

Ⅱ. 研究成果の刊行に関する一覧表

研究成果一覧

書籍

著者氏名	論文タイトル名	書籍全体の編集者名	書籍名	出版社名	出版地	出版年	ページ
後藤雄一	ミトコンドリア病	小牧宏文	小児筋疾患診療ハンドブック	診断と治療社	東京	2009	156-160
後藤雄一	ミトコンドリア遺伝病		遺伝子診断学第2版	日本臨床社	東京	2010	27-32
後藤雄一	ミトコンドリア脳筋症	亀井正邦、高久史磨	今日の診断指針	医学書院	東京	2010	675-677
後藤雄一	ミトコンドリア病	勝沼俊雄ら	小児の治療指針	診断と治療社	東京	2010	776-778
後藤雄一	MELAS症候群	井村裕夫 総編集 福井次矢、辻省次 編集	症候群ハンドブック	中山書店	東京	2011	73-74
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後藤雄一	ミトコンドリア病	水野美邦 監修 栗原照幸、中野今治 編集	標準神経病学	医学書院	東京	2012	46-52

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Ⅲ. 研究成果の刊行物・別刷

Case report

A novel *POMT2* mutation causes mild congenital muscular dystrophy with normal brain MRI

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Abstract

We report a patient harboring a novel homozygous mutation of c.604T > G (p.F202V) in *POMT2*. He showed delayed psychomotor development but acquired the ability to walk at the age of 3 years and 10 months. His brain MRI was normal. No ocular abnormalities were seen. Biopsied skeletal muscle revealed markedly decreased but still detectable glycosylated forms of alpha-dystroglycan (α -DG). Our results indicate that mutations in *POMT2* can cause a wide spectrum of clinical phenotypes as observed in other genes associated with α -dystroglycanopathy. Presence of small amounts of partly glycosylated α -DG may have a role in reducing the clinical symptoms of α -dystroglycanopathy.

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Keywords: *POMT2*; α -Dystroglycan; α -Dystroglycanopathy; Congenital muscular dystrophy; Limb girdle muscular dystrophy; Brain MRI

1. Introduction

Alpha-dystroglycan (α -DG) is a surface membrane protein that links extracellular basal lamina and intracellular cytoskeleton. α -DG is a highly glycosylated protein mainly composed of unique *O*-mannosyl glycans. Reduced/altered glycosylation of α -DG causes a wide variety of muscular dystrophies including Walker–Warburg syndrome (WWS), muscle-eye-brain disease (MEB), Fukuyama-type congenital muscular dystrophy (FCMD), congenital muscular dystrophies type 1C and type 1D, and limb girdle muscular dystro-

phies (LGMD) type 2I, 2K to 2N. They are collectively called alpha-dystroglycanopathies (α -DGP). So far, six causative genes for α -DGP have been identified including *protein-O-mannosyl transferase 1 and 2 (POMT1 and POMT2)*, *protein O-mannose β -1,2-N-acetylglucosaminyltransferase (POMGnT1)*, *fukutin (FKTN)*, *fukutin-related protein (FKRP)*, and *acetylglucosaminyl transferase-like protein (LARGE)*. Here we report a mild congenital muscular dystrophy patient associated with a novel homozygous mutation in *POMT2*.

2. Case report

A 4-year-old Japanese boy, the only child from healthy consanguineous parents, was delivered uneventfully at full term. During few days after birth, he was

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low spirited and showed sucking weakness. Floppiness was not prominent but serum CK levels were markedly elevated up to 33,000 IU/l (normal < 70). His condition was improved within 2 weeks, but serum CK levels were persistently higher than 1000 IU/l. His motor milestones were delayed and he could control his head at 5 months of age. At 6-month-old, he could not sit without support, and muscle weakness and atrophy were noticed in lower limbs. Deep tendon reflexes were normal. No high arched palate or macroglossia were seen. Enjoji Scale of Infant Analytical Development (ESID) at his age of 7 months revealed mild delay in body movement (developmental age was 4 months, expression of language: 5 months), and his DQ was 83. Brain computed tomography (CT) revealed no definite abnormalities. Nerve conduction study was normal. His motor functions developed gradually and he was able to walk without support at 3 years and 10 months old. Gowers' sign was positive. Mild calf hypertrophy was seen with no joint contractures (Fig. 1A). Deep tendon reflexes were normal except for diminished Achilles tendon reflexes. ESID performed at his age of 3 years and 11 months showed general developmental delay (body movement:

15 months, hand movement: 24 months, activity of daily living: 27 months, personal relations: 24 months, expression of language: 18 months, and comprehension of language: 24 months), and his DQ was 47. Brain magnetic resonance imaging at 4 years and 1-month-old revealed no notable anomaly or cortical dysplasia (Fig. 1B). Detailed ophthalmological examinations revealed no abnormalities. No cardiac involvement was detected by chest X-ray, electrocardiogram, and echocardiography.

Muscle biopsy taken at 7 months of age with informed consent showed dystrophic changes with scattered necrotic and regenerating fibers and mild endomy-sial fibrosis (Fig. 2A). No inflammatory changes were seen. On immunohistochemistry, glycosylated forms of α -DG detected by VIA4-1 antibody (Upstate Biotechnology, NY) was markedly reduced in the sarcolemma, while immunoreactions for the core region of α -DG using GT20ADG antibody [1] (data not shown) and for β -DG (43DAG1/8D5; Novocastra Laboratories, UK) was well preserved (Fig. 2A). On immunoblotting analysis, faint, broad band of around 140 kDa in size was detected by VIA4-1, whereas GT20ADG recognized a band of around 90 kDa in size. Laminin overlay assay showed barely detectable binding product (Fig. 2B). These results suggested altered glycosylation of α -DG in the muscle.

We performed mutation screening in all six causative genes for α -DGP. Genomic DNA was extracted from peripheral lymphocytes using standard technique after informed consent. Primer sequences we used are available on request. All exons and their flanking intronic regions were directly sequenced by ABI PRISM 3100 (PE Applied Biosystems, CA). We identified a homozygous missense mutation of c.604T > G (p.F202V) in exon 5 of *POMT2* (Fig. 1C), which is not described in previous publications [3–8] and the mutation database (<http://www.dmd.nl/>).

The protein *O*-mannosyltransferase (POMT) activity was measured as previously described [2]. Mutant *POMT2* (F202V) co-expressed with *POMT1* in COS cells showed barely detectable POMT activity (data not shown).

3. Discussion

POMT2 is the gene encoding an enzyme for protein *O*-mannosylation, and it is required to form a complex with *POMT1* for the enzyme activity [2]. Recently, some patients with mutations in *POMT2* have been reported [3–8]. Most patients showed floppiness at birth, delayed psychomotor development, congenital muscular dystrophy, and severe mental retardation with or without ocular involvement. Brain anomalies are prominent including hydrocephalus, lissencephaly, agenesis of the corpus callosum, fusion of the hemispheres, and cerebel-

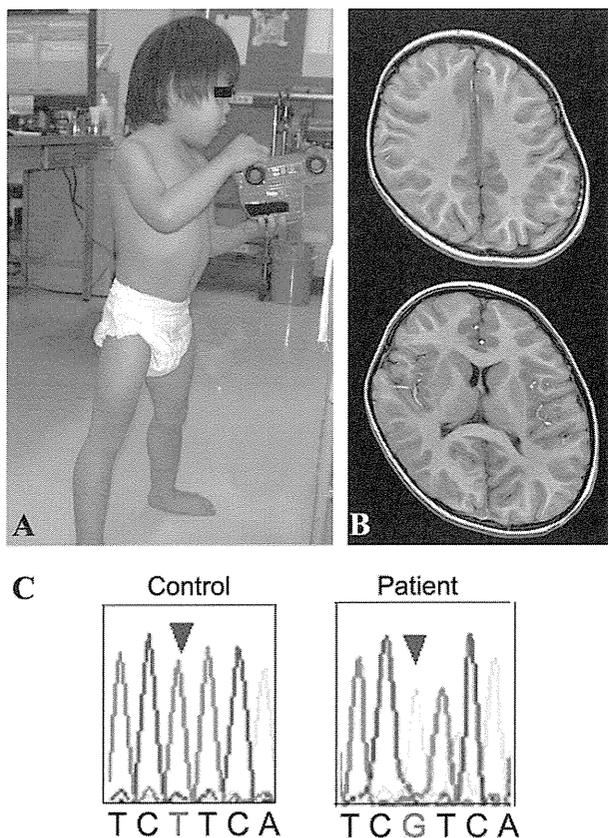


Fig. 1. (A) The patient can stand and walk with no support. Minimal calf hypertrophy is seen. (B) T2 weighted brain magnetic resonance imaging shows no obvious brain anomaly, cortical dysplasia, or white matter changes. (C) Sequence analysis of *POMT2* revealed a homozygous mutation at c.604T > G in exon 5.

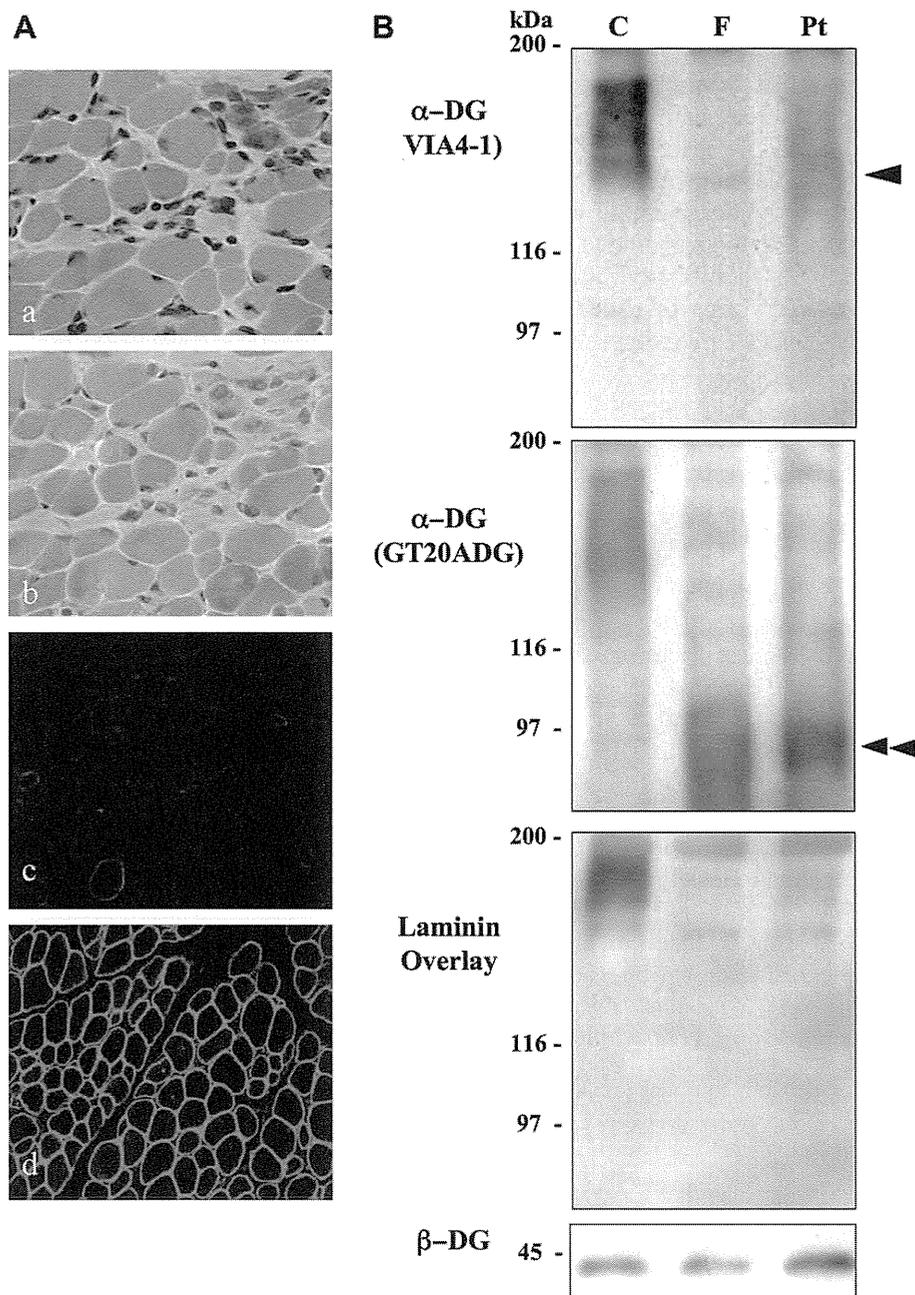


Fig. 2. (A) Histological analysis. On Hematoxylin and eosin (a) and modified Gomori-trichrome (b) staining, variation in fiber size and scattered necrotic and regenerating fibers are seen. Immunohistochemical analysis using antibodies VIA4-1 (c), which recognize heavily glycosylated form of α -dystroglycan (α -DG), showed greatly reduced sarcolemmal staining in patient, but well preserved immunoreactivities of β -DG (d) is seen. Bar = 50 μ m. (B) Immunoblotting analysis. Immunoblotting analysis using antibodies of VIA4-1, GT20ADG for α -dystroglycan (α -DG) and laminin overlay assay are performed using skeletal muscle from control (C), Fukuyama-type congenital muscular dystrophy (FCMD; F), and the patient (Pt). VIA4-1 recognizes a broad band about 156 kDa in size in control, and approximately 90 kDa in FCMD. In the patient muscle, reduced in size and amount compared with control was observed. GT20ADG revealed bands at approximately 90 kDa in both the patient and FCMD muscles. Laminin overlay assay shows barely detectable band in both the patient and FCMD.

lar hypoplasia [3–5]. In contrast, the patient reported here shows milder clinical features. Although his psychomotor milestones were delayed, he achieved independent ambulation with no marked brain malformation and ocular involvement. His clinical phenotype was intermediate between congenital muscular dystrophy

and limb girdle muscular dystrophy. Milder clinical features with mutations in *POMT2* have been recently reported and designated as limb girdle muscular dystrophy type 2N [6,7]. Mutations in *POMT2* can cause wide spectrum of clinical phenotypes from Walker–Warburg syndrome to limb girdle muscular dystrophy (LGMD),

as demonstrated in patients with *FKRP*, *FKTN*, or *POMT1* mutations.

Pathological changes of skeletal muscle also showed mild dystrophic changes consistent with clinical findings. Clinical and pathological severity may not be always correlated to the molecular mass of α -DG [9]. However, some clinically milder patients with α -DGP show reduced but positive glycosylated forms of α -DG detected by the VIA4-1 antibody [10]. Preservation of partly glycosylated forms of α -DG could contribute to the milder clinical phenotype of this patient.

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ORIGINAL ARTICLE

Defective Myotilin Homodimerization Caused by a Novel Mutation in *MYOT* Exon 9 in the First Japanese Limb Girdle Muscular Dystrophy 1A Patient

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Abstract

Myotilin is a muscle-specific Z disk protein. Several missense mutations in the myotilin gene (*MYOT*) have been identified in limb girdle muscular dystrophy (LGMD), myofibrillar myopathy, and distal myopathy patients. All previously reported pathogenic *MYOT* mutations have been identified only in Exon 2. We sequenced *MYOT* in 138 patients diagnosed as having LGMD, myofibrillar myopathy, or distal myopathy, and identified a novel *MYOT* mutation in Exon 9 encoding the second immunoglobulin-like domain in 1 patient with clinically typical LGMD. By light microscopy, there were scattered fibers with rimmed vacuoles and myofibrillary disorganization in the patient's muscle biopsy; accumulation of Z disk proteins was observed by immunohistochemistry. Immunoblot analysis demonstrated that the amount of myotilin monomer was increased in the patient muscle, but that the myotilin homodimeric band was decreased. Functional analysis of the myotilin mutation using a yeast 2-hybrid system revealed defective homodimerization of the mutant myotilin and decreased interaction between mutant myotilin and α -actinin. The homodimerization defect was further demonstrated by immunoprecipitation. This is the first *MYOT* mutation outside of Exon 2 in an LGMD type 1A patient and the first *MYOT* mutation identified in the Japanese population. This mutation in the second immunoglobulin-like domain impairs myotilin dimerization and alters the binding be-

tween myotilin and α -actinin, which is known to be important for actin bundling.

Key Words: Distal myopathy, Homodimer, Immunoglobulin-like domain, Limb girdle muscular dystrophy, Myofibrillar myopathy, Myotilin, Myotilinopathy.

INTRODUCTION

Myotilin (myofibrillar protein with titin-like immunoglobulin domains) is a sarcomeric Z disk protein encoded by the myotilin gene (*MYOT* or *TTID*) on chromosome 5q31 (1). Myotilin is composed of a unique serine-rich N-terminus and 2 immunoglobulin-like domains at the C-terminus (1–4). Myotilin forms a homodimer and interacts with α -actinin (1), actin (5), and filamin C (FLNC) (6, 7) at the Z disk through these immunoglobulin-like domains (Fig. 1A). Myotilin is highly expressed in skeletal muscle, cardiac muscle, and peripheral nerves (1). Myotilin plays a significant role in sarcomere assembly by acting together with α -actinin and FLNC to cross-link actin filaments into tightly packed bundles (1, 5, 8). The resulting structures support the integrity of the contracting muscle cell (6).

Missense mutations in *MYOT* cause myofibrillar myopathy (MFM) (9–11), limb girdle muscular dystrophy type 1A (LGMD1A) (11–13) and late-onset distal myopathy (14, 15). These myotilinopathies are usually associated with cardiac involvement and peripheral neuropathy and rarely with respiratory involvement. Currently, there are only 8 known *MYOT* mutations associated with myopathy (i.e. K36E, S39F, S55F, T57I, S60C, S60F, Q74K, and S95I) (8–11); all are located in Exon 2 encoding the serine-rich amino-terminal (Fig. 1A).

Here, we report the first Japanese LGMD1A patient associated with a novel mutation in the second immunoglobulin-like domain of myotilin and provide data suggesting the pathobiologic significance of this mutation.

MATERIALS AND METHODS

Clinical Materials

All clinical materials used in this study were obtained for diagnostic purposes with informed consent. We searched

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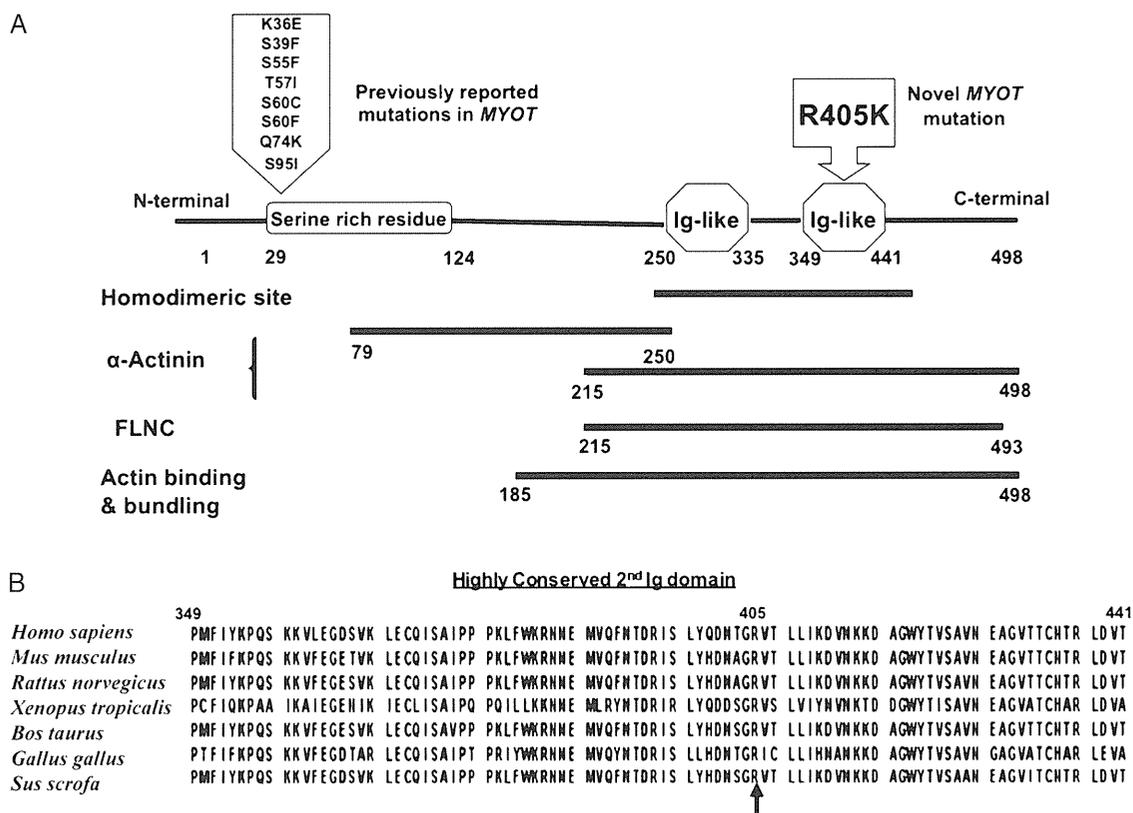


FIGURE 1. Myotilin structure, interacting partners, and reported mutations. **(A)** All previously reported mutations are located in the serine-rich domain; the novel mutation p.R405K identified in this study is located in the second immunoglobulin (Ig)-like domain of myotilin. Immunoglobulin domains of myotilin are regions of most myotilin interactions with other proteins. **(B)** The second Ig domain is highly conserved through species including the mutated residue p.R405 in the patient (arrow) (6–8). FLNC, filamin C.

for *MYOT* mutations in a total of 138 Japanese patients who had been diagnosed pathologically or clinically as MFM (n = 48), LGMD (n = 40), or distal myopathy (n = 50).

Genetic Analysis

Genomic DNA was isolated from peripheral lymphocytes or muscle specimens using standard techniques. Nine sets of primers were used to amplify genomic fragments of *MYOT*. All exons and their flanking intronic regions of *MYOT* were sequenced directly in all 138 patients using an ABI PRISM 3100 automated sequencer (PE Applied Biosystems, Foster City, CA). Nearly all of the patients with the different diagnoses were screened for *ZASP*, *DES*, and *CRYAB* mutations. Distal myopathy patients were also screened for *GNE* mutations. Primer sequences are available on request.

Histochemical Analysis

Biopsied muscle specimens were frozen in isopentane cooled in liquid nitrogen. Serial 10-µm cryosections were stained with hematoxylin and eosin, modified Gomori trichrome, nicotinamide adenine dinucleotide dehydrogenase-tetrazolium reductase, myosin ATPase phosphatase, and a battery of histochemical methods.

Immunohistochemistry and Immunoblotting

Immunohistochemistry and immunoblotting were performed as previously described (13, 16, 17). Antibodies used in this study are to: myotilin (kindly provided by Dr Carpén, University of Helsinki) (13), desmin (Abcam, Tokyo, Japan), Z-band alternatively spliced PDZ motif protein (*ZASP*) (Abcam), skeletal muscle actin (Nichirei, Tokyo, Japan), and αB-crystallin (Stressgen, Victoria, British Columbia, Canada).

Antibodies to dystrophin (Novocastra Laboratories, Newcastle upon Tyne, UK), sarcoglycans (Novocastra), α-dystroglycan (Upstate Biotechnology, Lake Placid, NY), dysferlin (Novocastra), caveolin-3 (BD Transduction Laboratories, Lexington, KY), calpain-3 (Novocastra), merosin (Chemicon International, Temecula, CA), collagen VI (ICN Biomedicals, Inc, Cleveland, OH), and emerin (Novocastra) were also used in the LGMD patients to exclude other diagnosable causes of muscular dystrophy.

Plasmid Construction

Total RNA was extracted from control human skeletal muscle using standard techniques; cDNA was synthesized by reverse transcription polymerase chain reaction with random hexamers. Full-length myotilin (wtMYOT), skeletal muscle

actin (ACTA1), α -actinin 2 (ACTN2), and the C-terminal portion (i.e. amino acids from 1967 to 2699) of FLNC were amplified using the following primers: MYOT, 5'-GGAATT CAGTAATAATTTGCCTTCA TCTTCCA-3' and 5'-CGGGATCCACAAATCCATATACCCAGATTTCT-3'; ACTA1, 5'-GGAATTCCAGAACTAGACACAATGTG CGA-3' and 5'-CGGGATCCAGTTGTTACAAAGAAAGT GACTGCG-3'; ACTN2, 5'-CCGGAATTCGCGGCCAC CATGGATTACAAGGATGACGACGACGATAAGAAC CAGATAGAGCCCGCGT-3' and 5'-CCGCTCGAGTCA CAGATCGCTCTCCCGTA-3'; and FLNC, 5'-GGAATT CAAGATCACCGAGAGTGATCTGAGC-3' and 5'-GTCGACCTCCTTGACAGTGTAGGTGACATTG-3'. The polymerase chain reaction products were cloned into the pGEM-T-easy vector (Promega, Madison, WI), and their sequences were confirmed. For expression in yeast, the cDNAs inserted in pGEM-T-easy were digested and ligated into the vectors pGBKT7 containing *GAL4* DNA-binding domain and pGADT7 containing *GAL4* activating domain (Takara Bio, Shiga, Japan). Mutant myotilin (mMYOT) (c.1214G>A) was generated by site-directed mutagenesis using the primers 5'-GATAACTGGAAAAGTTACTTTACTG-3' and 5'-CAGTAAAGTAACTTTCCAGTGTTATC-3'.

Yeast 2-Hybrid Experiment

Yeast 2-hybrid (Y2H) assays aimed at testing specific interaction pairs were carried out as previously described (18–20). *Saccharomyces cerevisiae AH109* was double transformed with pGBKT7 constructs and pGADT7 constructs and selected on minimal medium lacking leucine and tryptophan and containing histidine (SD/-Leu/-Trp/+His) plates (low-stringency plate). The transformants were picked up and spotted onto selective medium lacking histidine (SD/-Leu/-Trp/-His) plates with 0.2, 0.5, 1.0, 2.0, or 5.0 mmol/L 3-amino-1,2,4-triazole (3-AT), a competitive inhibitor of the HIS3 reporter gene (high-stringency plate) and plates without 3-AT (medium-stringency plate). The plates were then incubated at 30°C for 4 days, and the growth of the transformants was analyzed.

Immunoprecipitation and Immunoblot Analysis

For expression in mammalian cells, wtMYOT or mMYOT inserted in pGADT7 were digested by *EcoRI* and *BamHI*, and ligated into FLAG-tag-inserted pcDNA3.1/V5-HisA (kindly gifted by Dr Ishiura, University of Tokyo). The cDNAs inserted in pGADT7 were also digested by *SfiI* and *XhoI* and ligated into pCMV-Myc vector (Takara Bio).

COS-7 cells were cultured in Dulbecco modified Eagle medium (Sigma, St Louis, MO) supplemented with 10% fetal bovine serum (Invitrogen, Carlsbad, CA) at 37°C in a humidified atmosphere of 5% carbon dioxide. The cells were transiently transfected using FuGENE HD transfection reagent (Roche Diagnostics, Indianapolis, IN) according to the manufacturer's instructions. Mouse horseradish peroxidase-conjugated anti-Myc antibody (9E10) was purchased from Santa Cruz Biotechnology (Santa Cruz, CA). Rabbit anti-FLAG polyclonal antibody was purchased from Sigma.

COS-7 cells were cotransfected with 5 μ g of each plasmid. Forty-eight hours after transfection, the cells were then lysed in 1.0 mL of lysis buffer containing 20 mmol/L Tris-HCl (pH 7.5), 150 mmol/L NaCl, 10 mmol/L EDTA (pH 8.0), 10% glycerol, 1% Nonidet P-40, and Complete Protease Inhibitor Cocktail (Roche Diagnostics). The lysates were incubated at 4°C for 30 minutes with gentle rotation and then centrifuged at 15,000 \times g at 4°C for 30 minutes. The supernatants were collected, and their protein concentrations were determined using the protein assay kit (Bio-Rad, Hercules, CA).

For immunoprecipitation, the protein concentration of the cleared lysates was adjusted to 1.5 μ g/ μ L, and anti-FLAG M2 affinity gel (Sigma) was added. The mixtures were incubated at 4°C overnight. The resulting immune complexes were washed once with lysis buffer and 3 times with Tris buffered saline. The proteins were eluted by boiling at 95°C for 5 minutes in the sample buffer without reducing agent (50 mmol/L Tris-HCl [pH 6.8], 2% sodium dodecyl sulfate, 1% glycerol [vol/vol], 0.1% bromophenol blue), and resolved by sodium dodecyl sulfate-polyacrylamide gel electrophoresis. The polyacrylamide gel electrophoresis-separated proteins were transferred to Immobilon-P membranes (Millipore, Bedford, MA), and the membranes were blocked with blocking buffer (5% nonfat dry milk in PBS containing 0.05% Tween-20) at room temperature for 1 hour. The blocked membranes were incubated with a primary antibody at room temperature for 1 hour. Anti-Myc-horseradish peroxidase antibody was diluted in Can Get Signal solution 2 (Toyobo, Osaka, Japan) at 1:1000. Anti-FLAG polyclonal antibody was diluted in blocking buffer at 1:4000. Anti-FLAG was followed with horseradish peroxidase-conjugated anti-rabbit immunoglobulin G antibody at 1:4000 at room temperature for 30 minutes. Immunoreactive complexes on the membranes were visualized using enhanced chemiluminescence or enhanced chemiluminescence-plus detection reagent (GE Healthcare UK Ltd, Buckinghamshire, UK).

RESULTS

Genetic Analysis

We identified a novel heterozygous missense mutation c.1214G>A (p.R405K) in Exon 9 of *MYOT* in 1 LGMD patient (Fig. 1B). This mutation was not identified in a panel of 100 healthy Japanese controls.

Clinical Data

The 57-year-old female patient presented with gait disturbance. She started experiencing difficulty in standing up and climbing the stairs by age 41 years. Her condition gradually progressed, and by age 50 years, she could not walk long distances and could not stand up or climb stairs without support. Her deceased father and elder sister had a similar condition. Her sister was previously diagnosed as having sporadic inclusion body myositis, but further information could not be obtained. On examination, the patient had proximal dominant muscle weakness, especially in neck flexors, iliopsoas, hamstring, and quadriceps muscles (3/5 by

manual muscle test), but no facial muscle weakness. She also showed a waddling gait and decreased deep tendon reflexes. Serum creatine kinase was mildly elevated (385 IU/L; normal, <200 IU/L).

Histochemical and Immunohistochemical Analyses

Muscle tissue from the patient's vastus lateralis muscle showed marked variation in fiber size, scattered fibers with internally placed nuclei, and small angular fibers. There were scattered fibers with rimmed vacuoles (Fig. 2A). No obvious protein aggregates were seen. The intermyofibrillar networks were disorganized (Fig. 2B). Myosin ATPase staining showed an increase in the percentage of type 2C fibers (7%).

By immunohistochemistry, strongly immunoreactive aggregates of myotilin, α B-crystallin, ZASP, desmin (Figs. 2C–F), and actin (data not shown) were observed in a few fibers. Immunohistochemical and immunoblotting studies excluded other diagnosable causes of LGMD.

Immunoblotting Analysis of Myotilin

The patient's muscle specimen showed an increased intensity of the 57-kd band corresponding to the amount of

myotilin monomers compared with the band intensity in a control sample. On the other hand, the 110-kd band corresponding to myotilin dimer was fainter in the patient's sample than in the control muscle (Fig. 2G).

Y2H Analysis for the MYOT Mutation

To determine the effect of the p.R405K mutation on protein-protein interactions, we used a Y2H system. We first tested the homodimerization capacity of wild and mutant myotilin. We generated *GAL4* DNA-binding domain or activation domain constructs containing wtMYOT or mMYOT and cotransformed them to yeast. All MYOT double transformants grew on low-stringency plates, indicating that no MYOT constructs were intrinsically lethal to the yeast cells. Only wtMYOT double transformant grew on medium- and high-stringency plates; the wtMYOT and mMYOT transformant and the mMYOT double transformant did not grow. These results indicate defective dimerization of mutant myotilin with both wild-type and mutant myotilin.

We next tested the interaction between myotilin and its known binding protein partners ACTA1, ACTN2, and FLNC. We cotransformed yeast with wtMYOT or mMYOT with each of ACTA1, ACTN2, and FLNC. The wtMYOT and ACTA1, mMYOT and ACTA1, wtMYOT and ACTN2, and wtMYOT

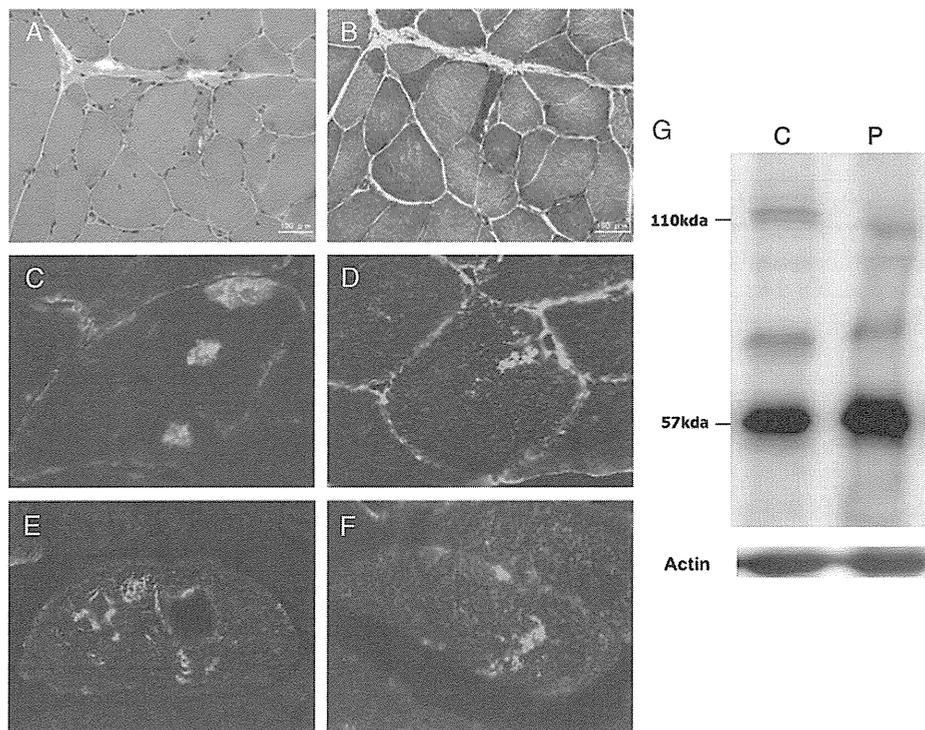


FIGURE 2. Histopathology and immunoblot of muscle from patient with p.R405K mutation. **(A)** Modified Gomori trichrome stain shows scattered fibers with rimmed vacuoles. **(B)** Nicotinamide adenine dinucleotide dehydrogenase–tetrazolium reductase stain shows myofibrillar disorganization. **(C–F)** Immunostaining reveals abnormal accumulation of myotilin **(C)**, desmin **(D)**, Z band alternatively spliced PDZ motif protein **(E)**, and α B-crystallin **(F)**. **(G)** Immunoblot analysis of myotilin in muscle from the patient shows an increased intensity of the 57-kd band that corresponds to monomeric myotilin and a decrease in intensity of the 110-kd band that corresponds to myotilin dimer compared with the control muscle sample. Scale bars = **(A, B)** 100 μ m; **(C–F)** 20 μ m. C, control; P, patient.

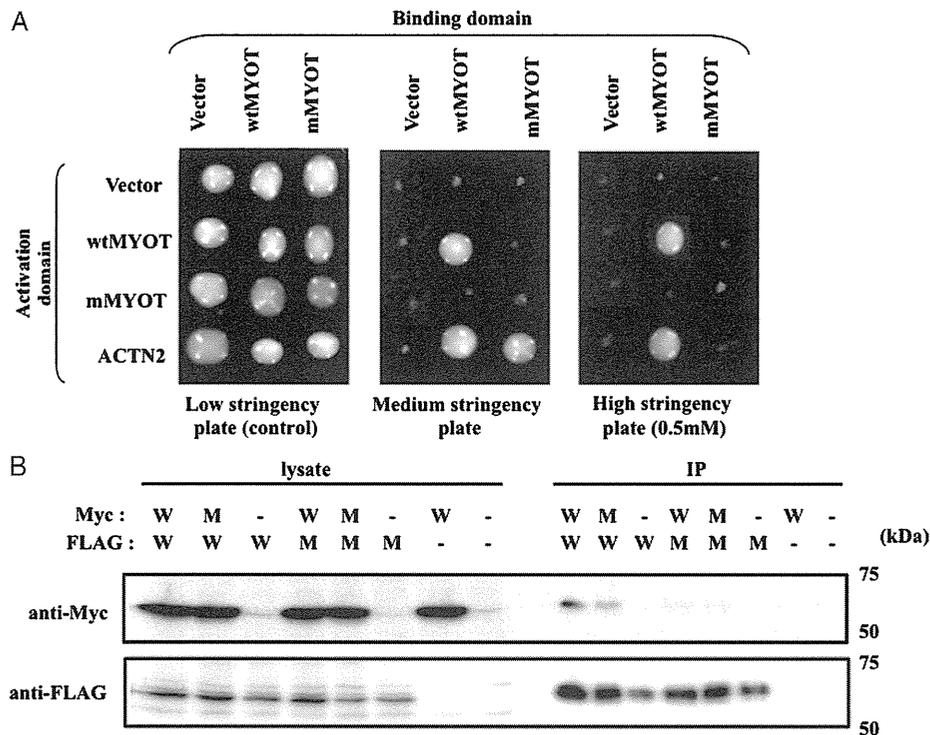


FIGURE 3. Defective homodimerization of mutant myotilin. **(A)** Yeast cells were cotransformed with expression plasmids containing Gal4 DNA-binding or activation domains alone (vector) or fused in frame to full-length human wild-type myotilin (wtMYOT), mutant myotilin (mMYOT), or α -actinin (ACTN2). Double transformants were first selected on low-stringency plates (used as control) and then spotted onto medium- and high-stringency plates. There is a lack of growth of cells coexpressing mMYOT and the corresponding constructs containing mMYOT and wtMYOT on medium- and high-stringency plates (0.5 mmol/L 3-amino-1,2,4-triazole [3-AT]). Cells cotransformed with mMYOT and ACTN2 did not grow on high-stringency plates (0.5 mmol/L 3-AT). **(B)** Myc-tagged myotilin and FLAG-tagged myotilin were coexpressed in COS-7 cells. The cell lysates were subjected to immunoprecipitation with an anti-FLAG M2 affinity gel. The immunoprecipitates (IP) were detected with anti-Myc (upper) or anti-FLAG (lower) antibodies. The mMYOT shows reduced interaction with both wild-type (W) and mutant (M) myotilin. -, empty vector transfected as a control.

and FLNC transformants grew on medium- and high-stringency plates (0.2–2 mmol/L 3-AT). By contrast, mMYOT and ACTN2 transformants grew on medium-stringency and high-stringency plates with 0.2 mmol/L 3-AT but did not grow on high-stringency plates with 0.5, 1, or 2 mmol/L 3-AT (Fig. 3A). This result indicates a decreased binding ability of mutant myotilin to α -actinin. In addition, mMYOT and FLNC transformants did not grow on medium- or high-stringency medium, but FLNC and mMYOT transformants grew on high-stringency medium when Gal4 DNA-binding domain construct containing FLNC was used as the bait (data not shown).

Immunoprecipitation Analysis of Homodimerization

We next used coimmunoprecipitation analysis to confirm the homodimerization defect of mutant myotilin. Myc-tagged wild-type myotilin (Myc-wtMYOT) coimmunoprecipitated with FLAG-tagged wild-type myotilin (FLAG-wtMYOT); this indicates that wild-type myotilin forms a homodimer. On the other hand, other combinations of FLAG-wtMYOT and Myc-tagged mutant myotilin (Myc-

mMYOT), FLAG- mMYOT and Myc-wtMYOT, and FLAG-mMYOT and Myc-mMYOT showed decreased interaction (Fig. 3B). These results suggest that the p.R405K mutation in the second immunoglobulin-like domain of myotilin can affect the homodimerization ability of myotilin protein.

DISCUSSION

Limb girdle muscular dystrophy type 1A is an autosomal-dominant muscular dystrophy characterized by progressive proximal muscle weakness and wasting. Distal muscle weakness may occur later (12, 13). The MYOT mutations are known to cause LGMD1A, but only a few genetically confirmed LGMD1A patients have been reported to date. Here, we report the first MYOT mutation in the Japanese population. The patient had a clinical severity similar to that in other reported LGMD1A patients, and there was also disorganization of myofibrils and rimmed vacuoles in the muscle biopsy tissue. Immunohistochemical analysis revealed accumulation of Z disk proteins (i.e. myotilin, α B-crystallin, ZASP, desmin, and actin) as seen in MFM, thus highlighting the similarities in the pathology of LGMD1A and MFM (21).

Myotilin has 2 immunoglobulin domains in the C terminus of the molecule. Several cytoskeletal proteins have been shown to contain immunoglobulin domains, and most of these proteins are specifically expressed in striated muscle, suggesting a special function for the immunoglobulin domains in this tissue (13, 22). Immunoglobulin domains are known to mediate protein-protein interactions and to serve as dimerization sites and regulators for molecular elasticity and act as modular “spacers” that place an interacting module in the correct position for performing its function (1, 7, 22, 23). The functional importance of the immunoglobulin domains in myotilin was demonstrated by introducing myotilin with mutant immunoglobulin domains in yeast cells that do not express endogenous myotilin (5); these immunoglobulin domains are the site for homodimerization necessary for the actin bundling (8). Our data indicate that the immunoglobulin domains in the C terminus are responsible for the actin binding and bundling ability of myotilin (Fig. 3B).

All previously reported disease-related mutations in *MYOT* are located in the serine-rich amino-terminus of myotilin. The novel p.R405K mutation we identified is located in the second immunoglobulin domain of myotilin, which is important for homodimeric formation and interaction with other proteins (Fig. 1A) (1, 5, 6); this region is highly conserved in vertebrate species, including the mutated residue (Fig. 1B). We found that the 110-kd myotilin dimer band was faint in the patient's muscle sample by immunoblotting, although, as in a previous report (24), the amount of myotilin in the patient's muscle sample was increased. Furthermore, the decreased homodimerization ability of mutant (p.R405K) myotilin was confirmed by the Y2H and immunoprecipitation studies in which interactions of mutant myotilin with both wild-type and mutant myotilin were greatly reduced (Figs. 3A, B). These results suggest that the disturbance of homodimerization caused by the mutated allele may affect the actin-bundling ability of myotilin at the Z disks, resulting in decreased filament stability and gradual disruption in the Z disk *in vivo*.

Myotilin interacts with 2 important actin-bundling (cross-linker) proteins (i.e. α -actinin and FLNC), forming a complex of 3 actin bundlers at the Z disk. Previous experiments have shown that myotilin enhances the binding of α -actinin to actin (8). The decreased binding ability of mutated myotilin to α -actinin we observed suggests that this altered interaction may loosen the complex formed by these actin bundler proteins leading to a decrease in strength and ability of the Z disk to resist mechanical stress during muscle contraction. On the other hand, mutant myotilin showed no apparent defect in interaction with actin but questionable defective interaction with FLNC by Y2H assay; this issue requires further analysis.

Several hypotheses have been proposed regarding the pathogenesis of the previously reported *MYOT* mutations in Exon 2, including the fact that the serine-rich domain contains a hydrophobic stretch that mediates the localization of small amounts of myotilin to the sarcolemmal membrane. *MYOT* mutations may elongate this hydrophobic stretch, possibly disturbing its interactions with the sarcolemmal membrane (12). It has also been suggested that these mu-

tations may disrupt the binding of myotilin with α -actinin, FLNC, or a novel protein-binding partner (12). None of these hypotheses have been proven. Disease-associated substitutions in myotilin did not affect the localization or actin-bundling ability of myotilin, suggesting that the pathogenic mechanism of the myotilin mutations examined may be independent of its actin-modulating effects (5). In contrast to the previously reported mutations (5, 13), ours is the first report to demonstrate a functional abnormality caused by mutated myotilin. Our data suggest that the p.R405K missense mutation disrupts myotilin homodimerization and decreases the interaction between myotilin and α -actinin, which subsequently may affect its actin-bundling ability.

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