Germline mutations in the PTEN/MMAC1 gene in patients with Cowden disease

Marcel R. Nelen1, Wilma C. G. van Staveren1, Els A. J. Peeters2, Mohammed Ben Hassel3, Robert J. Gorlin4, Henning Hamm5, Christian F. Lindboe6, Jean-Pierre Fryns7, Rolf H. Sijmons8, D. Geoffrey Woods9, Edwin C. M. Mariman10, George W. Padberg1 and Hannie Kremer1-10,*

1Department of Neurology, University Hospital Nijmegen, Nijmegen, The Netherlands, 2Department of Neurology, Leiden University, Leiden, The Netherlands, 3Radiotherapy and Oncology Department, Regional Cancer Institute, Rennes, France, 4Department of Oral Pathology and Genetics, University of Minnesota, Minnesota, USA, 5Department of Dermatology, University of Würzburg, Würzburg, Germany, 6Department of Pathology, Trondheim University Hospital, Trondheim, Norway, 7Centre for Human Genetics, University of Leuven, Leuven, Belgium, 8Department of Medical Genetics, University Hospital Groningen, Groningen, The Netherlands, 9Department of Clinical Genetics, St James’s University Hospital, Leeds, UK and 10Department of Human Genetics, University Hospital Nijmegen, Nijmegen, The Netherlands

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Cowden disease, also known as multiple hamartoma syndrome, is an autosomal dominant cancer syndrome with a high risk of breast and thyroid cancer. The gene involved has been localized to chromosome 10q22–23. Recently, the tumour suppressor gene PTEN/MMAC1, encoding a putative protein tyrosine or dual-specificity phosphatase, was cloned from that region and three mutations were detected in patients with Cowden disease. We confirmed that the PTEN/MMAC1 gene is indeed the gene for Cowden disease by a refined localization of the gene to the interval between D10S1761 and D10S541, which contains the PTEN/MMAC1 gene and by mutation analysis in eight unrelated familial and 11 sporadic patients with Cowden disease. Eight different mutations were detected in various regions of the PTEN/MMAC1 gene. One mutation was detected twice. All detected changes in the gene can be predicted to have a very deleterious effect on the putative protein. Five of the nine patients have a mutation in exon 5 coding for the putative active site and flanking amino acids. Evaluation of the clinical data of the patients in which a mutation could be detected gives no clear indications for a correlation between the genotype and phenotype. In 10 patients no mutation could be detected so far. In support of the linkage data, no evidence has emerged from the phenotype of these patients suggestive for genetic heterogeneity.

INTRODUCTION

Cowden disease (CD) (MIM 158350), also known as multiple hamartoma syndrome, is a rare familial cancer disease named after the first patient described in 1963 (1). The disease is inherited in an autosomal dominant pattern. Characteristic for CD are oral and facial papules together with hamartomatous features of the thyroid, breast and digestive tract (1,2). Multiple trichilemmomas are considered to be the pathological hallmark of the disease (3). CD patients have a predisposition to develop both benign and malignant neoplasms. Female patients have a high risk of developing fibrocystic disease and carcinomas of the breast; also goiter, adenomas and follicular cell carcinomas of the thyroid gland and polyps of the digestive tract are part of the disease (4–7).

Apart from the CD manifestations described above a variety of neurological symptoms can be found. Lhermitte-Duclos disease (LDD), or dysplastic gangliocytoma of the cerebellum is, together with megalencephaly, the most important central nervous system manifestation (8). Other neurological signs range from tremor and ataxia to epilepsy and mental retardation (8–10, reviewed in 11).

Recently, in an extensive linkage study in 12 CD families, we localized the gene for CD to 10q22–23 between the markers D10S215 and D10S564 (12). There were no indications for genetic heterogeneity. The recently cloned tumour suppressor gene PTEN/MMAC1, encoding a putative tyrosine or dual-specificity phosphatase (13,14), was suggested to be involved in CD (15). We confirmed that the gene is involved in CD by refinement of the linkage data and mutation analysis in the PTEN/MMAC1 gene in eight familial and 11 sporadic CD patients. We identified eight different mutations in nine patients.

*To whom correspondence should be addressed at: Department of Human Genetics, University Hospital Nijmegen, PO Box 9101, 6500 HB Nijmegen, The Netherlands. Tel: +31 24 3615296; Fax: +31 24 3540488; Email: j.kremer@czorlism.aun.nl
Table 1. Summary of the clinical data of the patients and description of the mutations

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex</th>
<th>Age</th>
<th>Skin</th>
<th>Thyroid</th>
<th>Breast</th>
<th>Intestine</th>
<th>Urogenital</th>
<th>LDD</th>
<th>Other neurological signs</th>
<th>Head</th>
<th>Mutation and predicted effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>n331</td>
<td>f</td>
<td>43</td>
<td>-</td>
<td>goitre</td>
<td></td>
<td>polyps</td>
<td>ovarian cysts</td>
<td>+</td>
<td>-</td>
<td>n/m</td>
<td>Insertion of TTAC (exon 2, nucleotide 1192/1193; frameshift, premature stop in codon 63)</td>
</tr>
<tr>
<td>N4 (F)</td>
<td>3m/2f</td>
<td>30-62</td>
<td>+ (5)</td>
<td>goitre</td>
<td>adenocarcinoma (2)</td>
<td>benign tumors (2)</td>
<td>ovarian cysts</td>
<td>+ (1)</td>
<td>+ (5)</td>
<td>meq (2)</td>
<td>GT to TT (intron 4, splice site mutation)</td>
</tr>
<tr>
<td>n40</td>
<td>m</td>
<td>57</td>
<td>+</td>
<td>goitre</td>
<td>n.r.</td>
<td>n.d.</td>
<td>n/d</td>
<td>-</td>
<td>+</td>
<td>meq</td>
<td>CAC to CGC: His132Arg (exon 5)</td>
</tr>
<tr>
<td>n130</td>
<td>f</td>
<td>42</td>
<td>+</td>
<td>adenoma</td>
<td>-</td>
<td>n.d.</td>
<td>n/d</td>
<td>-</td>
<td>-</td>
<td>mac</td>
<td>TGT to CGT: Cys132Arg (exon 5)</td>
</tr>
<tr>
<td>N2 (F)</td>
<td>2m/7f</td>
<td>29-65</td>
<td>+ (9)</td>
<td>goitre</td>
<td>adenofibroma (3)</td>
<td>adenocarcinoma (1)</td>
<td>uterus myomatosis</td>
<td>-</td>
<td>+</td>
<td>meq (8)</td>
<td>CGA to TGA: Arg130Stop (exon 5)</td>
</tr>
<tr>
<td>n264</td>
<td>f</td>
<td>38</td>
<td>+</td>
<td>goitre</td>
<td>fibrocystic disease fibroadenoma</td>
<td>polyps (3)</td>
<td>n/d</td>
<td>-</td>
<td>+</td>
<td>meq</td>
<td>CGA to TGA: Arg130Stop (exon 5)</td>
</tr>
<tr>
<td>n275</td>
<td>m</td>
<td>46</td>
<td>+</td>
<td>-</td>
<td>n.r.</td>
<td>polyps</td>
<td>polyps</td>
<td>n.d.</td>
<td>+</td>
<td>meq</td>
<td>GAA to TAA: Glu135Stop (exon 5)</td>
</tr>
<tr>
<td>n342</td>
<td>m</td>
<td>47</td>
<td>+</td>
<td>goitre</td>
<td>n.r.</td>
<td>polyps</td>
<td>kidney cysts</td>
<td>-</td>
<td>+</td>
<td>meq</td>
<td>Insertion of A in codon 183 (exon 6) frameshift, premature stop in codon 189</td>
</tr>
<tr>
<td>n269</td>
<td>m</td>
<td>33</td>
<td>+</td>
<td>-</td>
<td>n.r.</td>
<td>n.d.</td>
<td>n.d.</td>
<td>+</td>
<td>+</td>
<td>meq</td>
<td>Deletion of GA in N262 (exon 7) frameshift, premature stop</td>
</tr>
</tbody>
</table>

For the families the number of patients with a specific symptom are given between brackets. f, female; F, familial; LDD, Lhermitte-Duclos disease; m, male; mac, macrocephaly; meq, megalencephaly diagnosed by MRI scanning; n.d., no signs but not examined; nm, normal; n.r., not relevant; +, present; –, absent; Skin abnormalities include trichilemmomas, lichenoid and verrucous papules on the face, oral mucosal papillomatosis, hyperkeratotic lesion on the distal extremities, and punctate keratosis on the palms and soles. Neurological signs include tremor, clumsiness, incoordination, hearing defects, epilepsy and dizziness.

RESULTS

Fine mapping

Nineteen CA-repeat markers spanning the 10q22–23 region were tested in the families N1–N5 (12) and revealed that the Cowden critical region is between D10S1761 and D10S541 (Fig. 1). In the primary linkage study individual N4-II-10, determining the proximal border of the critical region, was considered to be affected (12) although his clinical status was disputed. He was known to have hyperkeratotic papules, macrocephaly and mild ataxia. Recently, clinical re-examination was carried out by an independent clinician leading to the conclusion that he is unaffected. Apart from macrocephaly and mild unsteadiness, he has two hyperkeratotic papules on his forearm and a naevus naevocellularis on his scalp. His skin abnormalities only do not fulfill the criteria for diagnosis of CD (12) and macrocephaly in itself does not justify the diagnosis of CD. Surgical treatment for cervical disc disease and a period of alcohol abuse might explain his mild unsteadiness. The haplotype in combination with the diagnosis of this individual are in accordance of PTEN/MMAC1 being the Cowden gene (Fig. 1).

Mutation analysis of the PTEN/MMAC1 gene

Mutation analysis of the PTEN/MMAC1 gene was performed using lymphocyte DNA of eight familial and 11 sporadic CD patients. The nine described exons of the gene were amplified and sequenced. In two families (N2 and N4) and seven sporadic patients a heterozygous mutation was detected. The mutations are listed in Table 1. We identified missense, nonsense, frameshift and splice site mutations.

There are three different mutations in the active site sequence motif HCxxGxxRS/T of protein tyrosine phosphatases and dual specificity phosphatases (16,17). Two of these mutations are missense mutations, His123Arg and Cys124Arg, and one is a nonsense mutation Arg130Stop, which occurred twice (Fig. 2). All three can be predicted to lead to a complete or severe loss of phosphatase activity (17). By sequencing the A-lane with the reversed primer, the Arg130Stop mutation was shown to cosegregate with CD in family N2 (Fig. 3). A second nonsense mutation Glu157Stop was detected in the sequences flanking the active site and therefore can be expected to reduce the phosphatase activity.

In family N4 the first nucleotide of intron 4 was changed from C to T causing a mutation in the nearly invariant splice site GU to UU. This will lead either to exon skipping or to insertion of an extra nucleotide at codon 63, Glu157Stop. To exclude common polymorphisms, 50 controls were tested in whom none of the mutations were found.

By sequencing the T-lane, the T130C mutation was shown to cosegregate with CD in the family by sequencing of the T-lane. The three remaining mutations lead to a frameshift and premature termination of the protein at codons 63, 189 and 297 which are the eighth, sixth and 36th codon after the frameshift mutation, respectively. Also these mutations can be predicted to be very deleterious to the protein.

Mutations were confirmed in independently amplified PCR fragments. To exclude common polymorphisms, 50 controls were tested in whom none of the mutations were found.
We have refined the localization of the CD gene and performed mutation analysis in the PTEN/MMAC1 gene thereby confirming that this gene is causalive of CD (15). A mutation was detected in nine patients, two of whom are familial (N1 and N4). Five of these mutations are in exon 5 in addition to three of four described by Liaw et al. (15). This suggests that exon 5 (amino acids 86–165), coding for the active site and flanking amino acids, is a "hotspot" for mutations in patients with CD. So far, missense mutations are only found in the active site. The Arg130Stop mutation was detected twice in our patient group and once in a glioma (14) and is caused by a mutation in a CG dinucleotide. Since these are known to have a relatively high mutation frequency, the CG in codon 130 might be prone to become mutated. In 10 patients no mutation was found. Three of these patients are from families linked to 10q22-23 (12). CD in these individuals might be due to a change in the promoter sequences, deletion of an entire exon which remains undetected with the method used, or a mutation in an intron leading to aberrant splicing. In support of the linkage data, no evidence has emerged from the phenotype of these 10 patients suggestive for genetic heterogeneity.

Since different types of mutations were detected in several regions of the gene, we made an attempt to correlate symptoms and specific mutations. Skin abnormalities including trichilemmomas were detected in patients with all types of mutations but not in patient n331 although trichilemmomas are pathognomonic for CD (3). Patient n331 testifies to the observation in families with CD that the skin abnormalities are not fully penetrant (4). The combination of oncological features including LDD justifies in our opinion the diagnosis of CD. At the same time it raises the question which and how many non-dermatological criteria allow the clinical diagnosis. The detection of a mutation in this patient indicates that the PTEN/MMAC1 gene is a good candidate for familial cancer disorders with (a combination of) neoplasms associated with CD, for example familial breast cancer and/or thyroid cancer, in the absence of skin abnormalities.

Involvement of the thyroid was found in the majority of patients with the exception of patient n275 with the Glu157Stop mutation.
and patient n269 with a frameshift mutation in exon 7. Patient D
described by Liaw and co-workers (15) also has the Glu157Stop
mutation and no thyroid symptoms too, suggesting that this is
specific for this mutation. A larger number of patients is necessary
to confirm a phenotype-genotype correlation for thyroid
symptoms in CD.

Breast abnormalities are found only in females with the
exception of one male patient. So far, all affected females have a
mutation in the N-terminal half of the protein. Within this group
of females, there are no indications for specific mutations leading
to breast involvement. Also for intestinal polyps, urogenital
involvement and neurological signs, there are no indications for
phenotype-genotype correlations.

LDD is associated with mutations leading to a premature
termination of the protein and a splice site mutation but not with
the detected missense mutations. This is also true for the patients
described by Liaw et al. (15). We cannot confirm their suggestion
that LDD is associated with the more N-terminal truncations
since patient n269 has a frameshift mutation in codon 262.
However, one could argue that the long stretch of 35 changed
amino acids between the frameshift and the termination might
have a more deteriorating effect on the protein in comparison to
the described Arg233 nonsense mutation which is not associated
with LDD (15).

The identification of the gene involved in CD makes early,
pre-symptomatic diagnosis of the disorder possible not only in the
familial cases but also in the large fraction of sporadic cases in
whom diagnosis based on linkage analysis cannot be performed.
This is of great clinical importance since accurate surveillance for
the occurrence of neoplasms associated with CD can be offered
now to the carriers. Our study underlines difficulties in the
diagnosis of CD based on clinical symptoms since we had two
sibs from CD families suspected for the disorder because of
macrocephaly: N4-II-10, who has been described in the results
section, and a 5 year old girl (N5-IV-1, Fig. 1) with macrocephaly
and a haemangioma on her ankle occurring regularly in CD. Both
individuals did not have the affected haplotype in the interval of
the PTEN/MMAC1 gene (Fig. 1) and for N4-II-10 we could show
the absence of the mutation cosegregating with the disorder in the
family. The mutation in family N5 has not yet been detected.
These results indicate that in families, macrocephaly as an early
indication for CD has to be treated with caution. In the Dutch
families N1–N5, macrocephaly is present in 24 of 25 patients but
also in five of 12 unaffecteds (E.A.J. Peeters, in preparation).

Mutations in the PTEN/MMAC1 gene causing CD can give
some clues as to the function of the gene. The presence of
megalecephaly, and the occasional hypertrophy of breasts and
increased size of hands and feet in patients with CD (18,19)
suggest that haploinsufficiency of the gene leads to disturbance
of growth restriction in development. Furthermore, as already
suggested by Liaw et al. (15), inactivation of the second allele
causes disorganization and proliferation resulting in hamartomas,
the hallmark of CD. Somatic mutations in other tumour
suppressor genes or oncogenes could then cause malignant
transformation. The rare occurrence of glioblastoma multiforme
in CD patients supports the notion that the appearance of this
tumour is the result of a cascade of events in which a mutation in
the PTEN/MMAC1 gene probably is the last step. Furthermore,
the putative nature of the gene i.e. a protein tyrosine or dual
specificity phosphatase is in agreement with the observed features
of CD: these phosphatases are involved in cell proliferation and
cell differentiation (17). The occurrence of acquired mutations in
the PTEN/MMAC1 gene in a number of tumour types (13,14) and
the germ line mutations causing the rare CD makes this gene
comparable to p53 showing mutations in many tumour types and
in the rare Li–Fraumeni syndrome, promising interesting future
results on the PTEN/MMAC1 gene.

MATERIALS AND METHODS

Patients

Diagnoses of patients were based on dermatological criteria with
the exception of patient n331 (see Table 1). In this patient
diagnosis was based on the oncological features and LDD.
Fine-mapping was performed in the families N1–N5. The
families N1 and N2 have been described by Starink et al. (4)
and the families N4 and N5 by Padberg et al. (8). Patient n275 is
described by Lindboe et al. (20). Clinical features of patients in
which a mutation was detected are summarized in Table 1.

Typing of CA repeat markers

Genomic DNA used for the typing of the DNA polymorphisms
was isolated as reported before (21). Amplification and
separation of the polymorphic CA-repeat fragments were
performed as described (22). The markers and their order were as
described by Lindboe et al. (20). Clinical features of patients in
which a mutation was detected are summarized in Table 1.

Mutation analysis

For mutation analysis, DNA fragments containing the exons were
amplified using the inner primers described in (14). PCR products
were purified from the reaction mixtures using QIAquick spin
columns (Qiagen) according to the gel extraction protocol. The
fragments were sequenced using the ds cycle-sequencing system
(Gibco–BRL) following the manufacturer’s protocol.

Analysis of control individuals

The presence of the detected mutations in 50 unrelated and
unaffected individuals was tested in lymphocyte DNA isolated as
described (21). For the mutations in the exons 4, 5 and 6, oligonucleotides of 14–16 bp were developed with approxi-
mately in the middle either the wildtype or mutated nucleotide. Exons were amplified as described and blotted onto geneScreen
Plus. Ten nanograms of the oligonucleotides were radioactively labeled and used for hybridization in 5x SSPE (0.15 M NaCl, 10
mM NaH2PO4, 10 mM EDTA, pH 7.4), 0.3% SDS at 37°C for at
least 6 h. After hybridization blots were washed in 5x SSPE,
0.3% SDS for 15 min at room temperature and 2–5 min at 37°C.
The insertions in exons 2 and 7 were tested as length
polymorphisms by amplifying the exons as described and
separating them as described for the CA repeat markers (22).

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