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Association of Variants at **UMOD** with Chronic Kidney Disease and Kidney Stones—Role of Age and Comorbid Diseases

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**Abstract**

Chronic kidney disease (CKD) is a worldwide public health problem that is associated with substantial morbidity and mortality. To search for sequence variants that associate with CKD, we conducted a genome-wide association study (GWAS) that included a total of 3,203 Icelandic cases and 38,782 controls. We observed an association between CKD and a variant with 80% population frequency, rs4293393-T, positioned next to the **UMOD** gene (GeneID: 7369) on chromosome 16p12 (OR = 1.23, P = 4.1 x 10^-15). This gene encodes uromodulin (Tamm-Horsfall protein), the most abundant protein in mammalian urine. The variant also associates significantly with serum creatinine concentration (**SCr**) in Icelandic subjects (N = 24,635, P = 1.3 x 10^-22) but not in a smaller set of healthy Dutch controls (N = 1,819, P = 0.39). Our findings validate the association between the **UMOD** variant and both CKD and **SCr** recently discovered in a large GWAS. In the Icelandic dataset, we demonstrate that the effect on **SCr** increases substantially with both age (P = 3.0 x 10^-17) and number of comorbid diseases (P = 0.008). The association with CKD is also stronger in the older age groups. These results suggest that the **UMOD** variant may influence the adaptation of the kidney to age-related risk factors of kidney disease such as hypertension and diabetes. The variant also associates with serum urea (P = 1.0 x 10^-6), uric acid (P = 0.0064), and suggestively with gout. In contrast to CKD, the **UMOD** variant confers protection against kidney stones when studied in 3,617 Icelandic and Dutch kidney stone cases and 43,201 controls (OR = 0.88, P = 5.7 x 10^-5).

**Introduction**

Chronic kidney disease (CKD) is a common disorder that can progress to kidney failure and is associated with an increased risk of cardiovascular disease and mortality [1,2]. The cause of CKD is not always known and frequently appears multifactorial with hypertension (HTN) and diabetes mellitus (DM) being the most important causes [3–6]. Other causes include intrinsic kidney disorders, atherosclerosis and nephrotoxic drugs [7,8]. Studies also indicate a dramatic increase in the prevalence of CKD with advancing age [9,10]. With greater lifespan, the burden of CKD is thus steadily rising in the Western world [11], resulting in a substantial impact on the health care system [12].

Previous studies have suggested a genetic contribution to the risk of kidney disease. Heritability estimates of serum creatinine (**SCr**) and estimated glomerular filtration rate based on **SCr** (eGFRcrea), both common measures of kidney function, have been reported as 29% and 33%, respectively [13]. Recently, Köttgen et al. [14] published the first genome-wide association study (GWAS) on eGFRcrea, eGFR based on cystatin C (eGFRcys), another measure of kidney function, and CKD, reporting significant association with eGFRcrea at three loci (**UMOD**, **SHROOM3** (GeneID: 57619) and **GATM-SPATA5L1** (GeneIDs: 2628 and 79029)), with eGFRcys at two loci (**GST3-** **GST4** (GeneIDs: 1471 and 128822) and **STC1** (GeneID: 6781)) and with CKD at one locus (**UMOD**) [14].
Author Summary

Chronic kidney disease (CKD) is a common condition that is associated with substantial morbidity and mortality and has been recognized as a major public health problem worldwide. Common causes of CKD include hypertension, diabetes, and inflammatory disorders. Previous studies have shown a significant genetic contribution to kidney disease and a recent genome-wide association study yielded a variant in the UMOD gene that affects the risk of CKD. Here, we replicate the association between UMOD and CKD in an independent analysis. We also demonstrate for the first time an interaction between the UMOD variant and age that suggests that this variant may adversely affect the aging kidney and its adaptation to age-related risk factors of kidney disease, such as hypertension and diabetes. Furthermore, we show that the UMOD variant that affects risk of CKD also provides protection against kidney stone disease.

With the aim of discovering sequence variants that associate with kidney function, we conducted a GWAS in a total of 3,203 Icelanders with CKD and 38,782 controls and in 24,635 Icelandic and 1,819 Dutch subjects with SCr information. We found a sequence variant at the UMOD locus that associates with both CKD and SCr at a genome-wide significant (GWS) level, providing an independent replication of the result by Kottgen et al [14]. We also show that this variant interacts with age-related increase in SCr levels with little or no effect on SCr before the age of 50 years, followed by a rapidly growing effect with increasing age. We demonstrate that this variant associates significantly with serum urea, uric acid and suggestively with gout. In contrast to the deleterious effect on kidney function, the variant confers protection against kidney stone disease.

Results/Discussion

Genome-wide association of variants at the UMOD locus with CKD and SCr

A GWAS of 2.5 million SNPs, either directly genotyped (Illumina HumanHap300 or HumanHapCNV370 bead chips) or imputed based on the HapMap CEU samples [15], was performed on a sample set of 2,903 Icelanders with CKD (see Materials and Methods for sample set description) and 35,818 controls and also on 22,256 Icelandic subjects with SCr information (See QQ-plots in Figure S1 and Figure S2). The Icelandic SCr measurements came from two laboratories; the Laboratory in Mjodd, a private outpatient laboratory, and the Clinical Biochemistry Laboratory of Landspitali University Hospital (LUH), serving both inpatients and outpatients. These subjects had 5.2 SCr measurements on average (geometric mean) and we used the median SCr value for each individual in the subsequent analysis. The SCr values from the two Icelandic laboratories showed similar dependence on age and sex but there was clearly a trend towards higher SCr in the hospital laboratory compared with the outpatient laboratory (Figure S3).

The GWAS on CKD and SCr both yielded several SNPs in high linkage disequilibrium (LD) on chromosome 16p12 with GWS (P<5x10^-8) association to increased risk of CKD and elevated SCr. For both phenotypes, this signal is tagged by rs4293393-T (Table 1 and Table 2). For CKD, the odds ratio (OR) conferred by rs4293393-T was 1.25 (95% CI = 1.16-1.34) with a corresponding P value of 6.2x10^-9. In an attempt to replicate this finding, rs4293393-T was typed in additional 300 Icelandic subjects with CKD and 2,964 controls. The association was nominally significant in the replication sample set and the effect size consistent with the initial observation (Table 1). The combined OR for rs4293393-T in the two Icelandic CKD sample sets was 1.25 (95% CI = 1.17-1.35) and P = 4.1x10^-10. The association between SCr and rs4293393-T on 16p12 was very strong with an effect of 1.86 μmol/L per allele carried and P = 6.7x10^-20 (Table 2). To follow up on these results, we genotyped rs4293393 in 2,379 additional Icelanders with SCr information, significantly replicating the initially observed effect (P = 1.4x10^-5; Table 2). Analysis of the combined Icelandic datasets showed a strong GWS association between rs4293393-T and elevated SCr (effect = 1.93 μmol/L per allele, 95% CI = 1.55-2.31 μmol/L; P = 1.5x10^-23). Our findings provide an independent replication of the recently reported results by Kottgen et al [14] of an association of this 16p12 locus with CKD and eGFRcrea. The strongest SNP associations outside the UMOD region on chromosome 16p12 are shown in Table S1 (for CKD) and Table S2 (for SCr), respectively.

For further assessment, we tested rs4293393 in 1,819 Dutch subjects with SCr information. These were healthy population-based controls (see Materials and Methods for sample set description) with SCr values substantially different from the Icelandic measurements, generally showing lower values and

| Table 1. Association of rs4293393-T with chronic kidney disease (CKD). |
|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| CKD population        | N                      | Frequency              | OR (95% CI)            | P                      |
| population            | case                   | control                | case                   | control                |
| Icelandic discovery   | 2,903                  | 35,818                 | 0.831                  | 0.798                  | 1.25 (1.16, 1.34)      | 6.2x10^-9              |
| Icelandic replication | 300                    | 2,964                  | 0.840                  | 0.798                  | 1.33 (1.05, 1.68)      | 0.019                  |
| Icelandic combined    | 3,203                  | 38,782                 | 0.832                  | 0.798                  | 1.25 (1.17, 1.35)      | 4.1x10^-10             |
| YOB=1950              | 143                    | 38,782                 | 0.811                  | 0.798                  | 1.09 (0.81, 1.46)      | 0.57                   |
| 1950>YOB=1940         | 355                    | 38,782                 | 0.821                  | 0.798                  | 1.16 (0.96, 1.41)      | 0.12                   |
| 1940>YOB=1930         | 1,029                  | 38,782                 | 0.834                  | 0.798                  | 1.28 (1.14, 1.43)      | 3.1x10^-5              |
| 1930>YOB=1920         | 1,242                  | 38,782                 | 0.838                  | 0.798                  | 1.31 (1.18, 1.46)      | 4.1x10^-7              |
| 1920>YOB              | 434                    | 38,782                 | 0.825                  | 0.798                  | 1.19 (1.00, 1.42)      | 0.045                  |

Association of rs4293393-T with CKD in Icelandic subjects. Association is shown for the discovery sample set, the replication sample set, the combined Icelandic sample, and finally, for the combined sample stratified by year of birth (YOB) as a proxy for age at onset.

doi:10.1371/journal.pgen.1001039.t001
Table 2. Association of rs4293393-T with serum creatinine concentration (SCr).

<table>
<thead>
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<th>N</th>
<th>Effect (95% CI)</th>
<th>P</th>
</tr>
</thead>
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<td>1.86 (1.46, 2.25)</td>
<td>6.7x10^-20</td>
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<tr>
<td>Icelandic replication</td>
<td>2,379</td>
<td>2.68 (1.47, 3.89)</td>
<td>1.4x10^-5</td>
</tr>
<tr>
<td>Icelandic combined</td>
<td>24,635</td>
<td>1.93 (1.35, 2.31)</td>
<td>1.3x10^-23</td>
</tr>
<tr>
<td>Dutch replication</td>
<td>1,819</td>
<td>0.38 (-0.48, 1.25)</td>
<td>0.39</td>
</tr>
</tbody>
</table>

Association of rs4293393-T with SCr in Icelandic and Dutch subjects. Association is shown for the discovery sample set, the Icelandic and Dutch replication sample sets and the combined Icelandic sample. The population frequency of rs4293393-T is 0.80 in Iceland and 0.81 in the Netherlands. Effects are given in μmol/L. doi:10.1371/journal.pgen.1001039.t002

much less variability (Figure S3). Interestingly, no association was observed in the 1,819 healthy Dutch subjects (effect = 0.38 μmol/L, 95% CI = -0.48 to 1.25 μmol/L; P = 0.39) (Table 2). Significant heterogeneity was observed between the SCr association results for the Icelandic and Dutch populations (I² = 90.4%, P = 0.0013).

The SNP rs4293393 is located 550 basepairs upstream of UMOD, encoding uromodulin, also known as the Tamm-Horsfall protein (Figure 1). The protein is a glycosylphosphatidylinositol (GPI)-anchored glycoprotein, exclusively expressed in the thick ascending loop of Henle [16] and distal convoluted tubule [17] of the mammalian kidney. It is the most abundant protein in urine of healthy individuals, where it is present in a highly aggregated state [18,19]. While the exact physiological function of uromodulin remains to be elucidated, it has the capacity to bind to a variety of ligands. It has been reported to prevent bacteria from adhering to human kidney cells [20] and to inhibit calcium oxalate crystallization [21]. It may also have a role in ion transport and immunological processes [22,23]. UMOD knockout mice have been shown to have decreased creatinine clearance [24] and predilection for both urinary tract infections [25] and calcium oxalate stone formation [26].

The rs4293393 variant is in perfect LD in the HapMap CEU samples [15] with a synonymous SNP in UMOD, rs13335818, coding for V264V (D' = 1.0, r² = 1.0). The same perfect correlation between rs4293393 and rs13335818 was observed in a set of 3,364 Icelanders (D' = 1.0, r² = 1.0). Both rs4293393 and rs13335818 are also in perfect correlation with rs12917707 (D' = 1.0, r² = 1.0 for both markers in the HapMap CEU samples [15]) near the UMOD, the variant reported by Kottgen et al [14] to associate with both CKD and eGFRcrea with similar effect, indicating that these SNPs are tagging the same signal. As rs4293393 is on the Illumina 300/370K chips we used for direct genotyping, we refer to rs4293393 in the remainder of this article.

The effect of the UMOD variant on SCr is age-dependent

Given that SCr varies substantially with both age and sex, we tested for an interaction between the effect of rs4293393-T and effects of age and sex on SCr. No interaction was found between the UMOD variant and sex (P = 0.41). In contrast, a strong interaction was observed between the UMOD variant and age in the Icelandic sample set (P = 3.0x10^-10). On average, SCr increased by an additional 0.09 μmol/L per year per allele of rs4293393-T (95% CI = 0.07 to 0.11). In order to visualize this interaction, we stratified our Icelandic samples based on age and
sex and tested for association within each stratum (Figure 2A). Interestingly, rs4293393-T has little or no effect on SCr before the age of 50 years, but thereafter the effect increases rapidly with advancing age, especially around 70 years. Thus, the variant does not affect SCr in young individuals but rather how SCr increases with age. We note that due to the relatively short time span in which the SCr data were collected there is an inherent confounding between age and generation in our study, which will require further investigation to resolve. Similar interaction between the SCr and CKD was also observed when the association analysis for CKD was stratified by year of birth used here as a proxy for age of onset (Table 1).

Although it is well known that kidney function declines with age, the exact mechanisms are not clear. Various age-dependent risk factors for CKD [3,4,6-8], the association between the SCr and age has been studied in many populations. These studies have shown that the number of comorbid conditions present (P = 0.0080) (Figure 2D). Interestingly, rs4293393-T has little or no effect on SCr before the age of 50 years, but thereafter the effect increases rapidly with advancing age. We note that due to the relatively short time span in which the SCr data were collected there is an inherent confounding between age and generation in our study, which will require further investigation to resolve. Similar interaction between the SCr and CKD was also observed when the association analysis for CKD was stratified by year of birth used here as a proxy for age of onset (Table 1).

UMOD-associated increase in SCr with age is affected by the number of comorbid conditions present

As HTN, type 2 DM and atherosclerosis are all well recognized age-dependent risk factors for CKD [3,4,6-8], the association analysis was repeated after stratifying the SCr data based on these conditions. Incompletely information regarding history of HTN (5,705 cases), type 2 DM (1,422 cases) and myocardial infarction (MI, 2,551 cases) was available for the Icelandic SCr sample set. In parallel with previous studies, the rate of increase in SCr with age was significantly higher in individuals with HTN than in individuals without this diagnosis (effect = 0.23 μmol/L/year, 95% CI = 0.19–0.26 μmol/L/year; P = 2.9x10⁻⁵). Similar results were obtained for type 2 DM (effect = 0.26 μmol/L/year, 95% CI = 0.19–0.34 μmol/L/year; P = 1.1x10⁻¹¹) and MI (effect = 0.36 μmol/L/year, 95% CI = 0.30–0.42 μmol/L/year; P = 1.4x10⁻³⁵) as well as the number of comorbid conditions (Figure 2B). We also found that the effect of rs4293393-T on SCr increases with the number of comorbid conditions present (Figure 2C).

To further assess the relationship between genotype, age and risk factors for reduced kidney function, we investigated the effect of the rs4293393-T allele count on the increase in SCr with age stratifying on HTN and type 2 DM. A trend was observed for a higher rate of increase in SCr with age and rs4293393-T allele count in individuals with HTN compared to those without a diagnosis of HTN (P = 0.077) as well as in those with type 2 DM compared to those without (P = 0.063). In other words, the age-related increase in SCr levels appears to be greater in rs4293393-T carriers that have either HTN or type 2 DM than in carriers who do not have these risk factors. However, an age effect was still observed after accounting for these age-related risk factors. Furthermore, we also observed a significantly higher rate of SCr increase with age and rs4293393-T allele count stratifying on the number of comorbid conditions present (P = 0.0060) (Figure 2D).

To determine whether rs4293393-T influenced kidney function by directly affecting known risk factors, we tested the association of rs4293393-T with other diseases tested. These data demonstrate that the effect of rs4293393-T on kidney function is not mediated through increased risk of these comorbid conditions, but rather suggest that the variant may affect the vulnerability of the kidney to these risk factors.

These findings, demonstrating not only the effect of age on UMOD-associated increase in SCr but also the effect of age-related comorbid conditions, may explain why no association was observed between rs4293393-T and kidney function in the Dutch sample set of healthy population-based subjects with much lower SCr values and of much less variability than observed in the Icelandic samples (Figure S3).

Association of the UMOD variant with serum urea

Urea is another small solute that is commonly used to assess renal function together with SCr. The correlation between SCr and serum urea in our data was 58%. We tested for association between rs4293393-T and serum urea in an Icelandic sample set that had urea measurements performed at the Laboratory in Mjodd (N = 4,084) and found significant association with increased serum urea concentration (effect = 0.36 mg/dL, 95% CI = 0.23–0.50 mg/dL; P = 1.0x10⁻⁵).}

Association of the UMOD variant with uric acid and gout

In humans, rare mutations in the UMOD gene that cause accumulation of abnormal uromodulin in the nephron and reduced urinary excretion of the normal protein [27] have been associated with two autosomal dominant kidney diseases with overlapping clinical features, medullary cystic kidney disease and familial juvenile hyperuricemic nephropathy [28]. These disorders are characterized by hyperuricemia, gout and progressive renal failure due to tubulointerstitial nephropathy. Given the link between UMOD and hyperuricemia, we tested rs4293393-T in Icelandic subjects with serum uric acid values from the Laboratory in Mjodd (N = 6,583) and observed significant association (effect = 6.1, 95% CI = 1.7–10.4; P = 0.0064). We then tested for association with gout in a set of 377 Icelandic cases and 39,916 controls (see Materials and Methods for sample set description) and found a suggestive association (OR = 1.17, 95% CI = 0.97–1.44; P = 0.097). These data contrast the work of Köttgen et al [14] that neither detected association with serum uric acid nor gout.

Reduced risk of kidney stone formation in carriers of the UMOD CKD risk variant

As uromodulin is thought to prevent the formation of calcium-containing kidney stones [21], we tested rs4293393 in a sample set of 1,689 Icelandic patients with radiopaque kidney stones and 37,076 Icelandic population controls. We observed a significant association between rs4293393-T and reduced risk of kidney stones (OR = 0.88, 95% CI = 0.81–0.96; P = 0.0053). In an attempt to replicate this observation, we genotyped rs429339 in two additional sample sets of European ancestry, one from Iceland (1,271 cases and 3,177 controls) and the other from the Netherlands (701 cases and 2,948 controls) (Table 3). The effect size in both replication samples is consistent with the initial observation and the association is significant in the combined replication samples (OR = 0.89, 95% CI = 0.81–0.97; P = 0.0059). There was no correlation between the effect size and year of birth of the kidney stone patients (Table S4).

Replication of the SHROOM3 and GATM-SPATASL1 eGFRcrea loci and the STC1 and CST3-CST9 eGFRcys loci

Köttgen et al [14] reported on variants at additional loci with GWS association to eGFRcrea (SHROOM3 and GATM-SPATASL1)
Figure 2. An overview of the effect of age and the number of comorbid conditions on SCr levels, directly and through the rs4293393-T allele count. (A) The effect of rs4293393-T on SCr stratified on age and sex. (B) The mean SCr stratified by the number of comorbid conditions and sex, compared to the mean SCr in those without any comorbid conditions. (C) The effect of rs4293393-T on SCr stratified by the
number of comorbid conditions and sex. The interaction effect between age and rs4293393-T allele count on SCR stratified by the number of comorbid conditions and sex. The circles give the point estimates and the vertical lines show their 95% confidence intervals. Estimates and confidence intervals are given in blue for males and red for females. Sample sizes (N) are given for each strata for males and females, respectively.

Effects are given in μmol/L in (A–C) and μmol/L/year in (D).

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TAS1R3 or eGFRcys (STC1 and GST3-GST9). We tested these variants in our Icelandic datasets, including a small sample set with cystatin C measurements (Table 4). The association with SCr replicated for both the SHROOM3 and GATM-SPATA5L1 SNPs (P = 0.00057 and P = 0.0067, respectively) and the association with cystatin C replicated for the GST3-GST9 SNP but not the STC1 SNP (P = 0.00037 and P = 0.73, respectively). It should be noted, however, that the Icelandic cystatin C sample set is very small (N = 284) and possibly underpowered to replicate the reported association with the STC1 SNP. The STC1 SNP did show association with SCr in our dataset (P = 1.6·10^{-6}) as was observed in the analysis by Kötting et al [14]. The SHROOM3 and GATM-SPATA5L1 SNPs showed suggestive association with CKD in the analysis by Kötting et al [14] and our data support this association but do not constitute a conclusive replication. In contrast to the UMOD variant, we did not observe an interaction between the variants at these other loci and age. Furthermore, none of the SNPs did associate with kidney stones in Iceland (data not shown).

Finally, Kötting et al [14] reported suggestive association between eGFRcera and variants at JAG1 (GeneID: 182); we did not replicate this finding in our SCr scan (for rs6040055-T: effect = -0.27, 95% CI = -0.60–0.05, P = 0.17).

In summary, we describe sequence variants next to and in UMOD that associate with increased risk of CKD and elevated SCr but confer protection against kidney stones. We also demonstrate an interaction between these variants and both age and comorbid conditions that are related to decline in kidney function. Our observations indicate that UMOD is important for maintaining kidney function with advancing age and exposure to risk factors that are associated with aging, such as HTN, type 2 DM and cardiovascular disease.

Materials and Methods

Study subjects from Iceland

Landspítali University Hospital (LUH) is a regional hospital for the greater Reykjavik area and a tertiary referral center for the entire Icelandic nation. The population of Iceland is comprised of 330,000 inhabitants of whom approximately 200,000 reside in the greater Reykjavik area. The nation’s only nephrology clinic is located at LUH and all laboratory tests for the primary care clinics of the greater Reykjavik area are performed in the hospital’s laboratories. We obtained results of all SCr measurements performed during the period 2003 to 2008 from the computerized database of the Clinical Laboratories at LUH and used the SCr values to identify those with chronic kidney disease (CKD) based on calculation of the estimated glomerular filtration rate (eGFR) by the original 4-variable Modification of Diet in Renal Disease (MDRD) study equation. We classified those with eGFR<60 ml/min/1.73 m² as having CKD. All individuals with acute kidney injury and those who had eGFR<60 ml/min/1.73 m² for less than 3 months duration were excluded from the CKD sample set. The study included CKD patients that had donated blood through various genetic programs at deCODE genetics.

Biochemical measurements including SCr, serum urica, serum uric acid and serum cystatin C were available from two laboratories, the Laboratory in Mjodd, Reykjavik, Iceland, a private outpatient laboratory, and the Clinical Biochemistry Laboratory of LUH, serving both inpatients and outpatients. The main referral center for the Laboratory in Mjodd is a multispecialty medical clinic in Reykjavik (Laeknasetrid). The laboratory tests were done in the years 1997–2008 at the Laboratory in Mjodd and in the years 2003–2008 at LUH. The Icelandic SCr measurements came from both laboratories, the Laboratory in Mjodd (N = 10,260) and LUH (N = 22,898, of whom 8,523 also had measurements from the Laboratory in Mjodd). At the LUH, the same enzymatic method was used for measurement of SCr during the study period (Nitros 950 Autoanalyzer, Ortho Clinical Diagnostics, Rochester, MN, USA), whereas at the Laboratory in Mjodd, SCr measurements were performed by modified kinetic Jaffe reaction assays until May 2007 when an enzymatic method was introduced.

The Icelandic kidney stone cases consisted of patients with confirmed radiopaque kidney stones from the Icelandic Kidney Stone Disease Registry at LUH. The study included kidney stone patients that had donated blood through various genetic programs at deCODE genetics.

The coronary artery disease [29], stroke [30] and type 2 DM [31,32] patient groups from Iceland have been described previously. The HTN sample set includes individuals who have been recruited into various genetic programs at deCODE and have: (1) self-reported HTN; (2) received the diagnosis of HTN at discharge from the LUH; or (3) have attended the Hypertension Clinic at LUH. The gout sample set includes subjects who were

<table>
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<th>Kidney stone</th>
<th>N</th>
<th>Frequency</th>
<th>OR (95% CI)</th>
<th>P</th>
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<tr>
<td>Population</td>
<td>Control</td>
<td></td>
<td></td>
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<tr>
<td>Icelandic discovery</td>
<td>1,689</td>
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<td>Combined</td>
<td>3,617</td>
<td>43,201</td>
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Association of rs4293393-T with kidney stone disease in Icelandic and Dutch subjects. Association is shown for the discovery sample set, the Icelandic and Dutch replication sample sets, the combined Icelandic sample, and all the sample sets combined.

doi:10.1371/journal.pgen.1001039.t003
Table 4. Replication of loci recently found to associate with eGFRcrea and eGFRcys.

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<tr>
<th>Gene</th>
<th>UM0D</th>
<th>SHROOM3</th>
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<td>Association</td>
<td>Age effect</td>
<td>Association</td>
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<td>Association</td>
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<td>1.003</td>
<td>1.06</td>
<td>0.996</td>
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<td>(0.72,0.83)</td>
<td>(0.999,1.008)</td>
<td>(1.01,1.12)</td>
<td>(0.86,1.01)</td>
<td>(0.98,0.91)</td>
</tr>
<tr>
<td>Scr</td>
<td>Effect</td>
<td>-1.81</td>
<td>0.097</td>
<td>0.69</td>
<td>0.007</td>
</tr>
<tr>
<td>P=0.044</td>
<td>0.27</td>
<td>1.30</td>
<td>0.053</td>
<td>0.006</td>
<td>0.03</td>
</tr>
<tr>
<td>Cystatin C</td>
<td>Effect</td>
<td>-0.22</td>
<td>0.011</td>
<td>-0.06</td>
<td>0.003</td>
</tr>
<tr>
<td>N=284/95% CI</td>
<td>(0.067,0.22)</td>
<td>(0.038,0.44)</td>
<td>(0.062,0.26)</td>
<td>(0.062,0.25)</td>
<td>(0.026,0.008)</td>
</tr>
<tr>
<td></td>
<td>0.32</td>
<td>0.46</td>
<td>0.72</td>
<td>0.77</td>
<td>0.85</td>
</tr>
</tbody>
</table>

We tested the loci recently identified by Kötting et al [14] to associate echGFRcrea and eGFRcys for association with chronic kidney disease (CKD), and serum concentrations of creatinine (Scr) and cystatin C in our imputed Icelandic datasets. Scr effects are given in μmol/L, and cystatin C effects are given in mg/L. The association analysis for all four SNPs was performed using expected allele counts from the IMPUTE software [34].

For CKD, the sample size was 2,944 cases and 35,592 controls. The allele frequencies of rs17319721-A, rs2467853-G, rs1731274-G, and rs13038306-T in Iceland are 0.832, 0.771, 0.905, and 0.438, respectively.
doi:10.1371/journal.pgen.1001039.s004

Study subjects from The Netherlands

All samples were obtained from the Nijmegen Biomedical Study. Subjects were genotyped with the Illumina HumanHap300 or HumanHapCNV370 bead chips; these were selected to serve as controls in GWAS on prostate and breast cancer and were selected primarily based on age. A total of 3,740 individuals had both serum creatinine measurements and genome-wide SNP data available for analysis in this study.

We recruited and controlled the samples were recruited from two sources: The outpatient clinics of the Nijmegen Biomedical Study and the Nijmegen Biomedical Study. All participants who present to the outpatient clinics of the Nijmegen Biomedical Study were invited to participate in the study. The outpatient clinics of the Nijmegen Biomedical Study are located on the development of the Nijmegen Biomedical Study. All patients who present to the outpatient clinics of the Nijmegen Biomedical Study were invited to participate in the study.

We used the controls for the recruitment of patients from outpatient clinics of the Nijmegen Biomedical Study and the Nijmegen Biomedical Study. All patients who present to the outpatient clinics of the Nijmegen Biomedical Study were invited to participate in the study. The outpatient clinics of the Nijmegen Biomedical Study are located on the development of the Nijmegen Biomedical Study. All patients who present to the outpatient clinics of the Nijmegen Biomedical Study were invited to participate in the study.

The study was approved by the Icelandic Data Protection Authority and by the National Biological Committee. All patients and controls were of self-reported European descent and were fully informed about the goals and the procedures of these studies. The study protocols for the recruitment of patients from outpatient clinics of the Nijmegen Biomedical Study and the Nijmegen Biomedical Study were approved by the Icelandic Data Protection Authority.

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Illumina genome-wide genotyping

All Icelandic case and control samples were assayed with the Illumina HumanHap300 or HumanHapCNV370 bead chips (Illumina, SanDiego, CA, USA), containing 317,503 and 370,404 haplotype tagging SNPs derived from phase I of the International HapMap project, respectively. Only SNPs present on both chips were included in the analysis and SNPs were excluded if they had: (a) yield lower than 95% in cases or controls; (b) minor allele frequency less than 1% in the population; or (c) showed significant deviation from Hardy-Weinberg equilibrium. The estimated information for the four SNPs imputed on both chips were included in the analysis and SNPs were expected to fall under the null hypothesis of no association. The observed P values shown were obtained from fitting the appropriate model without an interaction effect.

Estimation and testing of interaction effects

Interaction effects were tested by assuming all main effects and lower order interaction effects were present under the null model but not the interaction effect, resulting in a one degree of freedom model. For example, when testing for an interaction effect on SCr between age and the rs4293393-T allele count, the null model included as covariates age, sex and the rs4293393-T allele count. The alternative model included all these covariates as well as the product of the interaction of age and the rs4293393-T allele count. Similarly, when testing for the interaction between age, the number of comorbid conditions and the rs4293393-T allele count, the null model included as covariates age, sex, rs4293393-T allele count, the product of interaction of age and rs4293393-T allele count, the product of interaction of the number of comorbid conditions and rs4293393-T allele count and the product of interaction of age and the number of comorbid conditions and the alternative model added the product of interaction of age, the rs4293393-T allele count and the number of comorbid conditions. In the instances when an interaction effect was estimated, the main effect estimates and P values shown were obtained from fitting the appropriate model without an interaction effect.

Correction for relatedness of the subjects and genomic control

Some of the individuals in the Icelandic patient and control groups are related to each other, causing the chi-square test statistic to have a mean > 1 and median >0.675. We estimated the inflation factor for the genome-wide association by calculating the average of the 302,379 chi-square statistics, which was a method of genomic control [40] to adjust for both relatedness and potential population stratification. The inflation factor was estimated as 1.15 for CKD and 1.22 for SCr and all the results presented from association with these traits were adjusted based on these inflation factors.

Supporting Information

**Figure S1** QQ plot of 2.5 million SNPs in the genome-wide association scans for chronic kidney disease. The black dots represent the observed P values and the blue 'x's represent the P values scaled down by an inflation factor estimated using genomic control (1.15). The diagonal red line represents where the dots are expected to fall under the null hypothesis of no association. The horizontal green line represents the threshold for genome-wide significance.

Found at: doi:10.1371/journal.pgen.1001039.s001 (0.69 MB TIF)

**Figure S2** QQ plot of 2.5 million SNPs in the genome-wide association scans for serum creatinine. The black dots represent the observed P values and the blue 'x's represent the P values scaled down by an inflation factor estimated using genomic control (1.22). The diagonal red line represents where the dots are expected to fall under the null hypothesis of no association. The horizontal green line represents the threshold for genome-wide significance.

Found at: doi:10.1371/journal.pgen.1001039.s002 (0.69 MB TIF)

**Figure S3** The observed distribution of SCr measurements in Iceland and the Netherlands. The measurements from Iceland come from the Laboratory in Mýddal and the Clinical Biochemistry Laboratory of Landspítali University Hospital (LUH). The red line denotes the population median and the two dashed blue lines the 5% and 95% quartiles. Measurements above 200 are binned together for visualization purposes. The unit of measurement is mmol/L.

Found at: doi:10.1371/journal.pgen.1001039.s003 (0.05 MB EPS)

**Table S1** Strongest SNP associations (P<2·10^{-5}) with CKD outside the CMTF region on chromosome 16p12.
Table S2  Strongest SNP associations (P<10^-7) with SCr outside the UMOD region on chromosome 16p12.  
Found at: doi:10.1371/journal.pgen.1001039.s004 (0.10 MB DOC)  

Table S3  Association of rs4293393-T with risk factors of kidney function decline in Icelandic case-control groups.  
Found at: doi:10.1371/journal.pgen.1001039.s005 (0.03 MB DOC)  

Table S4  Results of age-specific association for rs4293393-T and kidney stones using year of birth (YOB) as a proxy for age at onset.  
Found at: doi:10.1371/journal.pgen.1001039.s006 (0.03 MB DOC)

References


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Author Contributions

Conceived and designed the experiments: DFG HH OSI VIE LAK RP UT KS. Performed the experiments: OSI VIE FChL MiH LF TR KK USB GIE LAK RP. Analyzed the data: DFG HH GT PS AK. Contributed reagents/materials/analysis tools: DFG VE LF GIE. Wrote the paper: DFG HH OSI GT VE LK RP UT KS.