The following full text is a publisher's version.

For additional information about this publication click this link.
http://hdl.handle.net/2066/81626

Please be advised that this information was generated on 2016-09-24 and may be subject to change.
A CASE OF ALS-FTD IN A LARGE FALS PEDIGREE WITH A K17I ANG MUTATION

Approximately 90% of amyotrophic lateral sclerosis (ALS) cases are sporadic (SALS), but 10% are familial (FALS). Mutations in SOD1, Alsin, Dynactin, SETX, Dj-1, VAPB, and TDP-43 have been reported (table e-1 on the Neurology® Web site at www.neurology.org). After the identification of sequence variation VEGF in patients with ALS, mutations in another angiogenic gene (ANG) were identified in SALS and FALS. Studies in other populations have identified ANG mutations in patients with ALS, but also in healthy controls. This suggests that not all mutations are pathogenic.

Methods. A total of 39 unrelated FALS patients, negative for SOD1 mutations, were screened for ANG mutations. This study was approved by the local ethics committee and participants provided informed consent. DNA was isolated from venous blood and ANG mutation analysis was performed as described in appendix e-1. A total of 275 unrelated, healthy controls were taken from a prospective population-based study on ALS in The Netherlands and were also screened. PMut (http://mmb2.pcb.ub.es:8080/PMut/) was used to predict the impact of an amino acid substitution on the structure and function of the protein.

Results. We identified one mutation in one patient (122 A>T) (figure, A), leading to an amino acid substitution of lysine to isoleucine (K17I) (figure, B). PMut analysis predicted this mutation to be pathogenic. Sequence alignments of ANG in different species demonstrated high conservation (figure, C).

Analysis of this pedigree revealed an autosomal dominant inheritance of the mutation (male to male transmission) (figure, D). DNA was available from 44 out of 62 family members (five affected individuals). All affected family members carried the K17I mutation.

Ten carriers were identified, but all were under 50 years of age (except one who was 75 years old without symptoms or signs of ALS). The K17I mutation was not found in 275 control samples.

Discussion. Several ANG mutations in FALS have been reported, but clear segregation of mutations with the disease has not been shown. Here, we report the K17I mutation segregating with disease in a large pedigree. The fact that II-2 and a carrier (75 years of age) were without symptoms of ALS suggests incomplete penetrance of the mutation. This might explain why mutations in this codon have only been found in SALS. The K17I mutation was previously reported in three cases and K17E in two cases.

This study provides a report of a patient with an ANG mutation and ALS, FTD, and parkinsonism. Five percent of patients with ALS also have FTD and up to 50% demonstrated mild cognitive impairment. Similarly, relatives of patients with ALS have an increased risk for developing PD. Therefore, genes involved in ALS are also considered candidate genes for...
other neurodegenerative disorders. Indeed, an Italian study reported a SALS patient with a 132C→T mutation and frontal lobe dysfunction.4

ANG is highly conserved between species, suggesting it has an important biologic function. Modeling of the K17I mutation using PMut predicted this to be pathogenic. Two functional studies demonstrated that the K17I mutation results in loss of function, possibly leading to insufficient ribosomes synthesis, decreased protein translation, and ultimately decreased motor neuron viability.6,7

We report segregation of the K17I mutation with FALS and a patient with FALS, FTD, and parkinsonism, which possibly implicates ANG in these diseases.

From the Department of Neurology, Rudolf Magnus Institute of Neuroscience (M.A.v.E., F.P.D., J.H.V., L.H.v.d.B.), Department of Medical Genetics and Rudolf Magnus Institute of Neuroscience (E.S., R.A.O.), and Department of Medical Genetics (E.A.M.H., D.L.), University Medical Center Utrecht; Department of Neurogenetics (F.B.), Academic Medical Center, Amsterdam, The Netherlands; Division of Neurology (P.R.B.), University of Ottawa, Ontario, Canada; and Department of Neurogenetics (H.J.S.), Radboud University Medical Center, Nijmegen, The Netherlands.

Supported by Netherlands Organization for Scientific Research (NWO) and the Prinses Beatrix Foundation (PBF).

Disclosure: The authors report no disclosures.

Received June 12, 2008. Accepted in final form August 12, 2008.

Address correspondence and reprint requests to Dr. Leonard H. van den Berg, Department of Neurology, Rudolf Magnus Institute of Neuroscience, University Medical Center Utrecht, Heidelberglaan 100, 3584 CX, Utrecht, The Netherlands; L.H.vandenBerg@umcutrecht.nl

ACKNOWLEDGMENT

The authors thank the families for their participation.

INFLAMMATORY PSEUDOTUMOR ASSOCIATED WITH HIV, JCV, AND IMMUNE RECONSTITUTION SYNDROME

A 37-year-old HIV-positive African woman developed severe chronic diarrhea. Her CD4+ T cell count was 25 cells/mm³. Within 1 month of initiation of highly active antiretroviral therapy (HAART) her plasma HIV viral load became undetectable and CD4+ T cell count rose to 96 cells/mm³, and continued to rise over the following months.

Two months after the initiation of HAART she developed vertigo, loss of balance, incoordination, slurred speech, and tremor of the neck and limbs. Neurological examination revealed ocular abnormalities, dysarthria, and monotonous speech. She had bilateral limb dysmetria, past-pointing and endpoint tremor, impaired heel-knee-shin testing, head tremor, and a wide based, ataxic gait.

Initial brain MRI revealed a confluent, nonenhancing area of signal abnormality predominantly involving the inferior right cerebellar hemisphere and extending to the posterior vermis, right cerebellar peduncle, and inferomedial aspect of the left cerebellar hemisphere. Six months later, MRI revealed progression of the cerebellar lesion, with nodular enhancement along the inferomedial aspect of the right cerebellar hemisphere. The patient remained clinically stable. MRI 8 months later revealed a large cystic ring-enhancing lesion in the location of the previously noted high signal intensity lesions of the cerebellum, with compression of the posterior fourth ventricle (figure, A).

CSF revealed WBC 1, Prot 64, Gluc 49, and negative cytomegalovirus DNA PCR, Cysticercosis IgG Ab, Epstein-Barr virus DNA PCR, Venereal Disease Research Laboratory, and Cryptococcus Ag. Bacterial, viral, and fungal cultures were negative. JCV PCR was positive. Stereotactic biopsy of the cerebellar lesion, performed 17 months after the onset of neurologic symptoms, revealed giant cells with pleomorphic hyperchromatic nuclei, often multiple, surrounded by a dense infiltrate of lymphocytes and plasma cells (figure, B). The bizarre, pleomorphic cells were GFAP positive, demonstrated diffuse nuclear reactivity for p53 antigen, a high MIB-1 (Ki-67) index, and focal, faint reactivity for polyoma virus T antigen (figure e-1 on the Neurology® Web site at www.neurology.org). Inflammatory infiltrates marked both for T and B cells (CD3, CD43, CD20, CD79a). The adjacent cerebellar folia were atrophic, with total loss of granular cell neurons, preservation of Purkinje cells, and infiltrates of lymphocytes and histiocytes. Four 10-μm-thick sections of the mass were cut and utilized for DNA extraction; PCR was performed and demonstrated a 173 base pair band diagnostic of polyoma virus; its identity as JCV was further confirmed with a BamHI digest which produces 2 DNA fragments of 120 and 53 base pairs (JCV, but not BKV or SV40 has this restriction site in the amplicon) (figure, C). A JCV-associated inflammatory pseudotumor was diagnosed. The patient has a stable pancerebellar syndrome 24 months after onset of neurologic symptoms.

Discussion. The immune reconstitution inflammatory syndrome (IRIS) in HIV-infected patients receiving HAART is characterized by paradoxical clinical or radiologic deterioration despite an increasing CD4+ T cell count and decreasing HIV viral load. Foreign organisms become unmasked and trigger a disproportionate immune response. IRIS has been reported in association with JCV infection, the cause of progressive multifocal leukoencephalopathy (PML). The radiologic features in the current patient, demonstrating a cystic lesion with nodular enhancement were unusual, raised the possibility of a secondary neoplastic or infectious non–JCV-related lesion, and led to the eventual performance of a brain biopsy.

PML is histologically characterized by the triad of oligodendroglial inclusions, demyelination, and bizarre, atypical astrocytes. In the cerebellum, selective loss of granular cell neurons, as seen in the present case, is common. PML may be associated with variable host inflammatory response. In the case of IRIS-associated PML, there are appreciable inflammatory infiltrates, with a preponderance of T cells. Oligodendroglial nuclei with characteristic viral inclusions may be rare or absent, and bizarre pleomorphic or multinucleated cells may have astrocytic or histiocytic origins. Pathology in the current patient was unusual, as the combination of dense inflammation and bizarre glial cells resulted in a pseudotumor formation, heretofore unreported in JCV-associated IRIS. In our patient, oligodendroglial inclusions were not evident, although the abnormal morphology of giant cells was typical of JCV-transformed astrocytes, and the granular cell loss was characteristic of PML. The juxtaposition of the intense predominantly lymphoplasmacytic infiltrate surrounding these transformed cells is likely to represent an IRIS-induced inflammatory response.

This JCV-associated pseudotumor is an unusual manifestation of the spectrum of IRIS neuropathologies. Given its clinical and radiologic overlap with
other tumoral and infectious entities, clinicians must be alert to the differential diagnosis.

From the Departments of Neurology, NeuroAIDS Program (A.G.-D., S.S., G.J.S., D.S.), Radiology (T.N.), Pathology (G.K., J.M., S.M.), Neurosurgery (I.G.), and Infectology (M.M.), Mount Sinai Medical Center, New York, NY.

Supported in part by NIH grant R24MH59724.

Disclosure: The authors report no disclosures.

Received December 4, 2007. Accepted in final form August 14, 2008.

Address correspondence and reprint requests to Dr. Alejandra Gonzalez-Duarte, Mount Sinai Medical Center, Annenberg 2nd Floor, Box 1052, New York, NY 10029; gonzalezduarte@aol.com


