria. Speech therapy can delay the

702   progression of dysarthria and augmentative-alternative communication **[**techniques such as

703   customised software are the treatment of choice and can enhance quality of life in the most advanced

704   phases of ALS [199]. Communication techniques based on brain-computer interfaces (BEST LEAVE THIS IN

705   PLACE] have been developed, but their use in the clinical setting is still very limited as their effectiveness

706   has not been definitely demonstrated [200]. Moreover, the use of brain-computer interfaces might be

707   hindered by patients' cognitive dysfunction or old age [201].

708

709   **[H3]** *Deep venous thrombosis.* Patients with ALS have leg weakness and reduced mobility, which can

710   increase the risk of symptomatic and asymptomatic deep venous thrombosis (DVT). The annual

711   incidence of DVT in patients with ALS ranges from 2.7 to 11.2% [202, 203]. In the absence of specific studies

712   on the prevention and treatment of DVT in ALS general guidelines should be applied, including the use

713   of compression stockings and anticoagulation therapies

714

715   *[H3] Mood alterations.* Depression is a relatively common symptom in patients with ALS and has been

716   found in up to 50% of patients. Depression is generally treated with selective serotonin reuptake

717   inhibitors (SSRI) or tricyclic antidepressants. Pseudobulbar affect (that is, episodes of uncontrollable

718   crying or laughing) is a distressing symptom that has been reported in up to 50% of patients with ALS [204]

719   **[**and can be treated with SSRIs and tricyclic antidepressants, although this is off-label.

720   Dextromethorphan (a sigma-1-receptor agonist and an uncompetitive NMDA receptor antagonist) and

721   low-dose quinidine were effective in reducing symptoms of pseudobulbar affect by 50% in patients with

722   ALS or those with multiple sclerosis [205].

723

724   *[H3] Cognitive impairment*. Cognitive impairment, in particular frontotemporal dementia, is one of the

725   most disabling symptoms in patients with ALS. No pharmacological therapy is effective for the treatment

726   of frontotemporal dementia, and acetylcholinesterase inhibitors, which are used for Alzheimer disease,

727   are not effective. However, some symptoms of frontotemporal dementia can be pharmacologically

728   treated; evidence suggests SSRIs might help to control the loss of inhibition, overeating and compulsive

729 behaviour, and antipsychotics can be used to reduce restlessness. Education of caregivers about the

730 symptoms of frontotemporal dementia can be useful to help the management of patients at home [206].

731

732 ### *[H3] Respiratory insufficiency.*

733 The vast majority of patients with ALS die from respiratory failure. Non-invasive ventilation is the

734 symptomatic treatment of choice for respiratory failure, and provides significantly longer survival

735 compared to those who do not use NIV (316 vs 229 days) and improves quality of life [207] [208]. Accepted

736 criteria for starting non-invasive ventilation are symptoms or signs related to respiratory muscle

737 weakness (such as, dyspnoea, orthopnoea or daytime fatigue), a vital capacity of < 80% of predicted

738 levels, $PaCo_2$ > 45 mmHg, SaO$_2$ < 90% during ≥ 5% of sleep time [176]. One distressing symptom that is

739 related to respiratory muscle weakness in patients with ALS is the inability to cough effectively. This can

740 be controlled by the use of cough-assist devices, such as the breath-stacking technique or a mechanical

741 insufflator-exsufflator [209].

742

743 ## [H2] End of Life Management

744 The end of life phase for patients with ALS can be difficult to define, although recent staging systems

745 including KINGS and MITOS [are useful in this regard. The end of life period can be particularly

746 challenging and is characterized by substantial mobility, communication and, in some cases, cognitive

747 difficulties. An early discussion of end of life issues will ensure that patients can communicate their

748 wishes before the onset of substantial communication and cognitive difficulties, can avoid unwanted

749 interventions or procedures, and can provide time for reflection and the integration of choices within

750 the patient's priorities and life plans. In addition, such discussions can alleviate patient's fears, especially

751 around fatally choking. The attitudes, culture and personal values of patients, caregivers and health care

752 providers can influence the timing and content of end of life discussions, decision-making and the

753 patient's acceptance or refusal of interventions and treatment options. Some patients with ALS might

754 choose life-prolonging measures, but others might contemplate life-limiting procedures; the availability

755 and utilization of different interventions and technologies, such as assisted death and tracheostomy,

756 varies across centres and between countries. Advance care directives are recognized as important at

757 end of life in ALS, and provide patients with the option to exercise autonomy regarding preferred end of

758 life management strategies. Formal care at the end of life should aim to maximize quality of life of both

759 the patient and caregiver and, where possible, incorporate appropriate multidisciplinary care including

760 palliative care options.

[H1] Quality of Life

Much of the effort of physicians and other health care providers is focused on optimizing the quality of life (QOL) of patients with ALS. **[Au: green text moved to here for flow. OK]** The choice of a specific QOL instrument is complex, and has been reviewed [210]. The perception by individuals with ALS of their QOL takes shape at the time of disclosing the diagnosis, and can be influenced by the manner in which they are informed . Well-recognized systematic approaches are available, such as the SPIKES approach, that can convey the diagnosis in a less distressing manner and can leave the patient feeling hopeful and supported [211-213].

 [Au: I've deleted the text stating healthy individuals think the QOL of patients with an illness is lower, and that HRQOL is not the same as QOL, as this isn't needed here] Health-related QOL (HRQOL) refers to an individual's perception of their QOL as a function of physical and mental well-being [214]; measures of HRQOL generally decline as ALS advances [210, 215]. In contrast, OQOL **[Au: overall QOL?]** encompasses medical factors and a wide variety of non-medical factors, such as family, friends, occupation, financial well-being, spirituality or religion and existential concerns [216]. Patients with ALS often view their OQOL as good, which persists despite the progression of physical disability [217, 218]. This might be explained by a 'response shift' (also called a frame shift or well-being paradox), whereby the individual recalibrates the factors that are deemed meaningful to maintenance of their QOL. Most commonly, this centres around the decreased importance of physical activities and the greater role of interactive and existential factors, such as social relationships and spirituality [219-221]. However, not all patients maintain a high QOL with advancing illness. Many factors can negatively affect QOL in patients with ALS, identifying potential areas for intervention, although other factors can improve QOL (Figure 5) [180, 207, 214, 222-228] **[Au: please restrict the number of references here to 1-2]** .

Despite good QOL of patients with ALS in aggregate **[Au: '..a good QOL of most patients with ALS'? edited for brevity]** , psychological health is, on average, poorer than that of the population as a whole [229]. This has substantial implications as depression, hopelessness and anxiety all associated with a poor QOL. **[Au: I've moved the green text to here from earlier on for flow]** Psychological interventions have

791 been less well studied **[Au: than what? please add a comparator here]** [230] and this warrants further

792 attention.

793

794

795 QOL can affect the wishes for care of patients with ALS at the end of their lives. **[Au: edited for flow]** In a

796 study from the Netherlands, 16.8% of patients with ALS chose physician-assisted death, common

797 reasons for which were hopelessness, loss of dignity, dependency on others and fatigue [215]. Similarly,

798 the decision for euthanasia in patients with ALS in Washington State was driven by loss of autonomy,

799 participation in enjoyable activities and dignity [216]. These studies do not prove poor QOL in these

800 individuals, but they do raise this as a concern. The quality of death in patients with ALS has been

801 studied less comprehensively **[Au: than QOL?]** . Death was perceived as peaceful by 88% to 98% of

802 caregivers in Germany, the United Kingdom, the United States and Canada [217, 231].However, caution must

803 be used in interpreting grouped statistics. Incompletely relieved symptoms such as coughing from **[Au:**

804 **excess?]** mucus, restlessness, anxiety and muscle **[Au: added muscle here]** cramps resulted in moderate

805 to severe suffering in the last 24 hours of life in 8 of 171 patients [217].

806

807 ## [H1] Outlook

808

809 The knowledge of ALS and the care of patients with this condition have increased substantially in recent

810 years, and this trend is likely to continue. 25 years ago, riluzole had not been enrolled in a clinical trial,

811 non-invasive ventilation was not in routine use for patients, the pathological basis of ALS as a TDP-43

812 proteinopathy was unknown and no genetic causes for ALS had been identified. In addition, the El

813 Escorial criteria were not developed, no simple ALS functional scale existed, multidisciplinary care was in

814 its infancy and the recognition of cognitive change in patients with ALS was limited, and the link with

815 frontotemporal dementia was not made. What will be different in another 25 years, and how much of

816 what we regard as self-evident now, will be overturned, is tempting to consider.

817

818 **[H2] Epidemiology**

819 We can expect that the numbers of patients with ALS will increase in the future [218], and that population

820 differences in incidence and phenotype will be recognized. Better multidisciplinary care and an

821 improved understanding of interventions means that a patient diagnosed with ALS can expect to live

822   longer than previously. In addition, the development of new drugs to improve respiratory function or

823   directly affect the disease process are expected to improve survival.

824

825   **[H2] Pathophysiology**

826   A big barrier to effective ALS treatments is due to our lack of knowledge of the pathological pathways

827   that lead to the disease, and how they affect the overall integrity of brain networks. Our understanding

828   of ALS is improving, including contextualizing the role of TDP-43, the importance of RNA processing for

829   motor neurons, the spread of disease and the molecular cascades that lead to neuronal death. The

830   development of new cellular and animal models of ALS is beginning to lead to improvements in our

831   understanding of the disease , both because the molecular pathways can be dissected more easily, and

832   because the models can be used to more effectively to identify drugs worth enrolling into human trials.

833   These insights are the result of genetic findings, which have led to experiments aiming to understand

834   how loss-of normal protein function and gain-of toxic function cause ALS. As the number of genes

835   implicated in ALS increases and laboratory models improve, we can expect to design new drugs to

836   intervene in those pathways.

837

838   Indeed, our understanding of the genetics of ALS has transformed over the last 25 years, with the

839   finding that both familial and sporadic ALS have a genetic basis and the number of validated involved

840   genes steadily increasing. These findings are in large part due to the willingness of the ALS research

841   community to collaborate, which has generated the huge datasets required for credible gene discovery.

842   The finding that the genetic architecture of ALS includes an important role for rare genetic variation has

843   consequences for the likelihood that gene therapy could be effective in this disease. Indeed, as rare

844   variants are more likely to have a large effect on the risk of disease and can be directly manipulated by

845   gene therapy, we can expect to see precision medicine spearheaded by targeted gene therapies.

846   The relationship between ALS and cognitive, cerebellar, autonomic and other non-motor changes is an

847   area of research that is expected to grow. One consequence of this research is that ALS is probably

848   primarily a disease of neural networks, which is defined by the involvement of upper and lower motor

849   neurons, but that can also affect other cell populations and neuronal networks. We can also expect an

850   increased understanding of the role of inflammation in ALS, both in triggering disease and influencing

851   the rate of progression.

852

853   **[H2] Diagnosis and prognosis**

854   The use of biomarkers for ALS has been investigated for many years, although our understanding has

855   only recently matured for research to yield useful results. Diagnostic biomarkers would be useful for

856   individuals with an atypical or complicated presentation, biomarkers for prognosis would be useful for

857   planning treatment options, and biomarkers of disease progression would be useful for monitoring

858   response to existing therapies or potential new therapies in a clinical trial. New signal analysis based

859   technologies will become available as biomarkers that can image the living human brain [139].

860

861   **[H2] Management**

862

863   **[H3] Clinical Trials**

864   The validity of pre-clinical studies should be evaluated rigorously by evidence-based analyses, and

865   translation of new therapies to humans should be undertaken only if findings are robust and

866   reproducible. Moreover, as ALS is a human disease, testing safe candidate compounds without prior

867   testing in animal models could be undertaken. In this instance, careful phase I and 2 studies including

868   detailed pharmacokinetic studies with extensive dose-finding and toxicity studies will be needed. As

869   some previous ALS clinical trials failed due to faulty trial design, a detailed correlative analysis of drug

870   levels in serum and CSF should be undertaken in early phases trials, and all trials should include a

871   biomarker readout to confirm that the drug is reaching its target. **[Au: what do you mean by 'target**

872   **engagement'? Please clarify]** .

873

874   The failure of previous clinical trials for ALS could also result from disease heterogeneity. Methods to

875   stratify patients that have a shared pathobiology are urgently required, and in the absence of this, pre-

876   specified, post-hoc analyses should be used to identify potential responder groups. This is exemplified

877   by a recent successful Phase 3 trial of edaravone [184], as recruitment to this trial was based on a post-hoc

878   analysis to identify possible responders, and stringent recruitment criteria were used to provide a

879   clinically homogeneous population that were likely to respond to treatment.

880

881   **[H3] New Drugs**

882   An extensive pipeline of new therapeutics for ALS is available, and some of these drugs target known

883   mutations and pathogenetic pathways. Symptomatic therapies including tirazemptiv based on

884   improving respiratory function in patients with ALS are currently in Phase 3 trials and exciting Phase I

885   trials assessing the use of antisense oligonucleotides in *SOD1* and *C9orf72* **[**related ALS are underway. In

886 the future, treatments are likely to be targeted at specific subgroups of patients and biomarkers that are

887 personalized to the individual disease subtype and have been developed from patient subcohorts that

888 have been extensively phenotyped and stratified using genomics, transcriptomics, metabolomics and

889 advanced imaging and signal analysis.

890

891

892

893   **Display items**

894

895   **Box 1. Mechanisms of SOD1 toxicity in cellular and rodent models [Au: Title OK? I have deleted this**
896   **figure as this is very repetitive with figure 3 and made the figure legend into a box. We can illustrate**
897   **the mechanisms included in this figure (prion-like seeding, etc.) in figure 3 if you wish, although I don't**
898   **think this is necessary as this is nicely described in this box]** .

899   Transgenic mice with mutations in *SOD1* (encoding superoxide dismutase, SOD1 **[Au: I've added the**
900   **gene product here as this is useful to note]**) can be used to study ALS pathophysiology. These mice
901   over-express mutant SOD1 and many have an aggressive disease course over approximately 80-90 days.
902   However, they display quite well clinical and pathological features similar to human ALS.

903   xx **[Au: Please add 1-2 sentences here discussing the phenotype of these mice – DONE do they show**
904   **sensorimotor dysfunction, for example? Reduced bowel and bladder function? I have adapted the**
905   **table that was in figure 1 into continuous prose (highlighted in yellow). I've also added a reference to**
906   **the NRNeuroscience review (ref 242) - please check this carefully OK]** . *SOD1* mutations can drive
907   neurotoxicity in several ways, including protein misfolding **[Au: presumably the misfolded protein here**
908   **is SOD1? BUT ALSO AGGREGATES OF NEUROFILAMANT PROTEINS],** proteasome impairment,
909   excitotoxicity, oxidative stress, ER stress, impaired axonal transport, axonopathy, inflammation, altered
910   RNA processing and mitochondrial dysfunction. [232] Other mechanisms of SOD1-related neurotoxicity
911   have recently emerged and have gained interest. SOD1 can acts as a transcription factor for genes
912   involved in **resistance to oxidative stress PLEASE LEAVE AS IS. '?]** and repair of oxidative damage **[Au:**
913   **DNA repair?]** [233]. RNA oxidation is emerging as a prominent pathological outcome of generalized
914   oxidative stress in the cell with increasing importance in neurodegeneration **[Au: does RNA oxidation**
915   **occur in *SOD1* transgenic mice?YES]** . **[Au: what do you mean by this? Do you mean astrocytes and**
916   **oligodendrocytes with mutations in *SOD1*?]**   Astrocytes and oligodendrocytes reprogrammed from
917   fibroblasts of patient with SOD1 mutations have been shown to induce hyperexcitability and cell death
918   **[Au: cell death of the motor neurons only, or also of astrocytes and oligos?]** in healthy control motor
919   neurons. Glial toxicity is mediated through both contact (lactate independent) and soluble mechanisms
920   and is rescued by SOD1 knockdown using short hairpin RNA in glia derived from patients with AOS1-
921   related familial ALS, but also in glia derived from patients with sporadic ALS without SOD1 mutation [113].
922   Wild-type and mutant SOD1 proteins form insoluble **intraneuronal** fibrils, which aggregate with
923   increased propensity in the mutant form. A prion-like transmission of mutant SOD1 fibrils can seed wild-
924   type SOD1 protein aggregation in neighbouring neurons and propagate neuronal injury[234].

925   **Box 2. El Escorial criteria [Au: please add these criteria here]** .

926

927

928

935 **Figure 1. Clinical manifestations of ALS** **[Au: Note this has been renumbered as figure 1, so the**
936 **symptoms of ALS are introduced early on in the manuscript]** .

937 Although motor manifestations such as muscle weakness and difficulty swallowing are the main clinical
938 manifestations of amyotrophic lateral sclerosis, up to half of patients have non-motor symptoms, such
939 as cognitive defects.

940 **Figure 2.** Histopathology of ALS.
941 a) **[Au: I've edited this for brevity and house style, please check this carefully]** Normal localization of
942 TDP-43 in the nucleus (black arrow head), and aberrant localisation in a diseased neuron with loss of
943 nuclear expression and a 'skein-like' inclusion in the cytoplasm (black arrow). b) **[Au: I've deletd the**
944 **H&E image as this isn't needed here OK]** Normal motor neuron (black arrow) and a hyaline
945 conglomerate inclusion that stains for SMI31 (black arrow head) in a patient with ALS caused by a *SOD1*
946 mutation. c) TDP-43-negative, **p62 positive [OK]** dipeptide repeat inclusions with a 'stellate' morphology
947 in the pyramidal cells of CA4 (black arrow) and granule cells of the dentate fascia (black arrow head) in
948 the hippocampus of a patient with ALS caused by a mutation in *C9orf72*. d) The spinal cord ventral horn
949 of a patient with ALS and a **[Au: I've deleted normal, healthy is sufficient here]** healthy individual (e)
950 showing a depleted numbers of motor neurons in ALS (arrows). F) CD68 (a microglial marker)
951 immunohistochemistry shows marked microglial **[Au: I'm not sure what you mean by this, please clarify**
952 **DONE]** reactivity in the lateral tracts (black arrow) and ventral **[Au: I've changed anterior to ventral,**
953 **OK? OK]** horns (black arrowhead), with no labelling **[Au:OK? OK]** in the dorsal columns (white arrow).
954
955

956 **Figure 3. Pathophysiology of ALS [Au: figure title OK?]** .

957 Mutations in several amyotrophic lateral sclerosis (ALS) causative genes **[Au: do you mean mutations in**
958 **these genes? reworded]** can exert motor neuronal injury through more than one pathophysiological
959 mechanism, although these mechanisms are often interlinked. *SOD1* is the longest studied gene
960 implicated in ALS and has been linked to the most pathophysiological mechanisms, although the effects
961 of **mutations in** *ALS3* and *ALS7* are still unknown. Aberrant RNA metabolism and impaired protein
962 homeostasis are predominant factors linking multiple ALS causative genes **[Au: what do you mean by**
963 **'most causative genes'? Please clarify DONE]** to neuronal injury. Mitochondrial dysfunction can arise
964 from a mutation in *CHCHD10* and from secondary respiratory chain deficiencies that arise from protein
965 aggregates generated in the presence of other ALS genetic mutations **[Au: can we just say 'arise from**
966 **protein aggregates' here? REWORDED]**. Both cases lead to an increase in oxidative stress, which puts
967 further stress on an already impaired protein homeostasis system. Other mechanisms of ALS can directly

968 ==alter neuronal function (such as nuclear export, impaired DNA repair, dysregulated vesicle transport and==
969 ==axon dysfunction) and the function of non-neuronal glial cells.== **[Au: I've added in the highlighted text so**
970 **all pathologies illustrated in the figure are mentioned in the legend, OK? Please feel free to edit this**
971 **OK]** The interplay of mechanisms is indicated by arrows.

972

973 **Figure 4. Staging systems for ALS.**

974 **[Au: green text moved here from the main manuscript text for flow, and edited for brevity]** The King's
975 staging system is based on the number of body regions affected by ALS and the presence of respiratory
976 or nutritional failure [162]. The Milano-Torino staging **[Au: definition of MITOS OK?]** (MITOS) system is
977 based on the ALS functional rating scale (ALSFRS-R), a 48 point clinical measurement scale that records
978 changes in bulbar, gross motor, fine motor and respiratory parameters **[Au: can we edit this to**
979 **'...changes in four functional domains: bulbar, gross motor, fine motor and respiratory'? If not, what**
980 **are the functional domains that are referred to in the figure?]** [163]. These staging systems do not
981 incorporate cognitive or behavioural changes. The King's staging system is sensitive to early changes in
982 ALS, but the sensitivity of the MITOS scale is greater in the later stages of disease [164, 165].
983

984

985 **Figure 5. Factors affecting QOL in patients with ALS.**

986 Several factors that positively or negatively affect overall quality of life (QOL) and health-related QOL
987 (HRQOL) have been identified in patients with amyotrophic lateral sclerosis. These factors include motor
988 symptoms, psychological symptoms and therapeutic interventions. AAC, augmentative and assistive
989 communication; VC, verbal communication.

990

991

992 **Table 1. Genes implicated in ALS.**

Gene locus	Gene (protein) [Au: I've reformatted this so the gene name is first and the protein name following in brackets]	Inheritance	Implicated disease mechanisms	References
ALS1	*SOD1* (Superoxide dismutase 1)	AD/AR	Oxidative stress	235, 236
ALS2	*ALS2* (Alsin)	AR	Endosomal trafficking	237, 238
ALS3	*Unknown*	AD	Unknown	239
ALS4	*SETX* (Senataxin)	AD	RNA metabolism	240
ALS5	Unknown	AR	DNA damage repair, axon growth	241
ALS6	*FUS/TLS* (Fused in sarcoma/translated in liposarcoma)	AD/AR	RNA metabolism	242, 243
ALS7	Unknown	AD	Unknown	244
ALS8	*VAPB* (Vesicle associated membrane protein (*VAMP*) – associated protein B)**[Au: should this be split up into two rows? Have *VAMP* and *VAPB* both been implicated in ALS?]**	AD	ER stress	42
ALS9	*ANG* (Angiogenin)	AD	RNA metabolism	245
ALS10	*TARDBP* (TAR DNA binding protein)	AD	RNA metabolism	27, 246
ALS11	*FIG4* (Polyphosphoinositide 5-phosphatase [Au: protein name OK?]CORRECTED)	AD	Endosomal trafficking	247
ALS12	*OPTN* (Optineurin)	AD/AR	Autophagy	248
ALS13	*ATXN2* (Ataxin 2)	AD	RNA metabolism	249
ALS14	*VCP* (Valosin-containing protein)	AD	Autophagy	36
ALS15	*UBQLN2* (Ubiquilin 2)	XD	UPS, autophagy	34
ALS16	*SIGMAR1* (Sigma non-opioid intracellular receptor 1)	AD	UPS, autophagy	250, 251
ALS17	*CHMP2B* (Charged multivesicular body protein 2B)	AD	Endosomal trafficking	252
ALS18	*PFN1* (Profilin 1)	AD	Cytoskeleton	97
ALS19	*ERBB4* (V-erb-b2 avian	AD	Neuronal	253

	erythroblastic leukaemia viral oncogene homolog 4)		development	
ALS20	*HNRNPA1* (Heterogeneous nuclear ribonucleoprotein A1)	AD	RNA metabolism	82
ALS21	*MATR3* (Matrin 3)	AD	RNA metabolism	83
ALS22	*TUBA4A* (Tubulin alpha-4A) **[Au:protein name OK? corrected]**)	AD	Cytoskeleton	102
ALS-FTD1	*C9orf72* (Chromosome 9 open reading frame 72)	AD	RNA metabolism, autophagy	5, 6
ALS-FTD2	*CHCHD10* (Coiled-coil-helix-coiled-coil-helix domain containing 10)	AD	Mitochondrial maintenance	255
ALS-FTD3	*SQSTM1* (Sequestosome 1)	AD	Autophagy	256
ALS-FTD4	TBK1 (TANK-binding kinase 1)			53, 54

AD, autosomal dominant; AR, autosomal recessive; XD, X-linked dominant

References **[Au: Please select ~10 references of particular importance and give a single sentence for each stating why the paper is important. Please copy the whole reference (not just the number, since this will inevitably change) to a separate list and provide the justifying sentence after it.]**

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