Whole-exome sequencing reveals \textit{LRP5} mutations and canonical Wnt signaling associated with hepatic cystogenesis

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Polycystic livers are seen in the rare inherited disorder isolated polycystic liver disease (PCLD) and are recognized as the most common extrarenal manifestation in autosomal dominant polycystic kidney disease. Hepatic cystogenesis is characterized by progressive proliferation of cholangiocytes, ultimately causing hepatomegaly. Genetically, polycystic liver disease is a heterogeneous disorder with incomplete penetrance and caused by mutations in \textit{PRKCSH}, \textit{SEC63}, \textit{PKD1}, or \textit{PKD2}. Genome-wide SNP typing and Sanger sequencing revealed no pathogenic variants in hitherto genes in an extended PCLD family. We performed whole-exome sequencing of DNA samples from two members. A heterozygous variant c.3562C>T located at a highly conserved amino acid position (p.R1188W) in the low density lipoprotein receptor-related protein 5 (\textit{LRP5}) gene segregated with the disease (logarithm of odds score, 4.62) but was not observed in more than 1,000 unaffected individuals. Screening of \textit{LRP5} in a PCLD cohort identified three additional mutations in three unrelated families with polycystic livers (p.V454M, p.R1529S, and p.D1551N), again all undetected in controls. All variants were predicted to be damaging with profound structural effects on \textit{LRP5} protein domains. Liver cyst tissue and normal hepatic tissue samples from patients and controls showed abundant \textit{LRP5} expression by immunohistochemistry. Functional activity analyses indicated that mutant \textit{LRP5} led to reduced wingless signal activation. In conclusion, we demonstrate that germ-line \textit{LRP5} missense mutations are associated with hepatic cystogenesis. The findings presented in this study link the pathophysiology of PCLD to deregulation of the canonical wingless signaling pathway.

gene identification | \(\beta\)-catenin pathway

Polycystic liver diseases (PLD) consist of a group of inherited disorders characterized by abnormal proliferation and differentiation of the bile duct epithelium (1). Ductal plate malformation results in development of multiple fluid-filled cysts spread throughout the liver parenchyma. Progressive hepatic cystogenesis and cyst growth cause hepatomegaly and symptoms such as abdominal distension and pain, pyrosis, anorexia, and dyspepsia. Congenital PLD are clinically heterogeneous, and two major types can be distinguished. Autosomal dominant polycystic kidney disease (ADPKD) is a potentially lethal condition affecting about 1:400–1:1000 persons in the United States (2). Patients may develop end-stage renal disease resulting from polycystic kidneys, and 83% have the simultaneous presence of multiple hepatic cysts (3). Formal diagnostic criteria for ADPKD include age, number of renal cysts for each kidney, and family history of renal disease (4, 5). Isolated polycystic liver disease (PCLD) shares the phenotype of a polycystic liver but is distinct from ADPKD because renal disease is absent (6). Some patients may, however, have sporadic renal cysts. Diagnosis of PCLD is made by a family history consistent with autosomal dominant inheritance and the presence of at least one (<40 y) or more than three (>40 y) hepatic cysts (7).

The natural course of PCLD and ADPKD depends on a spectrum of factors that include age, sex, anticonceptives, pregnancy, and mutation(s) (8–10). Classical linkage analysis has identified four genes that underlie both inherited disorders. Mutations in \textit{polycystic kidney disease 1} or 2 (\textit{PKD1} or \textit{PKD2}) genes (NM_601313 and NM_173910, respectively), which encode polycystin-1 and polycystin-2, are responsible for almost all ADPKD cases (11–13). Both proteins are located in the cilium and are important in renal tubular cell morphogenesis and signaling functions, including the wingless (Wnt) signaling pathway (\(\beta\)-catenin pathway). Mutations in \textit{protein kinase C substrate 80K-H (PRKCSH)} and \textit{Saccharomyces cerevisiae homolog 63 (SEC63)} are linked to PCLD (NM_002743.2 and NM_007214.4, respectively), and both gene products are located to the endoplasmic reticulum and are involved in processing and folding of glycosylated proteins (14–16). In addition, the canonical Wnt signaling may be deregulated by the interaction partner nucleoredoxin of the Sec63 protein during oxidative stress (17). In contrast to ADPKD, only 25% of PCLD cases can be explained by mutations in already known genes (18), indicating that mutations in several other as yet unidentified genes are involved in this disease. We hypothesized that another PCLD gene is involved in an extended PCLD family negative for the known disease genes and performed whole-exome sequencing. This unique approach has proven to be successful for the identification of the genetic cause of other Mendelian disorders (19–21).

Significance

Polycystic liver disease (PCLD) is an autosomal dominantly inherited disorder characterized by multiple fluid-filled hepatic cysts that may cause an extremely enlarged liver. PCLD is genetically heterogeneous, and mutations in \textit{PRKCSH} and \textit{SEC63} are present in ~25% of PCLD patients. This research identifies four unique \textit{LRP5} mutations in four independent families that were all located at highly conserved protein domains. Functional activity analyses suggest that mutant \textit{LRP5} reduces wingless (Wnt) signal activation. This study suggests that imbalanced Wnt signaling is related to hepatic cyst formation.


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Results

Extended Polycystic Liver Disease Family. We assessed a 49-y-old female (III/18) by clinical history taking and physical and radiological examination. She presented to us with a severe symptomatic polycystic liver without renal cysts and complained of abdominal distension, pain, dyspea, and pyrosis. There was no history of renal disease, hypertension, or intracranial aneurysms. She used contraceptives for a total of 30 y and had two pregnancies. CT scanning revealed numerous cysts with diameters of 5–18 cm in liver segments I–III and VII. Despite aspiration sclerotherapy and laparoscopic deroofing of the liver cysts, her symptoms persisted, and she enrolled in a clinical trial for long-acting octreotide treatment (22). We expanded our clinical analysis and identified a 40-member Dutch family with three generations of early- and late-onset cystogenesis inherited in an autosomal dominant fashion (PCLD-1). Next, we studied 19 individuals with cystogenesis, of which 16 were affected with a polycystic liver according to the Reynolds criteria (5, 7), and three members were affected with renal cysts that came from the 40-member Dutch family (Fig. 1A). The proband (III/18) possessed no pathogenic variants affecting any of the known PCLD or ADPKD genes.

Whole-Exome Sequencing Identifies Pathogenic LRP5 Variant. We performed exome sequencing on genomic DNA in two members (III/18 and II/18) from the PCLD-1 family with an advanced polycystic liver phenotype (Fig. 1B). Exome capture and sequencing were performed using the Agilent SureSelect target enrichment system with SOLiD4 sequencing. We identified 24,178 and 25,332 genetic variants per proband, respectively (Tables S1 and S2). Variants were annotated by a bioinformatics pipeline as described previously (19, 20). Variant follow-up required the presence of at least five unique variant reads (different start sites), and the variant had to be present in at least 20–80% of all reads suggestive of heterozygous changes in a dominant model of disease. Next, we prioritized variants based on predicted amino acid consequences and overlap with common variation (presence in dbSNP v134 and/or an in-house database containing 1,300 analyzed exomes of predominantly European ancestry). We identified 11 unique nonsynonymous variants present in both affected relatives (Table S3). All 11 variants were tested for segregation in both probands and all other family members by Sanger sequencing. The only private nonsynonymous variant that cosegregated completely with the disease was a missense mutation (c.3562C > T) with evolutionary conserved amino acid change p.R1188W located on chromosome 11q13.2 in the low-density lipoprotein receptor-related protein 5 (LRP5) gene (NM_002335.2; Fig. 1C and D). We checked sequence coverage and excluded the presence of potential pathogenic variants in the 2 Mb surrounding LRP5. All 19 individuals with cystogenesis possessed LRP5 c.3562C > T (Table S4 and Fig. S1). Analysis of the sequence data revealed linkage at the LRP5 locus with the disease with a significant logarithm of odds (LOD) score of 4.62 (Fig. S2). This LRP5 variant (c.3562C > T) was not detected in genome-wide sequence data from the 1000 Genomes Project (23), 6,500 individuals from the National Heart, Lung, and Blood Institute Exome Sequencing Project (24), or exome data from 1,300 individuals of predominantly European ancestry sequenced in-house (19, 20) and excluded by Sanger sequencing in a control set of 1,000 Dutch DNAs of healthy, unrelated individuals. This LRP5 mutation affected a highly conserved amino acid and was predicted to be damaging by PolyPhen-2, MutPred, and sorting intolerant from tolerant (SIFT) models (Table 1).

LRP5 is a known disease gene causing severe skeletal bone or retinal disorders and is associated with metabolic disease (Fig. S3). Therefore, we actively investigated the possible presence of subtle clinical signs in our family by slit-lamp eye examination. These investigations excluded familial exudative vitreoretinopathy (FEVR) in any of the family members (SI Text). We assessed bone density of the lumbar spine and left hip in 13 patients and 9 unaffected relatives. The lumbar T-score was lower in LRP5 mutation carriers but within the normal range, and no member had a bone density disorder. Routine laboratory testing, including renal parameters, did not reveal differences between individuals with and without the LRP5 mutation (Table 2). Therefore, other LRP5-related disorders were ruled out in this index family.

Additional LRP5 Variants in Polycystic Liver Disease. To confirm our results, we sequenced LRP5 in a cohort of 150 unrelated PCLD probands without PRKCSH, SEC63, or PKD2 gene mutations. We identified two additional PCLD families (one Dutch and one Moroccan) and one Dutch PCLD singleton case with private LRP5 missense variants. Mutations c.1360G > A (p.V454M) and c.4587G > C (p.R1529S) segregated with the disease in both families, and unaffected relatives of the singleton case (c.4651G > A; p.D1551N) did not carry the mutation (Fig. S4).

Mutation c.1360G > A (p.V454M) was present in an 86-y-old polycystic liver patient. Her mutation-positive daughter had
several bilateral renal cysts and small hepatic cysts on CT scanning. The daughter died as a result of a metastasized liposarcoma at the age of 49. A 43-y-old Moroccan female had multiple dominant hepatic cysts without renal disease. Her 71-y-old mother had several hepatic cysts without renal cysts. Both carried the c.4587G > C (p.R1529S) mutation in the LRP5 gene. A fourth mutation [c.4651G > A (p.D1551N)] was present in a 65-y-old male with a polycystic liver and three renal cysts. There was no evidence for renal failure. The phenotype of his deceased parents was unknown, and both his healthy children were without hepatic or renal cysts and did not harbor the LRP5 mutation. None of the LRP5 variants were detected in chromosomes from healthy unrelated and ethnically matched controls (Dutch, n = 1,000; Moroccan, n = 525) nor were they present in the in-house or online exome sequencing datasets. In addition, all four LRP5 missense variants affected highly conserved amino acids and again were predicted to be damaging or deleterious by PolyPhen-2, MutPred, and SIFT (Table 1).

**LRP5 Expression in Liver Cyst Tissues.** LRP5 has a wide tissue distribution, including liver and kidney, and expression has been reported in Kupffer cells, macrophages, stellate cells, cholangiocytes, and hepatocytes (25). In line with Northern blotting experiments (26), we found abundant LRP5 protein presence in normal liver tissues and relevant for PCLD. In the affected proband (III/18), we observed intense LRP5 staining of cyst-lining epithelium and bile ducts. The intensity of LRP5 expression was comparable in cyst tissue sections derived from a female had multiple dominant hepatic cysts without renal disease. Her 71-y-old mother had several hepatic cysts without renal cysts. Both carried the c.4587G > C (p.R1529S) mutation in the LRP5 gene. A fourth mutation [c.4651G > A (p.D1551N)] was present in a 65-y-old male with a polycystic liver and three renal cysts. There was no evidence for renal failure. The phenotype of his deceased parents was unknown, and both his healthy children were without hepatic or renal cysts and did not harbor the LRP5 mutation. None of the LRP5 variants were detected in chromosomes from healthy unrelated and ethnically matched controls (Dutch, n = 1,000; Moroccan, n = 525) nor were they present in the in-house or online exome sequencing datasets. In addition, all four LRP5 missense variants affected highly conserved amino acids and again were predicted to be damaging or deleterious by PolyPhen-2, MutPred, and SIFT (Table 1).

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**Reduced Activation of Canonical Wnt Signaling.** To identify the underlying mechanism of mutated LRP5 on the Wnt pathway, we conducted luciferase activity assays with LRPsWT, one extracellularly (LRP5R1188W) and one intracellularly located (LRP5D1551N) mutant, and an empty expression vector as a control. Immunofluorescence imaging in WT and both mutant constructs presented similar localization of LRP5 (Fig. 2 C and D). Western blots of the cell lysates showed comparable protein expression of all constructs (Fig. 2G). Overexpression of the LRP5 constructs in CHO cells increased basal and Wnt3a-induced luciferase activity compared with the empty vector (P < 0.0001). In the presence of Wnt3a, signal

### Table 1. Summary and in silico analysis of four LRP5 variants in polycystic liver disease

<table>
<thead>
<tr>
<th>Family ethnicity</th>
<th>Mutation (c.DNA) NM_002335.2</th>
<th>Predicted effect on protein</th>
<th>PolyPhen2</th>
<th>MutPred</th>
<th>SIFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCLD-1 Caucasian (Dutch)</td>
<td>c.3562C &gt; T</td>
<td>p.R1188W</td>
<td>Probably damaging 1.00</td>
<td>0.552</td>
<td>Deleterious 0.00</td>
</tr>
<tr>
<td>PCLD-2 Caucasian (Dutch)</td>
<td>c.1360G &gt; A</td>
<td>p.V454M</td>
<td>Possibly damaging 0.872</td>
<td>0.520</td>
<td>Deleterious 0.01</td>
</tr>
<tr>
<td>PCLD-3 Moroccan</td>
<td>c.4587G &gt; C</td>
<td>p.R1529S</td>
<td>Possibly damaging 0.610</td>
<td>0.288</td>
<td>Deleterious 0.00</td>
</tr>
<tr>
<td>PCLD-4 Caucasian (Dutch)</td>
<td>c.4651G &gt; A</td>
<td>p.D1551N</td>
<td>Probably damaging 0.999</td>
<td>0.235</td>
<td>Deleterious 0.00</td>
</tr>
</tbody>
</table>

### Table 2. Baseline characteristics of PCLD-1 family

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No hepatic cystogenesis and no LRP5 mutation (n = 9)</th>
<th>Hepatic cystogenesis and LRP5 mutation (n = 13)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>55 ± 12</td>
<td>56 ± 13</td>
<td>NS</td>
</tr>
<tr>
<td>Female sex, no. (%)</td>
<td>6 (67)</td>
<td>9 (69)</td>
<td>NS</td>
</tr>
<tr>
<td>Bone density: Hip</td>
<td>T-score: −0.19 ± 0.78</td>
<td>−0.08 ± 0.93</td>
<td>NS</td>
</tr>
<tr>
<td>Z-score</td>
<td>0.69 ± 0.68*</td>
<td>0.95 ± 0.94</td>
<td>NS</td>
</tr>
<tr>
<td>Bone density: L1-L2-L3-L4</td>
<td>T-score: 1.18 ± 0.95*</td>
<td>0.19 ± 0.88</td>
<td>0.042</td>
</tr>
<tr>
<td>Z-score</td>
<td>1.81 ± 0.89*</td>
<td>1.18 ± 1.03</td>
<td>NS</td>
</tr>
<tr>
<td>Creatin (μmol/L)</td>
<td>69 ± 14</td>
<td>73 ± 20</td>
<td>NS</td>
</tr>
<tr>
<td>Cholesterol (mmol/L)</td>
<td>5.39 ± 0.71</td>
<td>5.44 ± 1.01</td>
<td>NS</td>
</tr>
<tr>
<td>GFR (MDRD) (ml/min/1.73 m²)</td>
<td>87 ± 13</td>
<td>85 ± 25</td>
<td>NS</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>25.7 ± 2.5</td>
<td>26.4 ± 5.2</td>
<td>NS</td>
</tr>
<tr>
<td>Triglycerides (mmol/L)</td>
<td>1.35 ± 0.71</td>
<td>1.80 ± 0.93</td>
<td>NS</td>
</tr>
<tr>
<td>HDL (mmol/L)</td>
<td>1.34 ± 0.40</td>
<td>1.38 ± 0.32</td>
<td>NS</td>
</tr>
<tr>
<td>LDL (mmol/L)</td>
<td>3.44 ± 0.82</td>
<td>3.25 ± 0.78</td>
<td>NS</td>
</tr>
<tr>
<td>Non HDL (mmol/L)</td>
<td>4.06 ± 0.93</td>
<td>4.07 ± 0.93</td>
<td>NS</td>
</tr>
<tr>
<td>HbA1C (%)</td>
<td>5.5 ± 0.6</td>
<td>5.7 ± 0.8</td>
<td>NS</td>
</tr>
<tr>
<td>HbA1C (mmol/mol)</td>
<td>37 ± 6</td>
<td>39 ± 9</td>
<td>NS</td>
</tr>
</tbody>
</table>

NS, not significant.  
*There was one missing value because of degenerative abnormalities of the lumbar spine in an 85-y-old woman.
activation was significantly down-regulated by 30% and 45%, taking into account the basal activity in both LR5 mutants compared with the LR5WT. We also detected a significant decrease (P < 0.001) of LR5 mutant p.D1551N without the presence of Wnt3a (Fig. 2H). Luciferase activity assays were repeated in HEK293 and human liver-derived H69 cells, where comparable significant results were obtained (Fig. S5).

Altered Expression Levels of Wnt Target Genes. Subsequently, we conducted quantitative PCR (qPCR) experiments of transducers and transcription factors associated with the canonical Wnt signaling. Our analyses show that HEK293 cells transfected with mutant LR5 led to altered expression levels of target genes compared with LR5WT (Fig. S6). There was a significant increased gene expression of transducers adenomatous polyposis coli, glycogen synthase kinase 3β (GSK3β), and leucine-rich repeat-containing G-protein-coupled receptor 5 (LGR5) and transcription factor v-myc avian myelocytomatosis viral oncogene homolog (c-Myc) in LR5R1188W or LR5D1551N compared with LR5WT. Similarly, axis inhibitor-1 (AXIN-1), axis inhibitor-2 (AXIN-2), lymphoid enhancer-binding factor 1 (LEF1), SRY-box 9 (SOX9), fibroblast growth factor 18 (FGF18), and cyclin D1 (CCND1) were also up-regulated. In the presence of the extracellular regulator Wnt3a, expression levels of several Wnt signaling components changed (Fig. S7). Decreased expression levels were found for GSK3β, AXIN-1, AXIN-2, LGR5, c-Myc, CCND1, and LEF1 compared with LR5WT in both mutated LR5 constructs. These results are in line with the functional consequences of these LR5 mutations as shown with luciferase activity assays (Figs. S8 and S9).

Discussion

This study identifies LR5 as a novel gene associated with hepatic cystogenesis in patients clinically diagnosed with PCLD. The initial discovery was made in two affected relatives from an extended Dutch family by exome sequencing (21). A private missense mutation c.3562C>T (p.R1188W) in the LR5 gene segregated with 18 affected relatives (>40 y), with a significant LOD score of 4.62. These findings are corroborated by the presence of three additional private missense LR5 variants in two PCLD families and one PCLD singleton. All unique variants identified in LR5 affected highly conserved amino acids and were predicted to be damaging or deleterious. The identification of LR5 as a causative gene follows that of PRKCSH (15%) and SEC63 (6%) for isolated polycystic liver disease in a PCLD cohort (18).

LR5 is a single-span transmembrane protein that acts as a co-receptor with Frizzled protein family members for transducing signals by Wnt proteins. Wnt signaling directs a number of fundamental physiological mechanisms such as cell proliferation, cell polarity, and cell fate determination during embryonic development (28). Until now, LR5 variants were linked to a spectrum of Mendelian genetic diseases. LR5-related disorders include autosomal dominant conditions with abnormal bone density, such as endosteal hyperostosis and osteosclerosis (29–32), but also eye disorders such as recessive and dominant forms of FEVR (29, 33, 34). Our findings expand the clinical spectrum of LR5-associated phenotypes because there were no extrahepatic features in patients with LR5 mutations in our studies. Specifically metabolic disorders, diabetes mellitus, skeletal bone, and retinal diseases were absent in the index family, and these were not reported for the other three families. We performed specific clinical investigations in extended family 1 and excluded FEVR in individuals with LR5 germ-line mutations by slit-lamp eye examination. Bone density measurements ruled out bone diseases in individuals with and without PCLD. Hepatic or renal cystogenesis has not been observed in association with FEVR or with bone diseases. Why different LR5 mutations can result in such a wide spectrum of complex diseases that targets different tissues remains to be determined. LR5 is detected by Northern blot analysis, immunohistochemistry, and in situ hybridization studies in several tissues including the liver and kidney (25, 26). Until now, LR5 mutations were linked to pathological retina or bone development. In the extended PCLD-1 family, we identified the LR5 variants c.3562C>T and p.R1188W in 22 individuals, all affected in hepatic and/or renal cystogenesis. Two members were too young (<40 y) to develop hepatic cysts, and one individual is an example of incomplete penetrance. Indeed, there was considerable clinical heterogeneity in affected patients without complaints or patients with severe abdominal discomfort in the PCLD-1 family. This clinical heterogeneity has been described in families with...
PRKCSH- and SEC63-associated PCLD (14, 18), and penetrance of PRKCSH-associated PCLD is estimated at ~80%. Intrafamilial phenotypic variability suggests that modifier genes and/or environmental factors play a major role in PCLD disease expression. Similarly, the clinical expression of LRP5-associated bone and eye diseases is highly variable (27).

There have been efforts to recapitulate the involvement of LRP5 mutations in a number of bone and eye disorders in mice. A targeted KO Lrp5<sup>Δp2066</sup>/Lrp5<sup>Δp2066</sup> mouse suffers from unspecified hepatobiliary abnormalities that might implicate phenotypic overlap with our observed human phenotypes (35). Human and mouse LRP5 share a high degree of amino acid identity to corepressor low density lipoprotein receptor-related protein 6 (LRP6) and have a similar domain structure (36). Furthermore, there has been speculation about functional redundancy between both transmembrane coreceptors of the canonical Wnt signaling pathway (37). The homozygous KO Lrp6 mouse is embryonic lethal and possesses poly cystic kidneys (37) compatible with the ADPKD phenotype. There is further experimental data to suggest that renal cystogenesis in ADPKD is linked to defective canonical Wnt signal transduction. Perturbations of polycystins cause inappropriate levels of β-catenin, and activation and inactivation of the Wnt signaling pathway are reported in different poly cystic kidney disease mice models during embryonic or postnatal development (38–42). Our findings provide a direct link between canonical Wnt signaling and poly cystic liver disease as Wnt signaling is reduced in mutant LRP5 compared with WT LRP5. A moderate reduction of signaling activity is in line with known LRP5 missense mutations in retina and bone disorders (43, 44). These observations support a role of an imbalanced canonical and noncanonical Wnt signal transduction in the pathogenesis of LRP5-associated poly cystic diseases. We speculate that LRP5, along with other genes implicated in hepatic cystogenesis, PKD1, PKD2, PRKCSH, and SEC63, is part of the functional genetic network. Experimental studies have observed that reduced dosage of these gene products, and in particular polycystin-1, is required to cause cyst formation (45, 46).

The identification of LRP5 associated with hepatic cystogenesis affords a better understanding of the pathophysiology of PCLD. Positivity for immunoreactive LRP5 in cyst epithelium suggests that the protein is structurally intact. Functional assays in three different cell systems indicate that the mutation renders the protein to be less functional and that leads to inhibition of the canonical Wnt signaling (41, 42).

In conclusion, PCLD is a genetically heterogeneous disorder that may be caused by LRP5 gene mutations. Our results link hepatic cystogenesis to dysregulated canonical Wnt signaling and are in line with data that were generated from ADPKD models (41, 42). Polycystins modulate Wnt signaling during organ development and contribute to hepatic and renal cystogenesis (42, 47, 48). Our study provides evidence that mutations in LRP5 are related to hepatic cyst development and fuels the hypothesis that canonical Wnt signal transduction is important in poly cystic diseases. It is possible that disruption of other (downstream) members of the Wnt signaling pathway may be associated with initiation of hepatic and renal cyst formation.

Materials and Methods

**Human Subjects.** Ultrasound images of liver and kidneys were acquired using a 3.6-MHz general purpose clinical echo system (Acuson ×150; Siemens AG) equipped with a linear array linear transducer. Blood samples were collected from all 40 subjects, and DNA was extracted from blood leukocytes using the HP-PCR Template Preparation kit (Roche Applied Science). Formalin-fixed paraffin-embedded liver cyst tissue specimens were available from proband III/18 after laparoscopic cyst fenestration. DNA samples from 1,000 Dutch and 525 Moroccan healthy unrelated individuals were used as controls. All subjects provided written informed consent for all investigations. This study was approved by the Medical Ethics Committee of the Radboud university medical center, The Netherlands.
HEK293 cells, and 5.0 × 10⁴ human cholangiocyte 69 (H69) cells per well were seeded in a 96-well plate in triplicate. After 24 h, cells were transiently transfected using Lipofectamine 2000 (100 ng LRP5 construct; LRP5wt; LRP5Δ1581; LRP5Δ1511) or empty vector and 100 ng of TCFEFL1 Reporter or 100 ng negative control according to the manufacturer's instructions (Cignal TCF/LEF1 Reporter Assay Kit; Qiagen). Sixteen hours after transfection, medium was replaced by medium with or without 250 ng/mL human Wnt3a (5036-WN; R&D Systems) to initiate Wnt signaling. Cells were cultured for another 24 h, and luciferase activity was detected using the Dual-Glo Luciferase Assay System (Cat. No. E2920; Promega) in an infiniteM200-Pro plate reader (Tecan). Firefly lucerase activity was normalized to Renilla lucerase activity for variations in transfection efficiencies. Values are reported as means ± SD. These experiments were conducted in triplicate and performed three times. Western blotting was also performed to analyze possible differences in expression levels between the WT and mutant LRP5.

qPCR. We conducted transient transfections of HEK293 cells with LRP5 constructs as previously described. The signaling was activated by addition of Wnt3a for 24 h. Total RNA was extracted with TRIzol (Invitrogen). Template cDNA was obtained using the i Script cDNA synthesis kit (Biorad). Expression levels of Wnt target genes were assessed twice by qPCR experiments (in triplicate) using the CFX96 real-time detection system (Biorad).

Immunoﬂuorescence Imaging. A total of 4.0 × 10⁴ CHO cells per well were seeded on poly-l-lysine–coated Ø12-mm cover glasses on a 24-well plate and transiently transfected with 100 ng of LRP5wt or mutant LRP5 construct. After 24 h, medium was refreshed, and cells were cultured for another 24 h followed by parafomaldehyde ﬁxation and immunoﬂuorescence staining.

Statistics. Groups were compared using descriptive statistics and compared by the Student t test. Both groups were compared by using the nonparametric Mann–Whitney U test. P < 0.05 was considered statistically signiﬁcant. All analyses were carried out by SPSS software v18.0.

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