A frameshift mutation in the gene for PAX3 in a girl with spina bifida and mild signs of Waardenburg syndrome


Abstract

Neural tube defects (NTD) are among the most prevalent congenital malformations in man. Based on the molecular defect of Splotch, an established mouse model for NTD, and on the clinical association between NTD and Waardenburg syndrome (WS), mutations in the PAX3 gene can be expected to act as factors predisposing to human NTD. To test this hypothesis, 39 patients with familial NTD were screened by SSC analysis for mutations in exons 2 to 6 of the human PAX3 gene. One patient with lumbosacral meningomyelecele was identified with a 5 bp deletion in exon 5 approximately 55 bp upstream of the conserved homeodomain. The deletion causes a frameshift with a stop codon almost immediately after the mutated site. Clinical investigation of the index patient indicated mild signs of WS type I. Varying signs of this syndrome were found to cosegregate with the mutation in the family. Our results support the hypothesis that mutations in the gene for PAX3 can predispose to NTD, but also show that, in general, mutations within or near the conserved domains of the PAX3 protein are only very infrequently involved in familial NTD.

(SSC ANALYSIS

DNA fragments overlapping exons 2 to 6 of the human PAX3 gene were amplified by the polymerase chain reaction (PCR) from genomic DNA together with 5' and 3' flanking intron sequences. Amplification was carried out in a total volume of 25 µl containing 50 ng of genomic DNA, 0·45 mmol/l of each primer, 0·1 mmol/l dCTP, 0·4 mmol/l dATP, 0·4 mmol/l dGTP, 0·4 mmol/l dTTP, 0·1 µl [α-32P]dCTP (Amersham) in PCR buffer (50 mmol/l KCl, 10 mmol/l Tris·HCl, pH 8·3, 1 mmol/l DTE, 0·001% gelatine, 1·5–6 mmol/l MgCl2) with 0·5 U Tag DNA polymerase (Boehringer Mannheim). Samples were denatured at 92°C for five minutes and then subjected to 35 cycles of amplification: 92°C for 30 seconds, 55°C for 30 seconds, 72°C for one minute 30 seconds. Exon 2 was analysed as two partly overlapping fragments. The following primers were used for amplification (fig 1), some of which are identical to those reported by Tassabehji et al.

Materials and methods

ASCERTAINMENT OF PATIENTS AND DNA ISOLATION

Patients were selected from the Dutch population in collaboration with the patient organisation BOSK and from the records of the Nijmegen hospital departments. Thirty nine families were selected with more than one patient who had an affected third degree or closer relative (first cousin, great aunt, or great uncle of the proband). Genomic DNA was isolated from one patient from every family according to the procedure of Miller et al. The types of NTD in the test patients were spina bifida (37), encephalocoele (1), and craniorachischisis (1).
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**Results**

**A PAX3 GENE MUTATION IN A PATIENT WITH SPINA BIFIDA**

*PAX3* belongs to a family of embryonic transcription factors, which are related by possession of the conserved paired domain. The paired domain of the *PAX3* gene is encoded by a segment of exon 4. In addition, the *PAX3* gene contains two other conserved domains: an octapeptide motif encoded by a segment of exon 2, and a homeodomain encoded by the 3' and 5' part of exons 5 and 6, respectively. To test the hypothesis that mutations in the *PAX3* gene might predispose to the development of NTD, genomic DNA was isolated from 39 patients of multiple case NTD families and the exons were screened for mutations by SSC analysis (Materials and methods, fig 1). When exon 5 was analysed, not only the normal band pattern, but several additional bands were observed in the DNA of one patient (fig 2A). To evaluate this further, the amplification products were subjected to denaturing gel electrophoresis, which showed the presence of a heterozygous deletion (fig 2B). The location and size of the deletion were determined by direct sequencing of the eluted allelic DNA fragments (Materials and methods). A 5 bp deletion was detected in exon 5 approximately 55 bp upstream of the homeodomain (fig 3A). This causes a shift in the normal reading frame for translation with premature termination of polypeptide synthesis almost immediately downstream of the mutated site (fig 3B).

**CLINICAL EXAMINATION OF THE PATIENT AND HER RELATIVES**

Knowing that *PAX3* mutations can cause WS (MIM 193500), signs of this disorder could be present in the patient and some of her relatives. Therefore, the family (fig 4) was clinically (re)-examined. The major signs of WS are a typical facies with dystopia canthorum as the most frequently observed characteristic, pigmentary disturbances like a frontal blaze of white hair, heterochromia irides, white eyelashes and leucoderma, and partial or complete cochlear deafness. WS follows an autosomal dominant pattern of inheritance with a wide variability of expressivity.

The index patient (III.5) was seen at the age of 11 ½ years. She was born with a lumbosacral meningomyelocele for which she was operated shortly after birth. Because of developing hydrocephalus, a ventriculoperitoneal shunt was inserted. She is mentally retarded. Her height is 128.5 cm (<3rd centile), she weighs 26 kg (50th centile for height), and has an occipitofrontal circumference of 53.7 cm (50th–90th centile). She has dystopia canthorum (ICD 43 mm, >97th centile; OCD 85 mm, 50th centile), leading to blepharophimosis, broad and high nasal root, hyp
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premature stop codon shortly after the site of the deletion. The boundary between exons 4 and 5 is indicated by a vertical bar.

poplastic nasal alae, a round nasal tip, and smooth philtrum. There is a naevus above the right eye. The palate is high arched and there is dental crowding. Below the spina bifida she has a deep sacral pit. She has no heterochromia irides, no pigmented disturbances, and no hearing loss.

The mother of the index patient (II.4) has a similar appearance with dystopia canthorum (ICD 41 mm, >97th centile; OCD 85 mm, 25th–50th centile), leading to blepharophimosis, brushy eyebrows, a high nasal root, hypoplastic nasal alae, and a round nasal tip. She has vitiligo of the left hand and wrist. She has no heterochromia irides and no hearing loss.

The maternal grandfather of the index patient (I.2) has heterochromia irides and dystopia canthorum, but no pigmented abnormalities and no long standing hearing loss. No abnormalities were seen on a photograph of the maternal grandmother (I.1).

The maternal aunt of the index patient (II.1) has no signs of WS. Another sister of the mother (II.3) was born with a lumbar meningomyelocele and hydrocephalus, but died at the age of 6 months without having left the hospital. It is unknown whether she had any sign of WS. No material was saved for genetic analysis.

Several sibs of the index patient III.4, III.8, III.9, and III.10, show the facial characteristics of WS. III.9 was born with a white forelock, which subsequently disappeared, and has unilateral hearing loss. III.8 had poliosis.

These observations show that WS is indeed segregating in this family and that the index patient has a mild expression of this syndrome in combination with spina bifida. Based on the presence/absence of specific symptoms, three subtypes of Waardenburg syndrome are distinguished. WS-I (MIM 193500) and WS-II (MIM 193510) are characterised by the presence or absence of dystopia canthorum, respectively, whereas the disorder is diagnosed as WS-III (MIM 148820) if limb deformities are among the symptoms. Accordingly, the present family can be categorised as having WS-I. So far, WS with NTD patients have only been reported in families with WS type I.
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Figure 4 Pedigree of the family with two closely related patients with lumbar meningomyelocele and hydrocephalus: the index patient III.5 and her maternal aunt II.3. All members were clinically examined for symptoms of WS. Those with a positive diagnosis of WS in addition to the index patient are indicated by shaded symbols.

Figure 5 Co-segregation of the exon 5 deletion with symptoms of WS. All available members of the family were examined for the presence of the mutant allele by PCR amplification of exon 5 and subsequent denaturing gel separation of amplified fragments. All members diagnosed as having WS symptoms appear to carry the mutant allele.

Here we show that mutations disrupting the open reading frame of the PAX3 gene may also be found in patients with WS and NTD.

Despite the fact that carriers of a PAX3 mutation probably have an increased risk for NTD, in the present study only one of 39 patients with familial NTD was found to have such a mutation indicating that, in general, PAX3 mutations are an infrequent cause of familial NTD. However, SSC analysis is not completely sensitive, leaving the possibility that some mutations have not been detected by this method. Further, mutations could be present in exons 1, 7, or 8, which have not yet been examined in detail. Nevertheless, mutations within or near the conserved domains of the PAX3 protein are not likely to play a major role in familial NTD.

Because of the findings in Splotch mice, it is not surprising that NTD may be present in humans carrying a mutation in the PAX3 gene. Homozygous Splotch embryos die on day 13 of gestation and 50% have lumbosacral spina bifida. Heterozygous animals display pigmentary disturbances, but have a normally closed neural tube, yet breeding experiments have shown that a heterozygous Pax3 mutation influences the incidence of NTD in animals already committed to NTD development. 9,10 Apparently, in those animals the occurrence of NTD depends on a combination of pre-determining factors. A similar situation may exist in humans, where additional factors may modify the phenotypic expression of the same PAX3 mutation in different persons. Spina bifida is not the only malformation of homozygous Splotch embryos. In 50% exencephaly is observed and congenital heart defects also occur, which are regarded as the major cause of death. In humans, exencephaly and congenital heart defects do not seem to be associated with WS but, considering the influence of other genetic factors on the phenotype, it may be worth looking for PAX3 mutations in patients with NTD and congenital heart defects.

The pathophysiological processes leading to NTD in Splotch have not yet been elucidated. Suggested mechanisms include delayed migration of neural crest cells and an abnormal curvature of the caudal region. More likely, these phenomena are secondary to a defect of the neuroepithelium, where the Pax3 gene is expressed before neural tube closure. 10 The detection and functional characterisation of PAX3 gene mutations in patients with NTD may help to clarify the pathogenesis of NTD further.

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