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Ⅲ. 研究成果の刊行物・別刷

Heterozygous Orthodenticle Homeobox 2 Mutations Are Associated with Variable Pituitary Phenotype

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Context: Although recent studies have suggested a positive role of *OTX2* in pituitary as well as ocular development and function, detailed pituitary phenotypes in *OTX2* mutations and *OTX2* target genes for pituitary function other than *HESX1* and *POU1F1* remain to be determined.

Objective: We aimed to examine such unresolved issues.

Subjects: We studied 94 Japanese patients with various ocular or pituitary abnormalities.

Results: We identified heterozygous p.K74fsX103 in case 1, p.A72fsX86 in case 2, p.G188X in two unrelated cases (3 and 4), and a 2,860,561-bp microdeletion involving *OTX2* in case 5. Clinical studies revealed isolated GH deficiency in cases 1 and 5; combined pituitary hormone deficiency in case 3; abnormal pituitary structures in cases 1, 3, and 5; and apparently normal pituitary function in cases 2 and 4, together with ocular anomalies in cases 1–5. The wild-type Orthodenticle homeobox 2 (OTX2) protein transactivated the *GNRH1* promoter as well as the *HESX1*, *POU1F1*, and *IRBP* (interstitial retinoid-binding protein) promoters, whereas the p.K74fsX103-OTX2 and p.A72fsX86-OTX2 proteins had no transactivation functions and the p.G188X-OTX2 protein had reduced (~50%) transactivation functions for the four promoters, with no dominant-negative effect. cDNA screening identified positive *OTX2* expression in the hypothalamus.

Conclusions: The results imply that *OTX2* mutations are associated with variable pituitary phenotype, with no genotype-phenotype correlations, and that *OTX2* can transactivate *GNRH1* as well as *HESX1* and *POU1F1*. **(*J Clin Endocrinol Metab* 95: 756–764, 2010)**

Pituitary development and function depends on the spatially and temporally controlled expression of multiple transcription factor genes such as *POU1F1*, *HESX1*, *LHX3*, *LHX4*, *PROP1*, and *SOX3* (1, 2). Whereas mutations of some genes (*e.g. POU1F1*) result in a relatively characteristic pattern of pituitary hormone deficiency, those of other genes (*e.g. HESX1*) are associated with a wide range of pituitary phenotype including combined pi-

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Abbreviations: CGH, Comparative genomic hybridization; CPHD, combined pituitary hormone deficiency; EPP, ectopic posterior pituitary; FISH, fluorescence *in situ* hybridization; HD, homeodomain; IGHD, isolated GH deficiency; IRBP, interstitial retinoid-binding protein; MLPA, multiplex ligation-dependent probe amplification; NMD, nonsense mediated mRNA decay; OTX2, orthodenticle homeobox 2; PH, pituitary hypoplasia; SOD, septooptic dysplasia; TD, transactivation domain.

tuitary hormone deficiency (CPHD), isolated GH deficiency (IGHD), and apparently normal phenotype. However, because mutations of these genes account for a relatively minor portion of patients with congenital hypopituitarism (2, 3), multiple genes would remain to be identified in congenital hypopituitarism.

Orthodenticle homeobox 2 (*OTX2*) is a transcription factor gene primarily involved in ocular development (4). It encodes a paired type homeodomain (HD) and a transactivation domain (TD) and produces two functionally similar splice variants, isoform-a (GenBank accession no. NM_21728.2) and isoform-b (NM_172337.1) with and without eight amino acids because of alternative splice acceptor sites at the boundary of intron 3 and exon 4 (5). To date, at least 10 pathological heterozygous *OTX2* mutations have been identified in patients with ocular malformations such as anophthalmia and/or microphthalmia (6, 7). Ocular phenotype is highly variable, ranging from anophthalmia to nearly normal eye development, even in patients from the same family. Furthermore, most patients also exhibit brain anomaly, seizure, and/or developmental delay.

Recent studies have indicated that *OTX2* is also involved in pituitary development and function. Dateki *et al.* (8) showed that *OTX2* is expressed in the pituitary and has a transactivation function for the promoters of *POU1F1* and *HESX1* as well as the promoter of *IRBP* (interstitial retinoid-binding protein) involved in ocular function and that a frameshift *OTX2* mutation identified in a patient with bilateral anophthalmia and partial IGHD barely retained the transactivation activities. Subsequently a missense *OTX2* mutation with a dominant-negative effect and a frameshift *OTX2* mutation with loss-of-function effect were identified in CPHD patients with and without ocular malformation (9, 10).

However, detailed pituitary phenotypes in *OTX2* mutation-positive patients as well as other possible *OTX2* target genes for pituitary development and function remain to be determined. Here we report five new patients with *OTX2* mutations and summarize clinical findings in *OTX2* mutation-positive patients. We also show that *OTX2* is expressed in the hypothalamus and has a transactivation function for the promoter of *GNRH1*.

Patients and Methods

Patients

We studied 94 Japanese patients consisting of: 1) 16 patients with ocular anomalies and pituitary dysfunctions accompanied by short stature (<−2 SD) (six with anophthalmia and/or microphthalmia and CPHD, five with anophthalmia and/or microphthalmia and IGHD, three with septooptic dysplasia (SOD) and CPHD, and two with SOD and IGHD) (group 1); 2) 12 patients with ocular anomalies whose pituitary functions were not investigated (one with bilateral microphthalmia and short stature, one with bilateral optic nerve hypoplasia and short stature, and 10 with anophthalmia and/or microphthalmia and normal stature) (group 2); and 3) 66 patients with pituitary dysfunctions but without ocular anomalies (five with IGHD and 61 patients with CPHD) (group 3). No demonstrable mutation was identified for *HESX1* in patients with SOD, *GH1* and *HESX1* in patients with IGHD, and *POU1F*, *HESX1*, *LHX3*, *LHX4*, *PROP1*, and *SOX3* in patients with various types of CPHD (2). All the patients had normal karyotype.

Primers and probes

The primers and probes used in this study are shown in Supplemental Table 1, published as supplemental data on The Endocrine Society's Journals Online web site at http://jcem.endojournals.org.

Sequence analysis of OTX2

This study was approved by the Institutional Review Board Committee at National Center for Child Health and Development. After obtaining written informed consent, the coding exons 3-5 and their flanking splice sites were PCR amplified using leukocyte genomic DNA samples of all 94 patients and were subjected to direct sequencing on a CEQ 8000 autosequencer (Beckman Coulter, Fullerton, CA). To confirm a heterozygous mutation, the corresponding PCR products were subcloned with TOPO TA cloning kit (Invitrogen, Carlsbad, CA), and normal and mutant alleles were sequenced separately.

Prediction of the occurrence of aberrant splicing and nonsense mediated mRNA decay (NMD)

To examine whether identified mutations could cause aberrant splicing by creating or disrupting exonic splicing enhancers and/or splice sites (11, 12), we performed *in silico* analyses with the ESE finder release 3.0 (http://rulai.cshl.edu/cgi-bin/tools/ESE3/esefinder.cgi) for the prediction of exonic splice enhancers and with the program at the Berkeley Drosophila Genome Project (http://www.fruitfly.org/seq_tools/splice.html) for the prediction of splice sites. We also analyzed whether identified mutations could be subject to NMD on the basis of the previous report (12, 13).

Deletion analysis

Multiplex ligation-dependent probe amplification (MLPA) was performed for *OTX2* intragenic mutation-negative patients as a screening of a possible microdeletion affecting *OTX2*. This procedure was performed according to the manufacturer's instructions (14), using probes designed specifically for *OTX2* exon 4 together with a commercially available MLPA probe mix (P236) (MRC-Holland, Amsterdam, The Netherlands) used as internal controls. To confirm a microdeletion, fluorescence *in situ* hybridization (FISH) was performed with a long PCR product for *OTX2* (a 6096 bp segment from intron 2 to exon 5) together with an RP11-566I2 BAC probe (14q11.2; Invitrogen, Carlsbad, CA) used as an internal control. The probe for *OTX2* was labeled with digoxigenin and detected by rhodamine anti-digoxigenin, and the control probe was labeled with biotin and

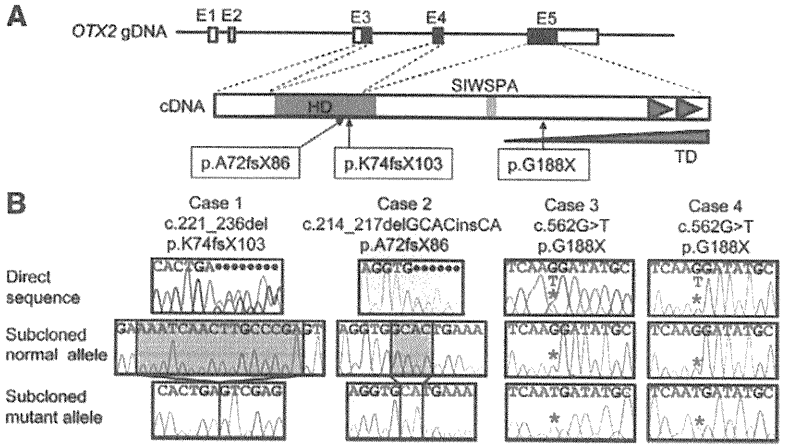

FIG. 1. Sequence analysis in cases 1–4. A, The structure of *OTX2* (the isoform-b) and the position of the mutations identified. The *black* and *white boxes* on genomic DNA (gDNA) denote the coding regions on exons 1-5 (E1-E5) and the untranslated regions, respectively. *OTX2* encodes the HD (a *blue region*), the SIWSPA conserved motif (an *orange region*), and the two tandem tail motifs (*green triangles*). The TD (a *gray triangle*) is assigned to the C-terminal side; deletion of each tail motif reduces the transactivation function, and that of a region distal to the SIWSPA motif further reduces the transactivation function. In addition, another TD may also reside in the 5′ side of the HD (17). The three mutations identified in this study are shown. B, Electrochromatograms showing the mutations in cases 1–4. Shown are the direct sequences and subcloned normal and mutant sequences. The deleted sequences are shaded in *gray*, and the inserted sequence is highlighted in *yellow*. The mutant and the corresponding wild-type nucleotides are indicated by *red asterisks*.

detected by avidin conjugated to fluorescein isothiocyanate. To indicate an extent of a microdeletion, oligoarray comparative genomic hybridization (CGH) was carried out with 1×244K human genome array (catalog no. G4411B; Agilent Technologies, Palo Alto, CA), according to the manufacturer's protocol. Finally, to characterize a microdeletion, long PCR was performed with primer pairs flanking the deleted region, and a long PCR product was subjected to direct sequencing using serial sequence primers. The deletion size and the junction structure were determined by comparing the obtained sequences with the reference sequences at the National Center for Biotechnology Information Database (NC_000014.7; Bethesda, MD), and the presence or absence of repeat sequences around the breakpoints was examined with Repeatmasker (http://www.repeatmasker.org).

Functional studies

Western blot analysis, subcellular localization analysis, DNA binding analysis, and transactivation analysis were performed by the previously reported methods (8) (for details, see Supplemental Methods). In this study, we used the previously reported expression vector and fluorescent vector containing the wild-type *OTX2* cDNA; the probes with the wild-type and mutated OTX2 binding sites within the *IRBP*, *HESX1*, and *POU1F1* promoter sequences; and the luciferase reporter vectors containing the *IRBP*, *HESX1*, and *POU1F1* promoter sequences (8). We further created expression vectors and fluorescent vectors containing mutant *OTX2* cDNAs by site-directed mutagenesis using Prime STAR mutagenesis basal kit (Takara, Otsu, Japan), and constructed a 30-bp probe with wild-type (TAATCT) and mutated (TGGGCT) putative OTX2 binding site within the *GNRH1* promoter sequence and a luciferase reporter vector containing the *GNRH1* promoter sequence (−1349 to −1132 bp) by inserting the corresponding sequence into pGL3 basic. The *GNRH1* promoter sequence was based on the report of Kelley *et al.* (15). Transfections were performed in triplicate within a single experiment, and the experiment was repeated three times.

PCR-based expression analysis of *OTX2*

Human cDNA samples were purchased from CLONTECH (Palo, Alto, CA) except for leukocyte and skin fibroblast cDNA samples that were prepared with Superscript III reverse transcriptase (Invitrogen). PCR amplification was performed for the cDNA samples (0.5 ng), using the primers hybridizing to exon 3 and 4 of *OTX2* and those hybridizing to exons 2/3 and 4/5 (boundaries) of *GAPDH* used as an internal control.

Results

Identification of mutations and substitutions

Three novel heterozygous *OTX2* mutations were identified in four cases, *i.e.* a 16-bp deletion at exon 4 that is predicted to cause a frameshift at the 74th codon for lysine and resultant termination at the 103rd codon (c.221_236del16, p.K74fsX103) in case 1; a 4-bp deletion and a 2-bp insertion at exon 4 that is predicted to cause a frame shift at the 72nd codon for alanine and resultant termination at the 86th codon (c.214_217delGCACinsCA, p.A72fsX86) in case 2; and a nonsense mutation at exon 5 that is predicted to cause a substitution of the 188th glycine with stop codon (c.562G>T, p.G188X) in two unrelated cases (3 and 4; Fig. 1). In addition, heterozygous missense substitutions were identified in patient 1 (c.532A>T, p.T178S) and patient 2 (c.734C>T, p.A245V). Cases 1 and 3 were from group 1, cases 2 and 4 and patient 2 were from group 2, and patient 1 was from group 3. Parental analysis indicated that frameshift mutations in cases 1 and 2 were absent from the parents (*de novo* mutations), whereas the missense substitution of patient 2 was inherited from phenotypically normal father. The parents of cases 3 and 4 and patient 1 refused molecular studies. All the mutations and the missense substitutions were absent from 100 control subjects.

Prediction of the occurrence of aberrant splicing and NMD

The two frameshift mutations and the nonsense mutation were predicted to influence neither exonic splice enhancers nor splice donor and acceptor sites (Supplemental Tables 2 and 3). Furthermore, the two frameshift mutations were predicted to produce the premature termination codons on the mRNA transcribed from the last exon

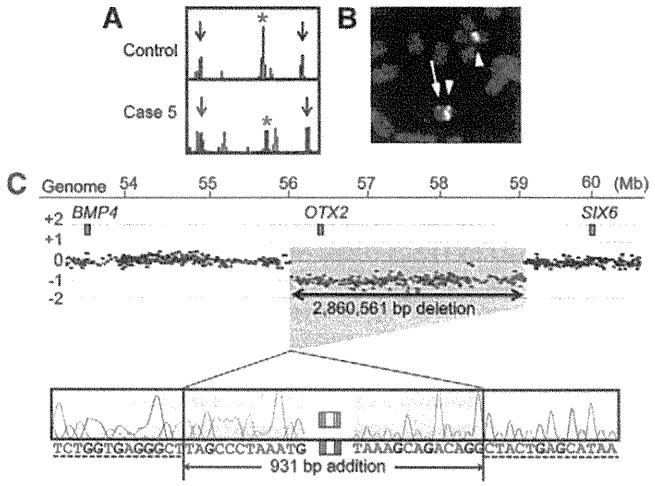

FIG. 2. Deletion analysis in case 5. A, MLPA analysis. The *red asterisk* indicates peaks for the *OTX2* exon 4, and the *black arrows* indicate control peaks. The *red peaks* indicate the internal size markers. Deletion of the MLPA probe binding site is indicated by the reduced peak height. B, FISH analysis. The probe for *OTX2* detects only a *single red signal* (an *arrow*), whereas the RP11-566I2 BAC probe identifies *two green signals* (*arrowheads*). C, Oligoarray CGH analysis and direct sequencing of the deletion junction. The deletion is 2,860,561 bp in physical size (shaded in *gray*) and is associated with an addition of a 931-bp segment (highlighted in *yellow*). The normal sequences flanking the microdeletion are indicated with *dashed underlines*.

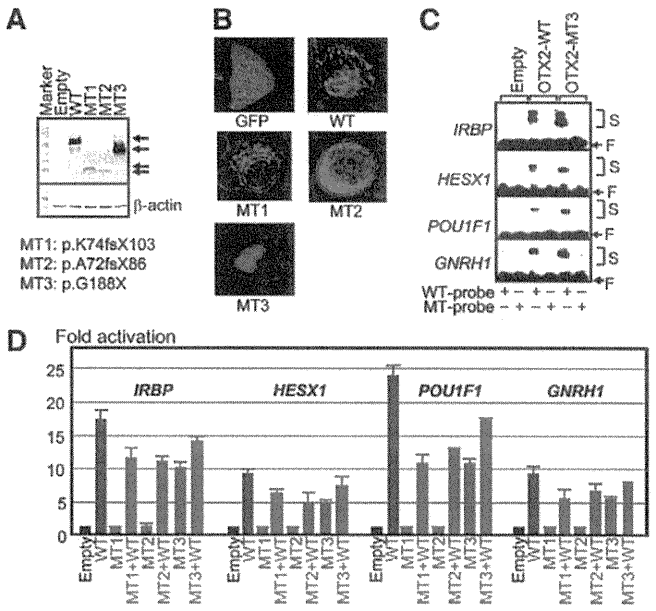

FIG. 3. Functional studies. A, Western blot analysis. Both WT and MT1-MT3 OTX2 proteins are detected with different molecular masses (*arrows*). WT, Wild type; MT1, p.K74fsX103; MT2, p.A72fsX86; and MT3, p.G188X. B, Subcellular localization analysis. Whereas green fluorescent protein (GFP) alone is diffusely distributed throughout the cell, the GFP-fused WT-OTX2 and MT3-OTX2 proteins localize to the nucleus. By contrast, the GFP-fused MT1-OTX2 and MT2-OTX2 proteins are incapable of localizing to the nucleus. C, DNA binding analysis using the wild-type (WT) and mutated (MT) probes derived from the promoters of *IRBP*, *HESX1*, *POU1F1*, and *GNRH1*. The symbols (+) and (−) indicate the presence and absence of the corresponding probes, respectively. Both WT and MT3 OTX2 proteins bind to the WT but not the MT probes. For the probe derived from the *IRBP* promoter, two shifted bands are found for both WT-OTX2 and MT3-OTX2 proteins as reported previously (17). S, Shifted bands; F, free probes. D, Transactivation analysis, using the promoter sequences of *IPBP*, *HESX1*, *POU1F1*, and *GNRH1*. The results are expressed using the mean and SD. The *black*, *blue*, *red*, and *green bars* indicate the data of the empty expression vectors (0.6 μg), expression vectors with WT *OTX2* cDNA (0.6 μg), expression vectors with MT1-MT3 *OTX2* cDNAs (0.6 μg), and the mixture of expression vectors with WT (0.3 μg) and those with MT1-MT3 *OTX2* cDNAs (0.3 μg), respectively; thus, the same amount of expression vectors has been used for each assay.

5, indicating that the frameshift mutations as well as the nonsense mutation had the property to escape NMD (Supplemental Fig. 1).

Identification of a microdeletion

A heterozygous microdeletion affecting *OTX2* was indicated by MLPA and confirmed by FISH in case 5 of group 1 (Fig. 2, A and B). Oligoarray CGH delineated an approximately 2.9-Mb deletion, and sequencing of the fusion point showed that the microdeletion was 2,860,561 bp in physical size (56,006,531–58,867,091 bp on the NC_000014.7) and was associated with an addition of a complex 931-bp segment consisting of the following structures (cen → tel): 2 bp (TA) insertion → 895 bp sequence identical with that in a region just centromeric to the microdeletion (55, 911, 347–55, 912, 241 bp) → 1 bp (C) insertion → 33-bp sequence identical with that within the deleted region (58, 749, 744–58, 749, 776 bp) (Fig. 2C). Repeat sequences were absent around the break points. This microdeletion was not detected in DNA from the parents.

Functional studies of the wild-type and mutant OTX2 proteins

Western blot analysis detected wild-type OTX2 protein of 31.6 kDa and mutant OTX2 proteins of 11.5 kDa (p.K74fsX103), 9.7 kDa (p.A72fsX86), and 15.4 kDa (p.G188X) (Fig. 3A). The molecular masses were as predicted from the mutations. The band intensity was comparable between the wild-type OTX2 protein and the p.G188X-OTX2 protein and was faint for the p.K74fsX103-OTX2 and p.A72fsX86-OTX2 proteins.

Subcellular localization analysis showed that the p.G188X-OTX2 protein localized to the nucleus as did the wild-type OTX2 protein, whereas the p.K74fsX103-OTX2 and p.A72fsX86-OTX2 proteins were incapable of localizing to the nucleus (Fig. 3B). The results were consistent with those of the Western blot analysis because nuclear extracts were used for the Western blotting, with some probable contamination of cytoplasm.

DNA binding analysis revealed that the p.G188X-OTX2 protein with nuclear localizing capacity bound to the wild-type OTX2 binding sites within the four promoters examined, including the *GNRH1* promoter, but not to the mutated OTX2 binding sites (Fig. 3C). The band shift

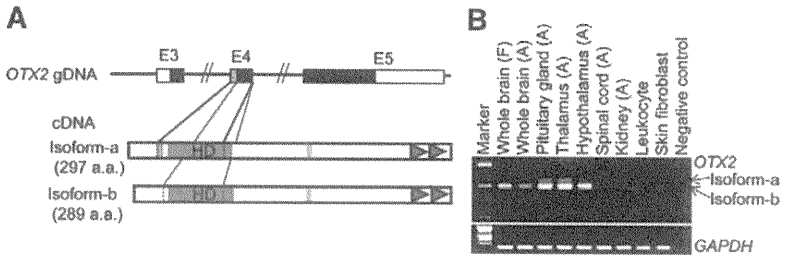

FIG. 4. PCR-based human cDNA library screening for *OTX2* (35 cycles). A, Schematic representation of the *OTX2* isoform-a (NM_21728.2) and isoform-b (NM_172337.1). Because of the two alternative splice acceptor sites at the boundary between intron 3 and exon 4, isoform-a carries eight amino acids (shown in *gray*) in the vicinity of the HD, whereas isoform-b is lacking the eight amino acids. B, PCR amplification data. *OTX2* is clearly expressed in the pituitary and hypothalamus, with isoform-b being the major product. *GAPDH* has been used as an internal control. F, Fetus; A, adult.

was more obvious for the wild-type OTX2 protein than for the p.G188X-OTX2 protein, consistent with the difference in the molecular masses.

Transactivation analysis showed that the wild-type OTX2 protein had transactivation activities for the four promoters examined including the *GNRH1* promoter, whereas the p.K74fsX103-OTX2 and p.A72fsX86-OTX2 proteins had virtually no transactivation function, and the p.G188X-OTX2 protein had reduced (~50%) transactivation activities (Fig. 3D). The three mutant OTX2 proteins had no dominant-negative effects. In addition, the two missense p.A245V-OTX2 and p.T178S-OTX2 proteins had apparently normal transactivation activities with no dominant-negative effect (Supplemental Fig. 2).

PCR-based expression analysis of *OTX2*

OTX2 expression was identified in the pituitary and the hypothalamus as well as in the brain and the thalamus but not detected in the spinal cord, kidney, leukocytes, and skin fibroblasts (Fig. 4). The isoform-b lacking the eight amino acids was predominantly expressed.

Clinical findings in *OTX2* mutation-positive patients

Clinical data are summarized in Table 1 (*left part*). Anophthalmia and/or microphthalmia was present in cases 1–5. Developmental delay was obvious in cases 1 and 3–5, whereas it was obscure in case 2 because of the young age. Prenatal growth was normally preserved in cases 1–5, whereas postnatal growth was compromised in cases 1, 3, and 5. Cases 1 and 5 had IGHD, and case 3 had CPHD (Table 2); furthermore, cases 1, 3, and 5 had pituitary hypoplasia (PH) and/or ectopic posterior pituitary (EPP) (Supplemental Fig. 3). Case 3 showed no pubertal development at 15 yr of age (Tanner pubic hair stage 2 in Japanese boys: 12.5 ± 0.9 yr) (16). Cases 2 and 4 had no discernible pituitary dysfunction and did not receive magnetic resonance imaging examinations. In addition, case 1 had right retractile testis. Patient 1 with p.T178S had CPHD but without ocular anomalies, and patient 2 with p.A245V had bilateral optic nerve hypoplasia and short stature.

Discussion

We identified two frameshift mutations in cases 1 and 2 and a nonsense mutation in unrelated cases 3 and 4. Furthermore, it was predicted that these mutations neither affected splice patterns nor underwent NMD, although direct analysis using mRNA was impossible due to lack of detectable *OTX2* expression in already collected leukocytes as well as skin fibroblasts, which might be available from cases 1–4. Thus, these mutations are predicted to produce aberrant OTX2 proteins *in vivo* that were used in the *in vitro* functional studies. In this context, the functional studies indicated that the two frameshift mutations were amorphic and the nonsense mutation was hypomorphic. The results are consistent with the previous notion that the HD not only has DNA binding capacity but also retains at least a part of nuclear localization signal on its C-terminal portion and the TD primarily resides in the C-terminal region (17) (Fig. 1A). Whereas the two missense substitutions were absent in 100 control subjects, they would be rare normal variations rather than pathological mutations because of the normal transactivation activities with no dominant-negative effect.

We also detected a heterozygous microdeletion involving *OTX2* in case 5 that was not mediated by repeat sequences. This implies the importance of the examination of a microdeletion. Indeed, such a cryptic microdeletion has been identified in multiple genes with the development of MLPA that can serve as a screening method in the detection of microdeletions (18). Whereas the microdeletion of case 5 has removed 16 additional genes (Ensembl Genome Browser, http://www.ensembl.org/), the clinical phenotype of case 5 is explainable by *OTX2* haploinsufficiency alone. Thus, hemizygosity for the 16 genes would not have a major clinical effect, if any.

Furthermore, the present study revealed two findings. First, *OTX2* was expressed in the hypothalamus and had a transactivation function for the *GNRH1* promoter. This implies that *GNRH1* essential for the hypothalamic GnRH secretion is also a target gene of *OTX2*, as has been demonstrated in the mouse (15). Second, the short isoform-b was predominantly identified in the *OTX2* expression-positive tissues. This sug-

TABLE 1. Summary of clinical findings in patients with heterozygous *OTX2* mutations

	Present study					Previous studies[a]			
	Case 1	**Case 2**	**Case 3**	**Case 4**	**Case 5**	**Case 6**	**Case 7**	**Case 8**	**Case 9**
Present age (yr)	3	1	15	10	2	3	6	14	6
Sex	Male	Female	Male	Male	Male	Female	Male	Female	Male
Mutation[b]									
cDNA	c.221_236del	c.214_217del GCACinsCA	c.562G>T	c.562G>T	Whole gene deletion	c.402_403insC	c.674A>G	c.674A>G	c.405_406insCT
Protein	p.K74fsX103	p.A72fsX86	p.G188X	p.G188X	Absent	p. S135fsX136	p.N225S	p.N225S	p.S136fsX178
Function	Severe LOF	Severe LOF	Mild LOF	Mild LOF	Absent	Severe LOF	DN	DN	Severe LOF
Ocular malformation									
Right	AO	MO	MO	MO	MO	AO	N.D.	N.D.	AO
Left	MO	MO	MO	MO	AO	AO	N.D.	N.D.	AO
Developmental delay	+	Uncertain	+	+	+	+	N.D.	N.D.	+
Prenatal growth failure[c]	−	−	−	−	−	−	N.D.	N.D.	−
Birth length (cm) (SDS)	46.5 (−1.2)	48.3 (±0)	50 (+0.5)	49 (±0)	47.9 (−0.5)	50 (+0.6)	N.D.	N.D.	49.5 (+0.2)
Birth weight (kg) (SDS)	2.77 (−0.5)	3.22 (+0.6)	3.62 (+1.5)	3.23 (+0.5)	2.96 (−0.1)	3.16 (+0.2)	N.D.	N.D.	3.49 (+1.2)
Birth OFC (cm) (SDS)	32.5 (−0.7)	34 (+0.7)	N.E.	32.5 (−0.7)	31.5 (−1.4)	33.7 (+0.6)	N.D.	N.D.	N.D.
Postnatal growth failure[c]	+	−	+	−	+	+	+	+	+
Present height (cm) (SDS)	76.9 (−3.3)[d]	73.2 (±0)	114.0 (−4.1)[e]	130.8 (−1.5)	78.1 (−2.4)	85.0 (−3.3)	N.D.	N.D.	81.8 (−5.3)[f]
Present weight (kg) (SDS)	8.9 (−2.6)[d]	8.3 (−0.4)	16.8 (−2.4)[e]	23.2 (−1.6)	9.9 (−1.4)	10.1 (−2.6)	N.D.	N.D.	10.7 (−2.5)[f]
Present OFC (cm) (SDS)	N.E.	N.E.	N.E.	N.E.	N.E.	46 (−1.9)	N.D.	N.D.	47.2 (−2.7)[f]
Paternal height (cm) (SDS)[c]	160 (−1.9)	168 (−0.5)	178 (+1.2)	167 (−0.7)	163 (−1.3)	170 (±0)	178 (+0.3)	188 (+1.8)	N.D.
Maternal height (cm) (SDS)[c]	150 (−1.6)	151 (−1.3)	166 (+1.5)	165 (+1.4)	170 (+2.2)	155 (−0.6)	158 (−0.8)	168 (+0.7)	N.D.
Affected pituitary hormones	GH	No	GH, TSH, PRL, LH, FSH	No	GH	GH	GH, TSH, ACTH, LH, FSH	GH, TSH, ACTH, LH, FSH	GH, TSH, ACTH, LH, FSH
MRI findings									
Pituitary hypoplasia	+	N.E.	+	N.E.	+	−	+	+	+
EPP	+	N.E.	+	N.E.	−	−	+	−	+
Other features	Retractile testis (R)			Seizure		Cleft palate			Chiari malformation

SDS, SD score; OFC, occipitofrontal head circumference; MRI, magnetic resonance imaging; LOF, loss of function; DN, dominant negative; AO, anophthalmia; MO, microphthalmia; N.D., not described; N.E., not examined; PRL, prolactin; R, right.

[a] Case 6, Dateki *et al.* (8); cases 7 and 8, Diaczok *et al.* (9); case 9, Tajima *et al.* (10); [b] the cDNA and protein numbes are based on the human *OTX2* isoform-b (GenBank accession no. NM_172337.1), and the A of the ATG encoding the initiator methionine residue is denoted position +1; thus, the description of the mutations in cases 7–9 is different from that reported by Diaczok *et al.* (9) and Tajima *et al.* (10); [c] assessed by the age- and sex-matched Japanese growth standards (27) (cases 1–6 and 9 and their parents) or by the American growth standards (28) (the parents of cases 7 and 8); [d] at 2 yr 4 months of age before GH treatment; [e] at 10 yr of age before GH treatment; [f] at 4 yr of age before GH treatment.

TABLE 2. Blood hormone values in cases 1–5 with heterozygous *OTX2* mutations

Patient Sex (age at examination)		Case 1 Male (2 yr)		Case 2 Female (1 yr)		Case 3 Male (14 yr)		Case 4 Male (10 yr)		Case 5 Male (2 yr)	
	Stimulus (dose)	Basal	Peak	Basal	Peak	Basal	Peak	Basal	Peak	Basal	Peak
GH (ng/ml)	Insulin (0.1 U/kg)[a]	1.9[b]	**4.0**[b]	3.3[b]	N.E.	0.8[b]	**1.3**[b]	12.1[b]	N.E.	0.5[c]	**9.0**[c]
	Arginine (0.5 g/kg)									1.1[c]	**7.0**[c]
	L-dopa (10 mg/kg)	1.5[b]	**3.8**[b]			0.3[b]	**1.0**[b]				
LH (mIU/ml)	GnRH (100 μg/m^2)	0.1	1.7	0.1	N.E.	2.3[d]	**4.5**	0.4	N.E.	0.1	3.1
FSH (mIU/ml)	GnRH (100 μg/m^2)	1.0	6.2	3.7	N.E.	1.3[d]	**6.3**	1.1	N.E.	1.5	9.9
TSH (μU/ml)	TRH (10 μg/kg)	4.2	23.8	1.1	N.E.	0.2	**1.9**	1.1	N.E.	5.2	19.5
Prolactin (ng/ml)	TRH (10 μg/kg)	17.9	34.5	N.E.	N.E.	5.5	**8.3**	9.1	N.E.	10.43	88.8
ACTH (pg/ml)	Insulin (0.1 U/kg)	31	195	N.E.	N.E.	24		N.E.	N.E.	41	222
Cortisol (μg/dl)[d]	Insulin (0.1 U/kg)	12.7		9.4	N.E.	19.4		N.E.	N.E.	25.4	39.2
IGF-I (ng/ml)		**8**		65	N.E.	**5**		214	N.E.	48	
Testosterone (ng/dl)		N.E.		N.E.	N.E.	**45**		<5	N.E.	N.E.	
Free T_4 (ng/dl)		1.32		1.17	N.E.	**0.87**		1.15	N.E.	1.17	
Free T_3 (pg/ml)		2.91		3.24	N.E.	**1.94**		3.92	N.E.	4.54	

The conversion factor to the SI unit: GH, 1.0 (μg/liter); LH, 1.0 (IU/liter); FSH, 1.0 (IU/liter); TSH, 1.0 (mIU/liter); prolactin, 1.0 (μg /liter); ACTH, 0.22 (pmol/liter); cortisol, 27.59 (nmol/liter); IGF-I, 0.131 (nmol/liter); testosterone, 0.035 (nmol/liter); free T_4, 12.87 (pmol/liter); and free T_3, 1.54 (pmol/liter). Hormone values have been evaluated by the age- and sex-matched Japanese reference data (29, 30); low hormone data are *boldfaced*. Blood sampling during the provocation tests: 0, 30, 60, 90, and 120 min. N.E., Not examined.

[a] Sufficient hypoglycemic stimulations were obtained during all the insulin provocation tests; [b] GH was measured using the recombinant GH standard, and the peak GH values of 6 and 3 ng/ml are used as the cutoff values for partial and severe GH deficiency, respectively; [c] GH was measured by the classic RIA, and the peak GH values of 10 and 5 ng/ml were used as the cutoff values for partial and severe GH deficiency; [d] Obtained at 0800–0900 h.

gests that the biological functions of *OTX2* are primarily contributed by the short isoform-b.

Clinical features of cases 1–5 are summarized in Table 1, together with those of the previously reported *OTX2* mutation-positive patients examined for detailed pituitary function. Here four patients with cytogenetically recognizable deletions involving *OTX2* are not included (19–22) because the deletions appear to have removed a large number of genes including *BMP4* and/or *SIX6* (Fig. 2B) that can be relevant to pituitary development and/or function (1, 23).

Several points are noteworthy for the clinical findings. First, although cases 1–5 in this study had anophthalmia and/or microphthalmia, ocular phenotype has not been described in cases 7 and 8 identified by *OTX2* mutation analysis in 50 patients with hypopituitarism (9). Whereas no description of a phenotype would not necessarily indicate the lack of the phenotype, *OTX2* mutations may specifically affect pituitary function at least in several patients. This would not be unexpected because several *OTX2* mutation-positive patients are free from ocular anomalies (6).

Second, pituitary phenotype is variable and independent of the *in vitro* function data. This would be explained by the notion that haploinsufficiency of developmental genes is usually associated with a wide range of penetrance and expressivity depending on other genetic and environmental factors (24), although the actual underlying factors remain to be identified. In this regard, because direct mRNA analysis was not performed, it might be possible that the mutations have not produced the predicted aberrant protein and, consequently, *in vitro* function data do not necessarily reflect the *in vivo* functions. Even if this is the case, the quite different pituitary phenotype between cases 3 and 4 with the same mutation would argue for the notion that pituitary phenotype is independent of the residual OTX2 function.

Third, cases 1, 3, 5, and 6–9 with pituitary dysfunction have IGHD or CPHD involving GH, and show the combination of preserved prenatal growth and compromised postnatal growth characteristic of GH deficiency (25). This suggests that GH is the most vulnerable pituitary hormone in *OTX2* mutations. Consistent with this, previously reported patients with ocular anomalies and *OTX2* mutations also frequently exhibit short stature (6, 8). Thus, pituitary function studies are recommended in patients with ocular anomalies and postnatal short stature to allow for appropriate hormone therapies including GH treatment for short stature, cortisol supplementation at a stress period, T_4 supplementation to protect the developmental deterioration, and sex steroid supplementation to induce secondary sexual characteristics. Furthermore, *OTX2* mutation analysis is also recommended in such patients.

Lastly, PH and/or EPP is present in patients with IGHD and CPHD, except for case 6 with IGHD. In this regard, the following findings are noteworthy: 1) heterozygous loss-of-function mutations of *HESX1* are associated with a wide phenotypic spectrum including CPHD, IGHD, and apparently normal phenotype and often cause PH and

EPP, whereas homozygous *HESX1* mutations usually lead to CPHD as well as PH and EPP (2); 2) heterozygous loss-of-function mutations of *POU1F1* usually permit apparently normal pituitary phenotype, whereas homozygous loss-of-function mutations and heterozygous dominant-negative mutations usually result in GH, TSH, and prolactin deficiencies and often cause PH but not EPP (2); and 3) heterozygous *GNRH1* frameshift mutation are free from discernible phenotype, whereas homozygous *GNRH1* mutations result in isolated hypogonadotropic hypogonadism with no abnormal pituitary structure (26). Collectively, overall pituitary phenotype may primarily be ascribed to reduced *HESX1* expression, although reduced *POU1F1* and *GNRH1* expressions would also play a certain role, and there may be other target genes of *OTX2*.

In summary, the results imply that *OTX2* mutations are associated with variable pituitary phenotype, with no genotype-phenotype correlations, and that *OTX2* can transactivate *GNRH1* as well as *HESX1* and *POU1F1*. Further studies will serve to clarify the role of *OTX2* in the pituitary development and function.

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Novel Insights from Clinical Practice

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Hypothalamic Dysfunction in a Female with Isolated Hypogonadotropic Hypogonadism and Compound Heterozygous *TACR3* Mutations and Clinical Manifestation in Her Heterozygous Mother

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Established Facts

- *TAC3* and *TACR3* have recently been shown to be causative genes for an autosomal recessive form of isolated hypogonadotropic hypogonadism (IHH).

Novel Insights

- Hypothalamic dysfunction may be the primary cause for IHH in patients with biallelic *TACR3* mutations.
- Clinical phenotype may be exhibited by females with heterozygous *TACR3* mutations.
- *TAC3* and *TACR3* mutations remain rare in patients with IHH.

Key Words
Heterozygous manifestation · Hypogonadotropic hypogonadism · Hypothalamus · *TACR3* mutation

Abstract
Background/Aims: *TAC3* and *TACR3* have recently been shown to be causative genes for an autosomal recessive form of isolated hypogonadotropic hypogonadism (IHH). Here, we report a Japanese female with IHH and compound heterozygous *TACR3* mutations and her heterozygous parents, and discuss the primary lesion for IHH and clinical findings. ***Case Report:*** This female was identified through mutation analysis of *TAC3* and *TACR3* in 57 patients with IHH. At 24 years of age, an initial standard GnRH test showed poor gonadotropin response (LH <0.2–0.6 IU/l), whereas the second GnRH test performed after GnRH priming (100 μg i.m. for 5

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consecutive days) revealed ameliorated gonadotropin responses (LH 0.3–6.4 IU/l; FSH 2.2–9.6 IU/l). The mother exhibited several features suggestive of mild IHH, whereas the father showed an apparently normal phenotype. ***Results:*** She had a paternally derived nonsense mutation at exon 1 (Y145X) and a maternally inherited single nucleotide (G) deletion from the conserved 'GT' splice donor site of intron 1 (IVS1+1delG). ***Conclusions:*** The results suggest hypothalamic dysfunction as the primary cause for IHH in patients with biallelic *TACR3* mutations and clinical manifestation in heterozygous females, together with the rarity of *TAC3* and *TACR3* mutations in patients with IHH.

Introduction

Isolated hypogonadotropic hypogonadism (IHH) is a genetically heterogeneous condition that lacks other pituitary hormone deficiency [1]. Recently, Topaloglu et al. [2] and Guran et al. [3] have reported homozygous *TAC3* or *TACR3* missense mutations in 11 patients with IHH from 5 Turkish or Kurdish families. TAC3 belongs to an evolutionally conserved neuropeptide family, and TACR3 belongs to a G-protein-coupled receptor family [4]. Topaloglu et al. [2] and Guran et al. [3] also performed functional studies using an intracellular calcium flux system, successfully revealing markedly attenuated activities of the TAC3 and TACR3 mutant proteins. These data provide the first evidence of genetic defects in TAC3/TACR3 signaling being involved in an autosomal recessive form of IHH.

However, there is no other report of *TAC3* or *TACR3* mutations, and further studies are necessary to define the underlying factor(s) for IHH and clinical findings in *TAC3* or *TACR3* mutations. Here, we report a female with IHH and *TACR3* mutations, and discuss the primary cause for IHH and the clinical phenotypes of the patient and her heterozygous parents.

Methods

Mutation Analysis

This study was approved by the Institutional Review Board Committees at the National Center for Child Health and Development and Keio University School of Medicine. After obtaining written informed consent, leukocyte genomic DNA samples from 57 Japanese cases with IHH (38 with 46,XY and 19 with 46,XX) were PCR-amplified with the previously reported primers [2], and subjected to direct sequencing on a CEQ 8000 autosequencer (Beckman Coulter, Fullerton, Calif., USA). To confirm a heterozygous mutation, the corresponding PCR products were subcloned with a TOPO TA Cloning Kit (Invitrogen, Carlsbad, Calif., USA), and the two alleles were sequenced separately.

Prediction of Aberrant Splicing and Nonsense-Mediated mRNA Decay

We utilized the splice site prediction program at the Berkeley Drosophila Genome Project (http://www.fruitfly.org/seq_tools/splice.html) to predict aberrant splicing. On the basis of the previous report [5], we also analyzed whether identified mutations could be subject to nonsense-mediated mRNA decay (NMD) that functions as an mRNA surveillance mechanism to prevent the formation of aberrant proteins.

PCR-Based cDNA Screening for TACR3

Human cDNA samples from control subjects were prepared by RT-PCR or purchased from Clontech (Palo Alto, Calif., USA). PCR amplification was performed for *TACR3* with primers for exon 1 (5′-TTGTGAACCTGGCTTTCTCC-3′) and exon 3 (5′-GGATTTCTCCTCCCCAGAGA-3′), as well as for *GAPDH* utilized as an internal control with primers for the boundary of exons 2/3 (5′-TCGGAGTCAACGGATTTGGTCG-3′) and the boundary of exons 4/5 (5′-TTGGAGGGATCTCGCTCCTG-3′).

Results

Mutation Analysis

Mutation analysis identified two heterozygous mutations of *TACR3* in a female patient, i.e. a nonsense mutation at exon 1 (Y145X) and a single nucleotide (G) deletion from the conserved 'GT' splice donor site of intron 1 (IVS1+1delG; fig. 1A, B). The father was heterozygous for Y145X, and the mother was heterozygous for IVS1+1delG. No demonstrable mutation was detected for *TAC3* in this patient and for *TAC3* and *TACR3* in the remaining 56 cases.

Prediction of Aberrant Splicing and NMD

The IVS1+1delG mutation was predicted to add a 1,153-bp intronic sequence to exon 1 and to cause aberrant splice formation between the added sequence and the normal splice acceptor site of exon 2 (fig. 1C). Furthermore, because of the presence of a stop codon on the added intronic sequence, the IVS1+1delG mutation was predicted to cause a premature termination at the 210th codon. Thus, both IVS1+1delG and Y145X satisfied the conditions for the occurrence of NMD.

PCR-Based cDNA Screening for TACR3

TACR3 expression was clearly identified in the hypothalamus and the pituitary as well as in the whole brain, the ovary, the placenta, and the fetal kidney, but not detected in the testis and leukocytes (fig. 2).

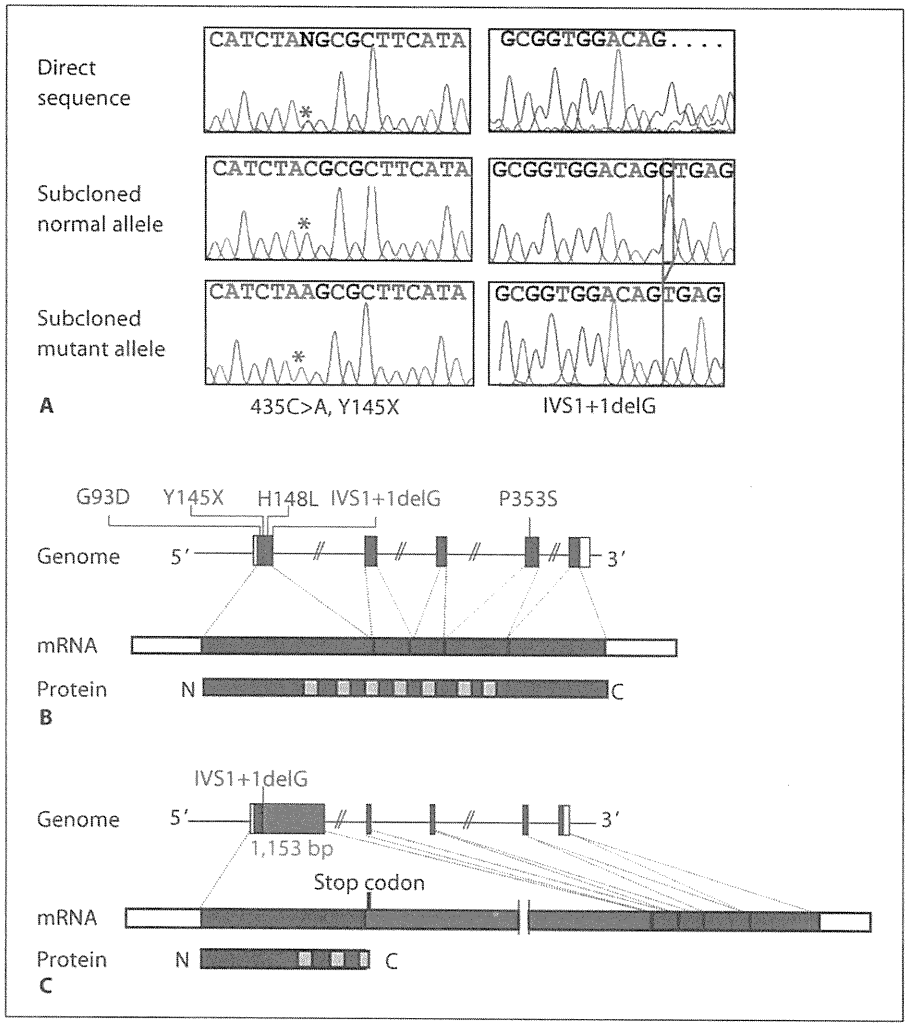

Fig. 1. *TACR3* mutations of the female Japanese patient. **A** Electrochromatograms showing 435C>A (Y145X; indicated by asterisks) and IVS1+1delG (highlighted by red lines). The mutation was indicated by direct sequencing, and confirmed by the subsequently performed sequencing of the subcloned normal and mutant alleles. **B** Schematic presentation of the positions of the mutations. The gray and white boxes on genomic DNA (Genome) and mRNA indicate the coding regions and the untranslated regions on exons 1–5. TACR3 protein (Protein) harbors 7 transmembrane domains (yellow boxes). The mutations identified in the Japanese patient are shown in red, and those reported by Topaloglu et al. [2] and Guran et al. [3] are shown in blue. **C** Predicted consequences of the IVS1+1delG mutation. In silico analysis indicates that IVS1+1delG causes addition of 1,153-bp intronic sequences (green box) to exon 1 and an aberrant splice formation between the added sequence and the normal splice acceptor site of exon 2. The transcribed intronic sequence (green box) harbors a stop codon on its very proximal 5′ region.

Case Report

This Japanese female patient was born as the sole child to nonconsanguineous parents at 42 weeks of gestation after an uncomplicated pregnancy and delivery. Her postnatal growth and development were normal until pubertal age. At 19 years of age, she was seen at a local clinic because of primary amenorrhea. She exhibited poor pubertal development (breast, Tanner stage 1; pubic hair, stage 2), with low basal gonadotropin and estradiol values (table 1). Thus, she received cyclic estrogen and progesterone therapy, and showed periodic withdrawal bleeding. She showed markedly high educational achievement at a university.

At 24 years of age, she was referred to us for further investigations. She measured 163 cm (+0.7 SD) and weighed 48.5 kg (–0.6 SD). Her breast development was at Tanner stage 3–4, and her pubic hair at stage 4. Magnetic resonance imaging delineated normal pituitary structure. Basal blood hormone values measured at 4 weeks after discontinuation of the hormone replacement therapy were consistent with IHH (table 1). Furthermore, while an initial standard GnRH test showed a poor gonadotropin response, the second-time GnRH test performed after GnRH priming (100 μg i.m. for 5 consecutive days) revealed obviously ameliorated gonadotropin responses (table 1).

The 58-year-old mother had menarche at 14.6 years of age (the menarchial age of Japanese females is 9.75–14.75 years). Subsequently, she had regular but long (~45 days) menstrual cycles with occasionally slight intermenstrual bleeding. She had no signs of androgen excess such as hirsutism. She married at 25 years of age, and failed to conceive for 3 years despite an ordinary conjugal life. Basal body temperature records indicated frequent, though not invariable, occurrence of monophasic cycles. Thus, she was treated with chlomiphene citrate by a local medical doctor, and became pregnant at the second cycle of this therapy. Polycystic ovary was excluded by repeatedly performed ultrasound studies during pregnancy. Her menses became irregular from ~45 years of age and ceased at 56 years of age (the menopausal age of Japanese females is 45–56 years). She was otherwise healthy with normal stature (150 cm, –0.5 SD for her age) and intelligence. The 59-year-old father was clinically normal with normal stature (168 cm, +0.9 SD for his age) and intelligence. Allegedly, he had an age-appropriate pubertal development and started shaving at 16 years of age.

Table 1. Endocrine data of the mutation-positive Japanese female

Hormone	Stimulus	Patient		Reference values[1]	
		basal	peak	basal	peak
Examinations at 19 years of age					
LH, mIU/ml		0.4		1.1–4.5	
FSH, mIU/ml		1.7		2.0–6.0	
Estradiol, pg/ml		<4.0		11–82	
Examinations at 24 years of age					
LH, mIU/ml	GnRH[2, 3]	<0.2	0.6	1.1–4.5	2.0–9.2
LH, mIU/ml	GnRH (after priming)[2, 4]	0.3	6.4	1.1–4.5	2.0–9.2[5]
FSH, mIU/ml	GnRH (after priming)[2, 4]	2.2	9.6	2.0–6.0	4.5–12.0[5]
Estradiol, pg/ml		15		11–82	
Prolactin, ng/ml		12.6		2.4–18.7	
TSH, mIU/l		0.75		0.30–4.50	
GH, ng/ml		8.3		<0.1–10.0	
ACTH, pg/ml		8.0		7–56	
AMH, ng/ml		3.4		0.1–7.4	

[1] Reference values in age-matched Japanese females.
[2] Hormone replacement therapy was discontinued for 4 weeks before GnRH tests.
[3] GnRH 100-μg bolus i.v. and blood sampling at 0, 30, 60, 90, and 120 min; FSH was not measured.
[4] GnRH 100-μg bolus i.v. after priming with GnRH 100 μg i.m. for 5 consecutive days.
[5] Reference peak values in a standard GnRH test; there are no reference data after GnRH priming.

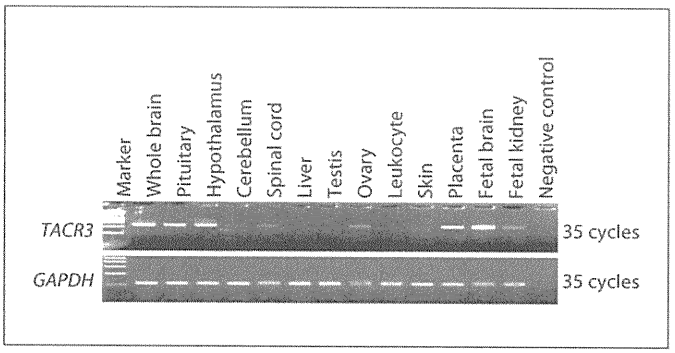

Fig. 2. PCR-based human cDNA screening for *TACR3*. *GAPDH* = Glyceraldehyde-3-phosphate dehydrogenase.

Discussion

This patient had compound heterozygous mutations of *TACR3*. In this regard, both IVS1+1delG and Y145X were predicted as a pathologic mutation missing most of the transmembrane domains. Furthermore, although mRNA was not studied because of absent *TACR3* expression in available leukocytes, both Y145X and IVS1+1delG were predicted to undergo NMD. Thus, the results provide further support for *TACR3* mutations being involved in IHH. Furthermore, the results of the 57 cases suggest the rarity of *TAC3* and *TACR3* mutations in IHH (none for *TAC3* and 1.8% for *TACR3*).

In this patient, it is notable that gonadotropin responses to GnRH stimulation were ameliorated after GnRH priming. This may suggest that the primary lesion for IHH resides in the hypothalamus rather than in the pituitary. Indeed, TACR3 protein is strongly expressed in the human hypothalamus (fig. 2) [6]. Furthermore, rodent Tacr3, Kiss1r (Gpr54), and Gnrh1 proteins are clearly expressed in the median eminence that regulates pulsatile GnRH secretion [7, 8], and human TAC3, KISS1, and ESR1 proteins are co-expressed in the infundibular nucleus that modulates estrogen feedback for gonadotropin secretion [9, 10]. In addition, hypertrophy of TAC3-positive neurons and increased *TAC3* expression have been observed in the hypothalamus of postmenopausal females with hypoestrinism [9]. These data suggest that a molecular network involving TAC3/TACR3, KISS1/KISS1R, and estrogen/ESR1 may underlie the regulation of GnRH secretion in the hypothalamus.

The heterozygous mother exhibited several clinical features suggestive of mild IHH [11]. While such manifestations are apparently absent from the previously re-

ported females heterozygous for *TACR3* missense mutations (G93D, P353S, and H148L) [2, 3], this may be due to the residual activity being retained by the missense mutations but not by the splice donor site mutation of the mother, or to the ethnic difference. Similarly, while the heterozygous father of this patient apparently lacked discernible clinical features, this may be due to sex dimorphism that GnRH secretion remains fairly constant in males and shows dynamic change with menstrual cycles in females [11, 12].

In this study, it appears worthwhile to point out that *TACR3* was clearly expressed in the ovary, but not in the testis. Although the role of *TACR3* in ovarian tissue has not been well studied, a possible involvement of *TACR3* in the development of the corpus luteum has been suggested [13]. Thus, *TACR3* mutations may also have exerted a direct impact on the ovarian function in this patient, independent of gonadotropin deficiency. In addition, the gonadal expression pattern of *TACR3* may be relevant to the phenotypic difference between the mother and father.

In summary, the present study suggests a probable hypothalamic dysfunction in patients with biallelic *TACR3* mutations and heterozygous manifestation in females, together with the rarity of *TAC3* and *TACR3* mutations in patients with IHH. Further studies will help to clarify the clinical and molecular characteristics in *TACR3* mutations.

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CASE REPORT

Semen analysis and successful paternity by intracytoplasmic sperm injection in a man with steroid 5α-reductase-2 deficiency

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Objective: To report semen parameters and successful paternity by intracytoplasmic sperm injection (ICSI) in a male patient with molecularly confirmed steroid 5α-reductase-2 deficiency.
Design: Case report.
Setting: National research institute and an infertility clinic.
Patient(s): A 29-year-old Japanese man with 5α-reductase-2 deficiency who had failed to have a child despite an ordinary conjugal life for 2 years with his wife.
Intervention(s): Mutation analysis, semen analysis, and execution of ICSI.
Main Outcome Measure(s): Mutation detection, semen assessment, and production of a child.
Result(s): Mutation analysis revealed a homozygous p.R246Q missense mutation on exon 5 of *SRD5A2*. Semem analysis showed oligozoospermia (semen volume 0.3 mL, sperm count 15×10^6/mL, total sperm count 4.5×10^6, motile cells 17%, and normal morphologic sperm 8%). ICSI resulted in a production of a healthy male infant.
Conclusion(s): The results, in conjunction with those of previously reported patients who received semen analysis and/or achieved paternity, suggest that male patients with 5α-reductase-2 deficiency, especially those with hypomorphic mutations including p.R246Q, could retain some degree of spermatogenic function and achieve paternity with and without assisted reproductive technology. (Fertil Steril® 2010;■:■–■. ©2010 by American Society for Reproductive Medicine.)

Key Words: Steroid 5α-reductase-2 deficiency, SRD5A2, hypomorphic mutation, semen analysis, intracytoplasmic sperm injection, paternity

Steroid 5α-reductase type 2 (5α-reductase-2) plays a crucial role in male sex differentiation by converting testosterone (T) into 5α-dihydrotestosterone (DHT) in the peripheral target tissues (1, 2). It is known that masculinization of wolffian ducts is primarily caused by T, whereas that of external genitalia and prostate is primarily caused by DHT (1). Therefore, 5α-reductase-2 deficiency, although it permits wolffian development, results in various degrees of 46,XY disorders of sex development (DSD) with undermasculinized or feminized external genitalia and hypoplastic prostate, depending on the residual enzyme activity (1–3).

Furthermore, semen quality also appears to be deteriorated in 5α-reductase-2 deficiency. Indeed, semen analysis in nine socially male patients derived from a single large Dominican pedigree revealed that sperm are low in number and reduced in motility, and that seminal plasma is characterized by markedly reduced volume, increased viscosity, and poor liquefaction (3, 4). To date, however, one of the nine Dominican male patients achieved paternity by intrauterine insemination (5), and two Swedish brothers with 5α-reductase-2 deficiency fathered children naturally (6, 7).

Here, we report semen data and successful paternity by intracytoplasmic sperm injection (ICSI) in a man with 5α-reductase-2 deficiency. The results provide further information about fertility in 5α-reductase-2 deficiency.

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CASE REPORT

This Japanese male patient was born at term after an uncomplicated pregnancy and delivery. The parents were allegedly nonconsanguineous, and there was no individual with DSD in this pedigree. At birth, he was found to have micropenis, bilateral retractile testes, and penoscrotal hypospadias. Thus, he received testosterone enanthate injections (25 mg/dose, three times) for micropenis at 1 year of age, urethroplasty at the age of 6 years 5 months, and orchidopexy at age 9 years 11 months at a local hospital. Because endocrine studies at the time of orchidopexy showed an apparently normal serum T response to hCG stimulation as well as elevated gonadotropin values (actual data were not available), a provisional diagnosis of incomplete androgen insensitivity syndrome was made. Subsequently, he exhibited spontaneous pubertal development from his early teens. He worked as an office worker and married at 27 years of age. He always recognized himself as male, and never had a psychosocial problem.

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