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MOLECULAR BACKGROUND AND GENOTYPE-PHENOTYPE CORRELATION IN
APECED PATIENTS FROM CAMPANIA AND IN THEIR RELATIVES.

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Short title: Genotype in APECED patients from Campania

Key Words: APECED, AIRE, genotype-phenotype correlation, autoimmune diseases, pediatric
endocrinology

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Number of figures: 1

Disclosure summary: the authors have nothing to declare.
LIST OF ABBREVIATIONS

Addison’s disease: AD
Autoimmune Hepatitis: AH
Atrophic Gastritis: AG
Autoimmune Thyroiditis: AT
Autoimmune REgulator gene: AIRE
Autoimmune Polyendocrinopathy - Candidiasis – Ectodermal - Distrophy: APECED
Autoantibodies: Abs
Autoantibodies against Adrenal Cortex: ACA
Autoantibodies against Aromatic-L-Aminoacid decarboxylase: AADCAbs
Autoantibodies against Glutamic acid decarboxylase: GADA
Autoantibodies against Islet cells: ICA
Autoantibodies against Intrinsic Factor: IFA
Autoantibodies against 17α-hydroxilase: 17α-OHAbs
Autoantibodies against 21 hydroxilase: 21-OHAbs
Autoantibodies against melanin producing cells: MPCA
Autoantibodies against Parietal cells: PCA
Autoantibodies against Side-chain cleavage enzyme: sccAbs
Autoantibodies against Steroid-producing cells: StCA
Autoantibodies against tissue transglutaminase: tTgAbs
Autoantibodies against Thyroglobulin: TgAbs
Autoantibodies against Thyroid microsomal: TMAbs
Autoantibodies against Tryptophan hydroxylase: TPHAbs
Autoantibodies against Thyroperoxidase: TPOAbs
Caspase-recruitment domain: CARD
Chronic Hypoparathyroidism: CH
Chronic Mucocutaneous Candidiasis: CMC
1  Ectodermal Dystrophy: ED
2  Growth Hormone Deficiency: GHD
3  Hypergonadotropic Hypogonadism: HH
4  Posterior Reversible Encephalopathy Syndrome: PRES
1 ABSTRACT

Background: Autoimmune-Polyendocrinopathy-Candidiasis-Ectodermal-Dystrophy (APECED) is a recessive disease, caused by mutations in the AutoImmune REgulator (AIRE) gene. Different mutations are peculiar of particular populations. In Italy three hot spots areas where APECED shows an increased prevalence, have been identified in Sardinia, Apulia and in the Venetian region.

Aim: in this study we analyzed AIRE mutations and genotype-phenotype correlation in APECED patients originating from Campania and in their relatives.

Patients and methods: in six patients affected with APECED clinical findings, genetic analysis of AIRE and APECED-related autoantibodies were performed.

Results: all patients carried at least one mutation on exon 1 or on splice-site flanking exon 1. Two siblings carried a complex homozygous mutation [IVS1 + 1G>C; IVS1 + 5delG] on intron 1; two patients were compound heterozygous for [T16M]+[W78R] (exons 1+2); one patient was compound heterozygous for [A21V]+[C322fs] (exons 1+8) and another was homozygous for [T16M]+[T16M] on exon 1. Expression of the disease showed wide variability while circulating autoantibodies paralleled to phenotype in each patient. Analysis of relatives allowed the identification of 8 heterozygotes. None of heterozygous subjects presented major findings of APECED.

Conclusions: mutations localized on exon 1 and the region flanking exon 1 are common in APECED patients originating from Campania. Genotype-phenotype correlation failed to reveal a relationship between detected mutations and clinical expression. Mutations in heterozygosis in AIRE gene are not associated to major findings of APECED.
INTRODUCTION

Autoimmune Polyendocrinopathy-Candidiasis-Ectodermal-Dystrophy (APECED) is a rare autosomal recessive disease (OMIM 240300) which affects many tissues especially endocrine glands (1). The diagnosis is primarily based on the presence of two out of the three most common clinical features: chronic mucocutaneous candidiasis (CMC), chronic hypoparathyroidism (CH) and Addison’s disease (AD). CMC is often the first clinical manifestation to appear before the age of 5 years, followed by CH and later by AD. APECED is caused by mutations in the AutoImmune REgulator gene (AIRE), which maps to chromosome 21q22.3 (2, 3) and encodes a 55-kDa protein that acts as a transcription regulator. Over 60 mutations have by now been localized in the AIRE gene of different APECED patients (4). Even though it occurs throughout the world, its incidence is higher in some genetically isolated populations. The estimated prevalence of APECED is 1:9,000 in Iranian Jewes (5), 1:25,000 in Finns (6,7) and 1:14,400 in Sardinians (8). Some different mutations have been found to be peculiar of specific areas. R257X is the most common mutation among Finnish and other European patients (9-11), 1094-1106del113 (or 967-979del13 bp) is the most common mutation in British (12), Irish (13), North America (14,15) and Norwegian patients (16) and the Y85C mutation is more frequent among Iranian Jewes (17).

In Italy three hot spots areas where APECED shows an increased prevalence, have been identified in Sardinia, Apulia and in the Venetian region. Moreover, both in Sardinia and Apulia a peculiar mutation of AIRE has been identified: the mutation R139X on exon 3 in Sardinia (18) and the mutation W78R on exon 2 in Apulia (19). In Veneto region AIRE gene mutations were different from the other Italian regions but similar to that identified in finnish and anglo-saxon patients (20).

A typical mutation has been recently identified also in Sicily (R203X on exon 5) (20).

However, the different mutations have not to date been convincingly associated with particular disease manifestations (4).

To the best of our knowledge, only one patient with AIRE mutation was described from Campania so far, having the homozygous mutation c1314-1326 del13/insGT on exon 11 (21).
Aim of this study was to characterized genotype and phenotype of 6 new APECED patients originating from Campania, in the attempt to evaluate their genotype-phenotype correlation. Moreover we studied the relatives of these patients in order to evaluate the clinical and biochemical effects of heterozygous mutations of the gene.

PATIENTS AND METHODS

Patients

Six patients originating from Campania (a region of Southern Italy) affected with APECED (5 F, 1 M), were investigated. In all of them the onset of the disease was in early childhood; two of them were followed up until young adult age. Patients were selected for the presence of signs or symptoms suggestive of APECED. Two of the three major criteria of APECED (hypoparathyroidism and chronic candidiasis) were present at diagnosis in 5 of them. One patient presented only candidiasis as major criteria, but she was enrolled for the association of chronic mucocutaneous candidiasis with other autoimmune diseases (vasculitis, autoimmune thyroiditis, alopecia) in early childhood. The patients were originating from 5 unrelated families. They were all originating from Campania region, but the areas where they lived or from they had their origins were not close to each other. Consanguinity between the parents was identified in only one family with two affected children (third cousins). In the 6 patients a complete clinical and biochemical evaluation of the major and minor signs and symptoms of APECED disease, molecular analysis of AIRE gene and assessment of all APECED-related autoantibodies were performed.

Analysis of AIRE gene

Major and minor clinical features of APECED, molecular analysis of AIRE and autoantibodies related to APECED syndrome were also evaluated in eight out of the ten parents of the affected patients (4M, 4F) (aged 40±10 years), who gave their consent. They all were originating from Campania.

Genomic DNA was extracted from peripheral blood by Maxwell 16 Systems (Promega Corporation, Madison WI, USA). All 14 exons of the AIRE gene were amplified with the use of primers located
on the respective flanking introns (17) and were analyzed by direct sequencing using the Big Dye
terminator cycle sequencing Kit and ABI PRISM 3130 automated sequencer (Applied Biosystems,
Foster City, CA, USA). The analysis included sequencing of the donor/acceptor sites of all the
introns.

Autoantibodies

Autoantibodies against the following antigens were performed by classical indirect
immunofluorescence technique, complement fixation, ELISA or RIA, as appropriate: Thyroglobulin
(TgAbs), Thyroid microsomal (TMAbs), Thyroperoxidase (TPOAbs), Parietal cells (PCA), Intrinsic
factor (IFA), Islet cells (ICA), Glutamic acid decarboxylase (GADA), tissue transglutaminase
(tTgAbs), Adrenal cortex (ACA), Steroid-producing cells (StCA), melanin producing cells (MPCA).

Autoantibodies to 21-hydroxilase (21-OHAbs) were tested using RSR’s kit (22). 17α-hydroxilase
(17α-OHAbs) as well as side-chain cleavage enzyme (sccAbs) autoantibodies were measured using
specific and sensitive immunoprecipitation assays (IPAs) (23). Autoantibodies to Aromatic-L-
Aminoacid decarboxylase (AADCAbs) and Tryptophan hydroxylase (TPHAbs) were measured in an
immunoprecipitation assay using (35)S-labelled full length and fragments of TPH and AADC (24).

RESULTS

Clinical presentation and autoantibodies

Clinical characteristics and autoantibodies’ profile of each patient are reported in Table 1.

**Patient 1** was born from consanguineous parents (third cousins). He first presented at 1.5
years of age with a history of transient hypertransaminasemia. At the age of 5 years, he suddenly
developed an unusually severe phenotype with many signs and symptoms outbreaking over a six
month period. In fact, the physical examination revealed the presence of vitiligo, nail dystrophy,
aloepecia, oral candidiasis and hepatosplenomegaly. He also suffered from alternating stipsis/diarrhea
and chronic abdominal pain. Laboratory testing led to diagnosis of autoimmune hepatitis, chronic
hypoparathyroidism, chronic thyroiditis and Addison’s disease. Endoscopy revealed the presence of
atrophic gastritis of the body. Six months after the onset of this accelerated phase, the patient
suddenly developed a severe neurological syndrome with neuroradiological findings suggestive of Posterior Reversible Encephalopathy Syndrome (PRES), a life-threatening event never described before in APECED patients (Table 1) (25). Screening of autoantibodies revealed the presence of TgAbs, TMAbs, TPOAbs, PCA, ACA, 21-OH-Abs, StCA, 17α-OHAbs, AADCAbs, TPHAbs and MPCAs. sccAbs and GADA were negative (Table 1).

Patient 2 (the younger sister of patient 1), presented at 4 years of age with chronic hypoparathyroidism, chronic mucocutaneous candidiasis and ectodermal dystrophy (Table 1). During three years of follow-up, she did not develop any other feature of the disease. None of the autoantibodies tested resulted positive (Table 1).

Patient 3 first presented at the age of 2 years with chronic mucocutaneous candidiasis, chronic abdominal pain and alternating stipsis/diarrhea. At the age of 8 years she was diagnosed as having chronic hypoparathyroidism, Addison’s disease, growth hormone deficiency, enamel dysplasia and alopecia. At the age of 14 years she developed ungual dystrophy, chronic thyroiditis and hypergonadotropic hypogonadism (Table 1). Autoantibodies’ profile revealed the presence of TgAbs, TMAbs, TPOAbs, ICA, ACA, 21-OH-Abs, StCA, 17α-OHAbs, sccAbs, AADCAbs and TPHAbs (Table 1).

Patient 4 first presented at the age of 8 months with vasculitis and splenomegaly. Thereafter, at the age of 2 years, she developed chronic mucocutaneous candidiasis and, at the age of 5 years, severe alopecia, chronic thyroiditis and recurrent abdominal pain with alternating stipsis/diarrhea (Table 1). Autoantibodies’ profile revealed the presence of TgAbs, TMAbs, PCA, ACA, 21-OH-Abs StCA, 17α-OHAbs and sccAbs (Table 1).

Patient 5 presented with chronic hypoparathyroidism at the age of 2 years. At the age of 3 years she developed Addison’s disease, chronic oral candidiasis and ungual dystrophy (Table 1). Only 21-OHAbs resulted to be positive. sccAbs, AADCAbs and TPHAbs were negative. During 4 years of follow-up, she did not show any other signs, symptoms or autoantibody (Table 1).

Patient 6 first developed chronic hypoparathyroidism, enamel dysplasia and chronic mucocutaneous candidiasis at the age of 6 years. At the age of 15 years, Addison’s disease and
alopecia were also diagnosed (Table 1). Autoantibodies’ profile revealed positivity for ACA, 21-OHAbs, and sccAbs (Table 1).

Noteworthy, autoantibodies paralleled clinical phenotype in each case. Infact, no antibodies were detected in patient 2 with only a mild expression of the disease whereas several autoantibodies were detected in patients 1 and 3 with a more severe expression of APECED. Globally, the most prevalent autoantibodies found were those against 21-Hydroxilase.

**AIRE mutation analysis**

Five different AIRE mutations were detected. Interestingly, all patients carried at least one mutation on exon 1 or on splice donor site of intron 1 (Table 1).

Two siblings carried a complex homozygous mutation in intron 1, consisting of a substitution of IVS1 + 1G by C accompanied in cis by a single nucleotide deletion at IVS1 + 5G residue [IVS1 + 1G>C; IVS1 + 5delG]. Two patients were compound heterozygous for [T16M]+[W78R] on exons 1 and 2 respectively; one patient was compound heterozygous for [A21V]+[C322fs] on exons 1 and 8, respectively and one patient was homozygous for [T16M]+[T16M] on exon 1. None of the mutation described is a novel mutation but the complex variant [IVS1 + 1G>C; IVS1 + 5delG] is uncommon. Figure 1 summarizes on both the gene and protein domains mutations detected in this study, as well as those previously described.

**Relatives**

Analysis of AIRE gene revealed that all parents were heterozygotes for one of the mutations found in the patients, confirming autosomal recessive model of inheritance of APECED. Three of them had a mutation on exon 1, two had a complex mutation in intron 1, two had a mutation on exon 2 and one had a mutated allele on exon 8.

Clinical evaluation revealed that none of them was affected by one of the major features of APECED. Four of them (3F, 1M) had positive autoantibodies: two against PC, one against TM and another against both Tg and PC.
1 DISCUSSION

2 Recent studies have documented that in four Italian regions different AIRE gene mutations have been identified. Typical mutations have been identified in Sardinia (R139X on exon 3) (18), in Apulia (W78R on exon 2) (19), in Veneto (R257X on exon 6 and 8) and in Sicily (R203X on exon 5) (20).

3 In Campania, a region of the Southern Italy, only one case with AIRE mutation has been described so far, carrying an homozygous mutation on exon 11 (c1314-1326 del 13/insGT) (21).

4 In our study we have delineated the molecular pathology and the clinical spectrum of 6 more probands affected with APECED originating from this region.

5 Our results suggest that mutations localized on exon 1 or on the region flanking exon 1, being present either in compound heterozygosis or homozygosis, are relatively common in APECED patients originating from Campania.

6 Exon 1 and the region flanking exon 1, are localized at the aminoterminus of AIRE. This domain was long referred to as a homogeneously staining region (HSR) domain but recent evidence suggest that this region encompasses a caspase-recruitment domain (CARD) (26). As shown in figure 1, in this area most other missense mutations have been located. CARD domains are involved in the process of homo- or hetero-dimerization. Aire’s CARD is needed for a correct dimerization of AIRE and interactions with other transcriptional control proteins. Thus, missense mutations and also small deletions affecting this domain lead to the production of a functionally defective protein due to the loss of its homodimerization properties (26).

7 None of the mutations detected in our patients is novel. However the complex homozygous mutation reported in the two siblings is uncommon. The sequence variant [IVS1 + 1G>C; IVS1 + 5delG] consists of two mutations, each likely to affect the splicing of intron 1. The IVS1 + 1G is 100% conserved in the major-class introns so that its change into C must render the splice site nonfunctional. The IVS1 + 5delG is also likely to have a negative effect because in the major-class introns at the IVS+5 position only G,A or T occur. This mutation has never been reported in APECED patients from Italy. So far, the IVS1 + 1G>C; IVS1 + 5delG mutation has been described in heterozygous state with the R257X in a single individual from Poland (10).
Noteworthy, in the six patients described the phenotype was characterized by the presence of several unusual (GH deficiency, vasculitis) and life-threatening (PRES, Chronic Hepatitis) complications of the disease. In particular, the PRES is a neurological acute syndrome never described before in APECED patients (25). GH deficiency and vasculitis also represent very rarely a feature of the disease. Moreover, three of our six patients, presented Addison’s disease in early childhood, whereas it is commonly reported after the second decade of life. In patients with early development of Addison, life-threatening complications (such as autoimmune hepatitis and squamous cell carcinoma of the oral mucosa) can occur, and therefore they should be followed more closely.

Analysis of genotype-phenotype correlation in our subjects failed to reveal a clear relationship, as previously reported in other series of patients. All patients had an early onset of the disease, but the phenotype and the severity of the disease widely differed even between patients with the same mutation of AIRE. In particular the 2 siblings carrying the same complex homozygous mutation (patient 1 and 2) showed a wide heterogeneity of clinical expression: one patient developed a severe phenotype culminating in a life-threatening event, whereas his sister presented with only a mild phenotype. Moreover, their phenotypes were different from the only other patient from Poland carrying the same complex mutation. Patient 3 and 4, presenting the same missense mutations [T16M]+[W78R], also widely differed in their phenotype: the first patient, in fact, had only a mild phenotype characterized by alopecia, ectodermal dystrophy and candidiasis, whereas the second patient developed a severe phenotype, with many signs and symptoms, since the first decade of life. Also in patients with Addison, the early development of disease was not apparently related to the genotype in that the three patients affected carried different mutations of the gene.

Autoantibodies paralleled clinical phenotype in each case, confirming their role in the pathogenesis of the disease.

The study of the relatives confirmed that the heterozygous state for AIRE mutations is not associated to the presence of major signs or symptoms correlated to APECED syndrome, as previously reported (20). Accordingly with Cervato et al, in fact, in our heterozygous subjects we only detected latent autoimmune diseases as demonstrated by the presence of thyroid or PC autoantibodies in 4 of the 8 studied heterozygous. We found only a slight prevalence in female versus male, whereas no
differences were detected on the basis of age. However, in all relatives, also those initially negative, a longitudinal evaluation of antibodies could be useful in order to identify those subjects that might develop clinical or subclinical disease over time.

In conclusion we described 6 patients characterized by several unusual and life-threatening complications of APECED. Our analysis failed to reveal a clear genotype-phenotype correlation according to previous reports. However, our data demonstrate that APECED in Campania region is more frequent than reported so far and that mutations on exon 1 and on region flanking exon 1 of AIRE gene are common in patients originating from this region.

References


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Table 1: Clinical manifestations, autoantibodies and AIRE mutations in the 6 APECED patients from Campania
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AD, Addison’s disease; AG, Atrophic Gastritis; AH, Autoimmune Hepatitis; AT, Autoimmune Thyroiditis; CH, Chronic Hypoparathyroidism; CMC, Chronic Mucocutaneous Candidiasis; ED, Ectodermal Dystrophy; HH, Hypergonadotrophic Hypogonadism; GHD, Growth Hormone Deficiency; PRES, Posterior Reversible Encephalopathy Syndrome.

AADCAbs, autoantibodies against Aromatic L-Amino Acid Decarboxylase; ACA, autoantibodies against Adrenal Cortex; GADA, autoantibodies against Glutamic Acid Decarboxylase; 17α-OHAbs, autoantibodies against 17α-Hydroxylase; 21-OHAbs, autoantibodies against 21-Hydroxylase; ICA, autoantibodies against Islet Cells; MPCA, autoantibodies against Melaning Producing Cells; PCA, autoantibodies against Parietal Cells; sccAbs, autoantibodies against side chain cleavage enzyme; StCA, autoantibodies against Steroid Producing Cells; TgAbs, autoantibodies against Thyroglobulin; TMAbs, autoantibodies against Thyroid Mycrosomal; TPOAbs, autoantibodies against Thyroperoxidase; TPHAbs, autoantibodies against Tryptophan Hydroxilase.
Figure 1. AIRE gene (top) and corresponding protein (bottom) with functional domains. Mutations detected so far are listed. Mutations found in our patients are in bold.

254x190mm (96 x 96 DPI)