Multiple Phenotypes in Phosphoglucomutase 1 Deficiency


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DOI: 10.1056/NEJMoa1206605
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ABSTRACT

BACKGROUND
Congenital disorders of glycosylation are genetic syndromes that result in impaired glycoprotein production. We evaluated patients who had a novel recessive disorder of glycosylation, with a range of clinical manifestations that included hepatopathy, bifid uvula, malignant hyperthermia, hypogonadotropic hypogonadism, growth retardation, hypoglycemia, myopathy, dilated cardiomyopathy, and cardiac arrest.

METHODS
Homozygosity mapping followed by whole-exome sequencing was used to identify a mutation in the gene for phosphoglucomutase 1 (PGM1) in two siblings. Sequencing identified additional mutations in 15 other families. Phosphoglucomutase 1 enzyme activity was assayed on cell extracts. Analyses of glycosylation efficiency and quantitative studies of sugar metabolites were performed. Galactose supplementation in fibroblast cultures and dietary supplementation in the patients were studied to determine the effect on glycosylation.

RESULTS
Phosphoglucomutase 1 enzyme activity was markedly diminished in all patients. Mass spectrometry of transferrin showed a loss of complete N-glycans and the presence of truncated glycans lacking galactose. Fibroblasts supplemented with galactose showed restoration of protein glycosylation and no evidence of glycogen accumulation. Dietary supplementation with galactose in six patients resulted in changes suggestive of clinical improvement. A new screening test showed good discrimination between patients and controls.

CONCLUSIONS
Phosphoglucomutase 1 deficiency, previously identified as a glycogenosis, is also a congenital disorder of glycosylation. Supplementation with galactose leads to biochemical improvement in indexes of glycosylation in cells and patients, and supplementation with complex carbohydrates stabilizes blood glucose. A new screening test has been developed but has not yet been validated. (Funded by the Netherlands Organization for Scientific Research and others.)
Protein N-glycosylation is a ubiquitous process in all organ systems. During N-glycosylation, glycan precursors are assembled from monosaccharide units and then covalently attached to asparagine residues in the nascent peptide chain of a protein (Fig. 1). The protein-bound glycans undergo further processing to generate mature glycopolypeptides. Genetic defects in protein N-glycosylation, designated as congenital disorders of glycosylation, lead to multisystem disorders. Mutations of genes involved in N-glycosylation may affect either the biosynthesis of the glycan precursor (congenital disorder of glycosylation type I [CDG-I]) or the processing of the glycan after its attachment to the protein (congenital disorder of glycosylation type II [CDG-II]) (Fig. 1).

Glucose-1-phosphate is an important intermediate in the pathways leading to protein N-glycosylation and in glucose homeostasis. Phosphoglucomutase 1 catalyzes the interconversion of glucose-6-phosphate and glucose-1-phosphate (Fig. 2). In the present study, we evaluated patients with phosphoglucomutase 1 deficiency, which has been identified previously as glycogenosis type XIV (Online Mendelian Inheritance in Man database number, 612934), and with glycosylation abnormalities affecting both the attachment and the processing of N-glycans.

METHODS

PATIENTS

We initially identified a pair of male siblings (Patients 1.1 and 1.2) from a consanguineous family (the index family; parents were first cousins) with clinical features suggestive of congenital disorders of glycosylation, including myopathy, hepatopathy, short stature, and hypoglycemia. Analysis of serum transferrin by means of isoelectric focusing was performed to screen for congenital disorders of glycosylation. Analysis revealed an atypical pattern (Fig. 1), suggesting a novel disorder.

Several additional affected persons were identified subsequently. A total of 19 patients from 16 families (including three sibling pairs) were included in the present study, showing clinical features suggestive of congenital disorders of glycosylation and an atypical pattern on isoelectric focusing (Fig. S1 and Table S1 in the Supplementary Appendix), available with the full text of this article at NEJM.org; some features of Patients 2, 4, 5.1, 5.2, 6, 8, and 9 have been described previously2,5-8. Approval by a human subjects committee was obtained for all the clinical studies. Written informed consent was obtained from all the participants or, in the case of children, from a parent or legal guardian.

GENETIC STUDIES

Because the parents of the index family were first cousins and were unaffected, we assumed autosomal recessive inheritance of the disease. We therefore performed homozygosity mapping with DNA from the two affected siblings, using Human1M-Duo BeadChips (Illumina; see the Supplementary Appendix). Within the regions of homozygosity thus identified, we used whole-exome sequencing to identify sequence variants that might be associated with the disease. After identification of mutations in the gene for phosphoglucomutase 1 (PGM1) in both siblings (see the Supplementary Appendix), PGM1 in additional patients was analyzed by means of Sanger sequencing (see the Supplementary Appendix).

TISSUE SPECIMENS

Blood samples and skin-biopsy and muscle-biopsy specimens were obtained from study participants after informed consent had been provided. Leukocytes were obtained from blood samples. Fibroblast cultures were prepared from skin-biopsy specimens from 15 patients (see the Supplementary Appendix). Biopsy specimens of the vastus lateralis muscle were obtained from 4 patients. Fibroblasts pelleted from cultures, leukocytes, and muscle-biopsy specimens were frozen in liquid nitrogen for use in study assays.

PHOSPHOGLUCOMUTASE 1 EXPRESSION AND ACTIVITY

Total RNA was extracted from fibroblast pellets, and PGM1 messenger RNA (mRNA) was quantified by means of a real-time polymerase chain reaction assay (see the Supplementary Appendix). Western blot analysis was performed on cytosolic proteins extracted from fibroblast pellets with the use of a monoclonal anti-PGM1 antibody (see the Supplementary Appendix). Phosphoglucomutase 1 enzyme activity was assayed spectrophotometrically on extracts from fibroblasts, leukocytes, or skeletal-muscle cells (see the Supplementary Appendix).
GLYCOSYLATION ASSAYS

Analysis of transferrin glycosylation was performed on serum samples with the use of isoelectric focusing, sodium dodecyl sulfate–polyacrylamide-gel electrophoresis (SDS-PAGE), or liquid chromatography–mass spectrometry (Fig. 3, and the Supplementary Appendix). The cell-surface glycoprotein intercellular adhesion molecule 1 (ICAM-1), the expression of which is markedly reduced by deficient glycosylation, was assayed.
GALACTOSE SUPPLEMENTATION IN CULTURE
Galactose powder was supplied by Falcento. Galactose levels in whole blood were determined in a healthy volunteer after the oral consumption of 250 ml of water in which 0.3 g of galactose per kilogram of body weight had been dissolved. Measurements of galactose levels in blood were made by means of spectrophotometry at intervals of 10 minutes during the first hour and at intervals of 30 minutes for an additional 3 hours. Lactose or galactose supplementation was administered as an aqueous solution at a dose of 0.5 to 1.0 g per kilogram per day, divided into three to six daily doses (on the basis of patient preference).

SCREENING ASSAY
To develop a potential presymptomatic screening test for phosphoglucomutase 1 deficiency, we developed a modified version of the Beutler test, which is used with Guthrie heel-prick test cards (dried blood spots) to screen for galactosemia. The Beutler test is dependent on the generation of glucose-1-phosphate and its metabolites by means of the GALT reaction (Fig. 2). The concentration used was 0.5 mM.

SUGAR METABOLITE AND GLYCOGEN QUANTIFICATION
The nucleotide sugars uridine diphosphate (UDP)–glucose and UDP-galactose were extracted from cultured fibroblasts and erythrocytes from patients and were quantified by means of reverse-phase high-performance liquid chromatography (see the Supplementary Appendix). Glucose-1-phosphate was analyzed by means of a photometric method (see the Supplementary Appendix), and galactose-1-phosphate was assayed with the use of 14C-labeled UDP-glucose. Glycogen was extracted from fibroblasts and digested with amyloglucosidase as described previously. The total amount of glucose was analyzed by means of gas chromatography–mass spectrometry. Glycogen content in fibroblasts from patients was also assessed by means of electron microscopy (see the Supplementary Appendix).

DIETARY SUPPLEMENTATION
Galactose powder was added to fibroblast culture medium to increase the concentration of intracellular UDP-galactose by means of the galactose-1-phosphate uridyltransferase (GALT) reaction (Fig. 2). The concentration used was 0.5 mM.
RESULTS

CLINICAL PHENOTYPE

A total of 19 affected family members, 3 to 43 years of age, were identified in 16 families (Table S1 in the Supplementary Appendix). At birth, a bifid uvula with or without cleft palate was the only clinical manifestation.

Subsequent clinical manifestations varied among the patients (Fig. 4). Signs of hepatopathy with moderately elevated serum aminotransferase levels developed in all patients. Dilated cardiomyopathy, cardiac arrest, or both occurred in six patients; three patients were listed for heart transplantation. The majority of the patients had muscle symptoms, including exercise intolerance, muscle weakness, and rhabdomyolysis. Malignant hyperthermia with severe rhabdomyolysis occurred in two patients after the administration of general anesthesia. Growth retardation...
was reported in all but four patients. Two girls had hypogonadotropic hypogonadism with delayed puberty. Hypoglycemia was common, especially in childhood, requiring treatment with frequent meals, complex carbohydrates, or overnight tube feeding.

**TRANSFERRIN GLYCOSYLATION**

Transferrin analysis by means of isoelectric focusing, supplemented by SDS-PAGE data, revealed that the affected family members in the other families had a distinctive pattern of glycosylation, as did the two siblings in the index family (Fig. S1 in the Supplementary Appendix). Mass spectrometry revealed the presence of a variety of transferrin glycoforms, including forms lacking one or both glycans as well as forms with truncated glycans (Fig. 3A). There was considerable variation in the transferrin-glycoform profile among the patients (Fig. S4 in the Supplementary Appendix).

**GENETIC IDENTIFICATION OF PHOSPHOGLUCOMUTASE 1 DEFICIENCY**

Homozygosity mapping of the two affected siblings in the index family identified autosomal regions of homozygosity totaling 87.5 megabases (Fig. S5 in the Supplementary Appendix). Whole-exome sequencing identified 1516 sequence variants within the regions of homozygosity. These variants were filtered to identify 10 genes carrying homozygous nonsynonymous mutations that had not already been identified as polymorphisms. Two of these genes were considered to be of potential functional relevance, but only the mutation in *PGM1* cosegregated with disease. Independently, functional filtering of whole-exome sequencing data for potential CDG-I candidate genes in another patient (Patient 6 in Table S1 in the Supplementary Appendix) led to the identification of a homozygous *PGM1* mutation.

A total of 21 different *PGM1* mutations were identified in 16 families. Nine patients were compound heterozygotes; all others were homozygotes. The locations of the individual mutations with respect to the structural domains of the phosphoglucomutase 1 protein are shown in Fig. S6 in the Supplementary Appendix.

**PHOSPHOGLUCOMUTASE 1 EXPRESSION AND ACTIVITY**

Quantification of *PGM1* mRNA was performed for 11 patients and showed considerable variation in expression (Fig. S7 in the Supplementary Appendix). Only two homozygous premature stop variants with predicted nonsense-mediated decay showed mRNA levels that were less than 10% of those in healthy controls. Likewise, Western blotting of phosphoglucomutase 1, performed for 13 patients, showed various amounts of protein (Fig. S8 in the Supplementary Appendix). Assays for phosphoglucomutase 1 enzyme activity, however, showed markedly decreased activity in all 17 patients who were tested, amounting to at most 12% of the activity seen in controls (Table S1 in the Supplementary Appendix).
In our study, we found that phosphoglucomutase 1 deficiency, which has been shown to be a glycogen storage disorder, is also a mixed-type congenital disorder of glycosylation. We identified 21 different mutations in PGM1 in 19 patients. Although all the patients had multisystem disease at the time of the study, the only apparent clinical feature at birth was a bifid uvula (in 16 of the 19 patients).

Extensive use of common protein polymorphisms of phosphoglucomutase 1 in paternity testing led to the discovery of a case of reduced enzyme activity in 1963, and since then additional
cases of reduced phosphoglucomutase 1 activity have been described sporadically.8,17-22 In 2009, data on an adult with exercise-induced muscle cramps and episodes of rhabdomyolysis (Patient 8 in the current study) were reported.2 Abnormal glycogen accumulation was noted in the muscles, the level of phosphoglucomutase 1 activity was only 1% of the normal level, and mutations in PGM1 were identified. The disease was designated as glycogenesis type XIV. However, the broad clinical and biochemical spectrum of phosphoglucomutase 1 deficiency remained unrecognized.

In contrast to many other congenital disorders of glycosylation, in which patients have psychomotor retardation, the brains of our patients were not affected. This is probably explained by the fact that other isoenzymes substitute for phosphoglucomutase 1 in the brain (see the Supplementary Appendix).

We did not attempt to show experimentally the mechanisms that account for the clinical phenotypes of phosphoglucomutase 1 deficiency. However, analysis of the literature provides at least three different mechanisms. Hypoglycemia, lactic acidosis, and exercise intolerance are presumably consequences of disordered glucose metabolism. After a dietary glucose load, large amounts of glucose-6-phosphate are generated, which cannot be converted into glycogen. Thus, a substantial portion is diverted to lactate and fatty acid production (Fig. 2). During fasting, liver glycogen cannot be converted into glucose via glucose-6-phosphate, and hypoglycemia may occur. The inability of skeletal muscles to quickly use glycogen for the anaerobic production of energy leads to exercise intolerance and potentially to rhabdomyolysis. These characteristics are also seen with glycogen storage disease Ia, in which there is a defect in hepatic glucose-6-phosphatase. Stabilizing glucose homeostasis by means of dietary intake of complex carbohydrates33 and restricting exercise to a level below the aerobic threshold might be beneficial.

Two endocrinologic features of phosphoglucomutase 1 deficiency may be directly linked to defective glycosylation. First, Patients 2 and 6 had hypogonadotropic hypogonadism without clinical manifestations of puberty. The gonadotropins and their receptors are glycoproteins, and their function has been shown to be reduced by inadequate glycosylation.24 Second, 15 patients had short stature, although the growth hormone (somatotropin) level was normal to high in the patients in whom it was measured. However, levels of insulin-like growth factor 1 (IGF-1) and IGF-binding protein 3 were low, as they are in patients with CDG-Ib, a glycosylation disorder in which dietary supplementation with mannose improves glycosylation and growth.3-25 A detailed discussion of the literature concerning the role of glycosylation in the gonadotropin and IGF-1 systems is provided in the Supplemental Appendix.

A third mechanism relates PGM1 mutations to dilated cardiomyopathy. Phosphoglucomutase 1 binds to the heart-muscle-cell-specific splice variant of ZASP (Z-band alternatively spliced PDZ-motif protein), and ZASP mutations that affect the binding of phosphoglucomutase 1 are associated with dilated cardiomyopathy.26,27 Our study shows that defects in PGM1 are also associated with dilated cardiomyopathy. A detailed discussion of this mechanism is provided in the Supplemental Appendix.

We also found that galactose supplementation can improve glycosylation both in fibroblast-cell culture and in patients. The extent to which this improvement in glycosylation mitigates the clinical features of phosphoglucomutase 1 deficiency was not investigated systematically in our study. In the six patients in this study who received dietary supplementation with galactose, some potentially important clinical changes were seen. In the two girls with hypogonadotropic hypogonadism, the levels of luteinizing hormone increased markedly, FSH levels normalized, and clinical signs of puberty appeared. However, a systematic clinical study of the effects of galactose supplementation will be necessary to determine the extent to which such therapy can correct the clinical features of this condition; such studies will also incidentally help to define the pathogenesis of the individual elements of the clinical syndrome of phosphoglucomutase 1 deficiency.

We devised a clinical test for the diagnosis of phosphoglucomutase 1 deficiency, which was based on the Beutler test for galactosemia. On initial evaluation, this modified Beutler test appeared to discriminate effectively between persons with phosphoglucomutase 1 deficiency and controls. However, validation is required before the assay can be recommended for routine clinical use.
In conclusion, we found that phosphoglucomutase 1 deficiency, previously identified as a glycogen storage disorder, is also a mixed-type congenital disorder of protein N-glycosylation. The presence of a bifid uvula at birth may be an early clinical clue to the presence of this syndrome. Supplementation with galactose leads to biochemical improvement in index of glycosylation. The degree to which galactose supplementation may lead to clinical improvement in the disease syndrome is not yet established.

Supported by grants from the Netherlands Organization for Scientific Research (40-00506-98-9001 and 91713359, to Dr. Lefeber), the Institute for Genetic and Metabolic Disease (to Drs. Veltman and Lefeber), the Rocket Fund and the National Institutes of Health (R01DK55615, to Dr. Freeze), and ERA-NET E-Rare-2. Dr. Vanderschaeghe is a postdoctoral fellow of Fonds Wetenschappelijk Onderzoek Vlaanderen. Galactose was supplied by Falcando. Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

We thank Dr. S. Angeleseu for pictures of the oral cavity, Ms. I. Du Chesne for help with DNA sequencing, Ms. M. Herting for help with isoelectric focusing and sodium dodecyl sulfate–polyacrylamide-gel electrophoresis, Ms. M. Jansen-Rust and Ms. T. Seehafer for library preparation (Leibniz-Institut für Arteriosklerosforschung), Ms. U. Mangels for determinations of galactose levels, Ms. M. Schreiner for data analysis, Drs. M. Gahr and W. Schrötzer for helpful discussions about their patient described in 1983, and Dr. A. Kocůrkengar for discussing patient information.

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