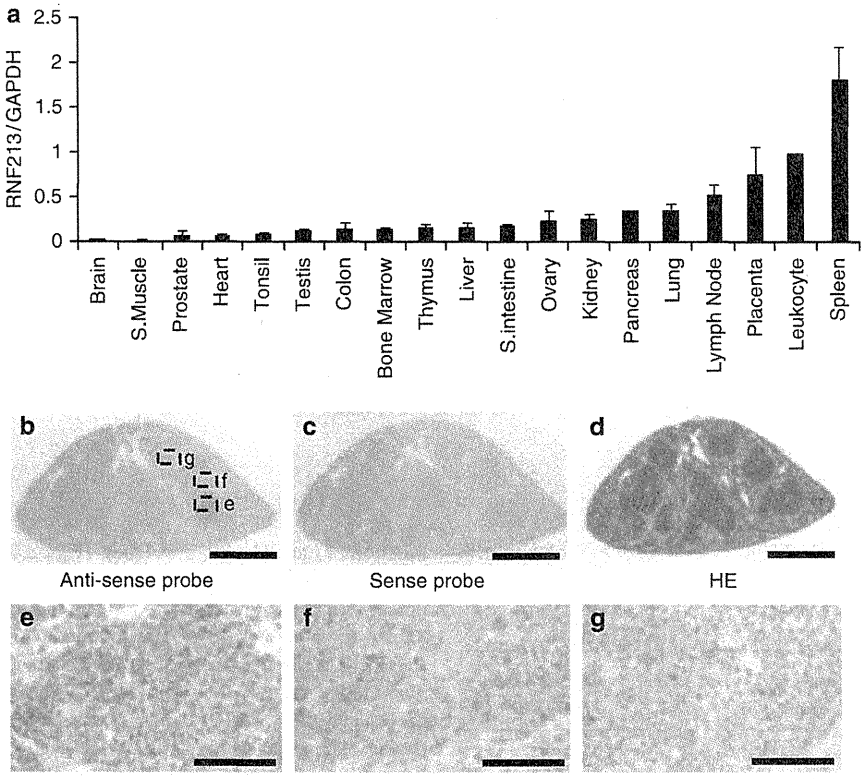

Figure 3 Expression of human RNF213 and murine Rnf213. (**a**) RT-PCR analysis of RNF213 mRNA in various human tissues. The expression levels of *RNF213* mRNA in various adult human tissues were evaluated by quantitative PCR using *GAPDH* mRNA as a control. The signal ratio of *RNF213* mRNA to *GAPDH* mRNA in each sample is shown on the vertical axis. (**b–g**) *In situ* hybridization (ISH) analysis of Rnf213 mRNA in mouse spleen. Specific signals for *Rnf213* mRNA were detected by ISH analysis with the anti-sense probe (**b**) but not with the sense probe (**c**). Hematoxylin–eosin staining of the mouse spleen (**d**). Signals for the *Rnf213* mRNA were observed in small mononuclear cells, which were mainly localized in the white pulps (dotted square, **e**) and partially distributed in the red pulps (dotted squares, **f** and **g**). Panels e, f and g show the high-magnification images of the corresponding fields in panel b. Scale bars, 1 mm (**b–d**) and 50 μm (**e–g**).

questions:[2,19] (i) why is MMD more prevalent in East Asia than in Western countries? The carrier frequency of p.R4859K in Japan is 1/72 (Table 2). In contrast, we found no p.R4859K carrier in 400 Caucasian controls (data not shown). Furthermore, no mutation was identified in five Caucasian patients with MMD after the full sequencing of *RNF213*. These results suggest that the genetic background of MMD in Asian populations is distinct from that in Western populations and that the low incidence of MMD in Western countries may be attributable to a lack of the founder *RNF213* mutation. (ii) Is unilateral involvement a subtype of MMD or a different disease?[2] We collected DNA samples from six patients with unilateral involvement and found a p.R4859K mutation in four of them (data not shown), suggesting that bilateral and unilateral MMD share a genetic background. (iii) Is pre-symptomatic diagnosis of MMD possible? In the present study, MMD never developed in the 15 mutation-negative family members in the 19 MMD families with the p.R4859K mutation (Table 3 and Supplementary Figure 1), suggesting the feasibility of presymptomatic diagnosis or exclusion by genetic testing.

How the mutant RNF213 protein causes MMD remains to be elucidated. The expression of *RNF213* was more abundant in a subset of leukocytes than in the brain, suggesting that blood cells have a function in the etiology of MMD. This observation agrees with a previous report that MMD patients have systemic angiopathy.[20] Recent studies have suggested that the postnatal vasculature can form through vasculogenesis, a process by which endothelial progenitor cell are recruited from the splenic pool and differentiate into mature endothelial cells.[21] Levels of endothelial progenitor cells in the peripheral blood are increased in MMD patients.[22] *RNF213* may be expressed in splenic endothelial progenitor cells and mutant *RNF213* might dysregulate the function of the endothelial progenitor cells. Further research is necessary to elucidate the role of *RNF213* in the etiology of MMD.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ACKNOWLEDGEMENTS

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SHORT COMMUNICATION

Androgenetic/biparental mosaicism in a girl with Beckwith–Wiedemann syndrome-like and upd(14)pat-like phenotypes

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This report describes androgenetic/biparental mosaicism in a 4-year-old Japanese girl with Beckwith–Wiedemann syndrome (BWS)-like and paternal uniparental disomy 14 (upd(14)pat)-like phenotypes. We performed methylation analysis for 18 differentially methylated regions on various chromosomes, genome-wide microsatellite analysis for a total of 90 loci and expression analysis of *SNRPN* in leukocytes. Consequently, she was found to have an androgenetic 46,XX cell lineage and a normal 46,XX cell lineage, with the frequency of the androgenetic cells being roughly calculated as 91% in leukocytes, 70% in tongue tissues and 79% in tonsil tissues. It is likely that, after a normal fertilization between an ovum and a sperm, the paternally derived pronucleus alone, but not the maternally derived pronucleus, underwent a mitotic division, resulting both in the generation of the androgenetic cell lineage by endoreplication of one blastomere containing a paternally derived pronucleus and in the formation of the normal cell lineage by union of paternally and maternally derived pronuclei. It appears that the extent of overall (epi)genetic aberrations exceeded the threshold level for the development of BWS-like and upd(14)pat-like phenotypes, but not for the occurrence of other imprinting disorders or recessive Mendelian disorders.
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Keywords: androgenesis; Beckwith–Wiedemann syndrome; mosaicism; upd(14)pat

INTRODUCTION

A pure androgenetic human with paternal uniparental disomy for all chromosomes is incompatible with life because of genomic imprinting.[1,2] However, a human with an androgenetic cell lineage could be viable in the presence of a normal cell lineage. Indeed, an androgenetic cell lineage has been identified in six liveborn individuals with variable phenotypes.[3–7] All the androgenetic cell lineages have a 46,XX karyotype, and this is consistent with the lethality of an androgenetic 46,YY cell lineage.

Here, we report on a girl with androgenetic/biparental mosaicism, and discuss the underlying factors for the phenotypic development.

CASE REPORT

This patient was conceived naturally to non-consanguineous and healthy parents. At 24 weeks gestation, the mother was referred to us because of threatened premature delivery. Ultrasound studies showed Beckwith–Wiedemann syndrome (BWS)-like features,[8] such as macroglossia, organomegaly and umbilical hernia, together with polyhydramnios and placentomegaly. The mother repeatedly received amnioreduction and tocolysis.

She was delivered by an emergency cesarean section because of preterm rupture of membranes at 34 weeks of gestation. Her birth weight was 3730 g (+4.8 s.d. for gestational age), and her length 45.6 cm (+0.7 s.d.). The placenta weighed 1040 g (+7.3 s.d.).[9] She was admitted to a neonatal intensive care unit due to asphyxia. Physical examination confirmed a BWS-like phenotype. Notably, chest roentgenograms delineated mild bell-shaped thorax characteristic of paternal uniparental disomy 14 (upd(14)pat),[10] although coat hanger appearance of the ribs indicative of upd(14)pat was absent (Supplementary Figure 1). She was placed on mechanical ventilation for 2 months, and received tracheostomy, glossectomy and tonsillectomy in her infancy, due to upper airway obstruction. She also had several clinical features occasionally reported in BWS[8] (Supplementary Table 1). Her karyotype was 46,XX in all the 50 lymphocytes analyzed. On the last examination at 4 years of age, she showed postnatal growth failure and severe developmental retardation.

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MOLECULAR STUDIES

This study was approved by the Institutional Review Board Committee at the National Center for Child health and Development, and performed after obtaining informed consent.

Methylation analysis

We first performed bisulfite sequencing for the *H19*-DMR (differentially methylated region) and KvDMR1 as a screening of BWS[11,12] and that for the IG-DMR and the *MEG3*-DMR as a screening of upd(14)pat,[10] using leukocyte genomic DNA. Paternally derived clones were predominantly identified for the four DMRs examined (Figure 1a). We next performed combined bisulfite restriction analysis for multiple DMRs, as reported previously.[13] All the autosomal DMRs exhibited markedly skewed methylation patterns consistent with predominance of paternally inherited clones, whereas the *XIST*-DMR on the X chromosome showed a normal methylation pattern (Figure 1a).

Genome-wide microsatellite analysis

Microsatellite analysis was performed for 90 loci with high heterozygosities in the Japanese population.[14] Major peaks consistent with paternal uniparental isodisomy and minor peaks of maternal origin were identified for at least one locus on each chromosome, with the minor peaks of maternal origin being more obvious in tongue and tonsil tissues than in leukocytes (Figure 1b and Supplementary Table 2). There were no loci with three or four peaks indicative of chimerism. The frequency of the androgenetic cells was calculated as 91% in leukocytes, 70% in tongue cells and 79% in tonsil cells, although the estimation apparently was a rough one (for details, see Supplementary Methods).

Expression analysis

We examined *SNRPN* expression, because *SNRPN* showed strong expression in leukocytes (for details, see Supplementary Data). *SNRPN* expression was almost doubled in the leukocytes of this patient (Figure 1c).

DISCUSSION

These results suggest that this patient had an androgenetic 46,XX cell lineage and a normal 46,XX cell lineage. In this regard, both the androgenetic and the biparental cell lineages appear to have derived from a single sperm and a single ovum, because a single haploid genome of paternal origin and that of maternal origin were identified in this patient by genome-wide microsatellite analysis. Thus, it is likely that after a normal fertilization between an ovum and a sperm, the paternally derived pronucleus alone, but not the maternally derived pronucleus, underwent a mitotic division, resulting both in the generation of the androgenetic cell lineage by endoreplication of

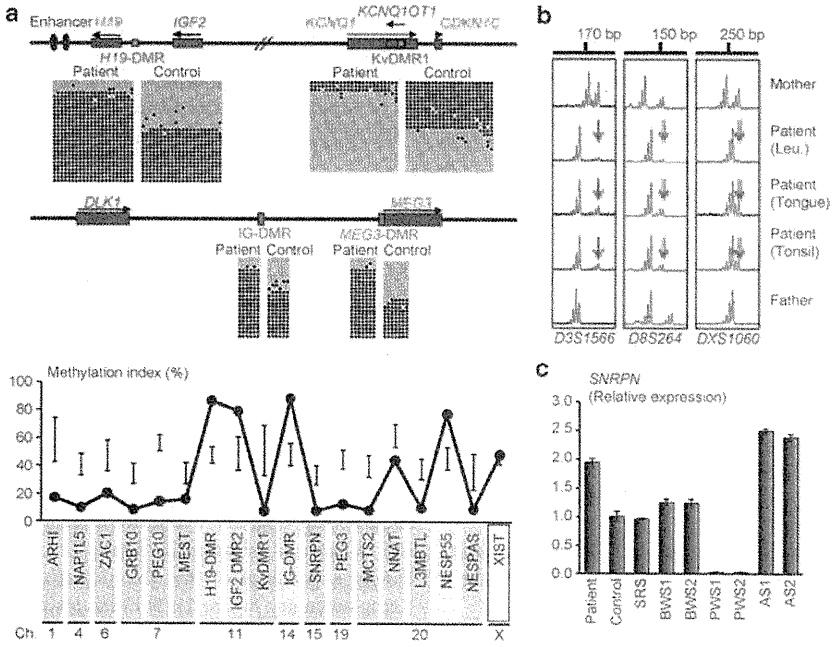

Figure 1 Representative molecular results. (**a**) Methylation analysis. Upper part: Bisulfite sequencing data for the *H19*-DMR and the KvDMR1 on 11p15.5, and those for the IG-DMR and the *MEG3*-DMR on 14q32.2. Each line indicates a single clone, and each circle denotes a CpG dinucleotide; filled and open circles represent methylated and unmethylated cytosines, respectively. Paternally expressed genes are shown in blue, maternally expressed gene in red, and the DMRs in green. The *H19*-DMR, the IG-DMR, and the *MEG3*-DMR are usually methylated after paternal transmission and unmethylated after maternal transmission, whereas the KvDMR1 is usually unmethylated after paternal transmission and methylated after maternal transmission.[10,11] Lower part: Methylation indices (the ratios of methylated clones) obtained from the COBRA analyses for the 18 DMRs. The DMRs highlighted in blue and pink are methylated after paternal and maternal transmissions, respectively. The black vertical bars indicate the reference data (maximum – minimum) in leukocyte genomic DNA of 20 normal control subjects (the *XIST*-DMR data are obtained from 16 control females). (**b**) Representative microsatellite analysis. Major peaks of paternal origin and minor peaks of maternal origin (red arrows) have been identified in this patient. The minor peaks of maternal origin are more obvious in tongue and tonsil tissues than in leukocytes (Leu.). (**c**) Relative expression level (mean ± s.d.) of *SNRPN*. The data are normalized against *TBP*. SRS: an SRS patient with an epimutation (hypomethylation) of the *H19*-DMR; BWS1: a BWS patient with an epimutation (hypermethylation) of the *H19*-DMR; BWS2: a BWS patient with upd(11)pat; PWS1: a Prader-Willi syndrome (PWS) patient with upd(15)mat; PWS2: a PWS patient with an epimutation (hypermethylation) of the *SNRPN*-DMR; AS1: an Angelman syndrome (AS) patient with upd(15)pat; and AS2: an AS patient with an epimutation (hypomethylation) of the *SNRPN*-DMR. The data were obtained using an ABI Prism 7000 Sequence Detection System (Applied Biosystems).

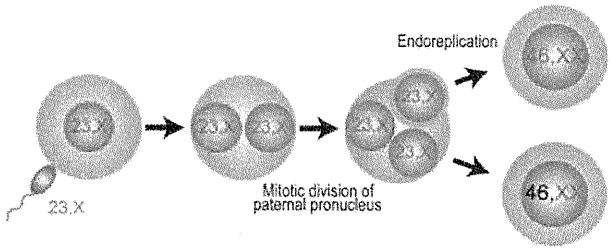

Figure 2 Schematic representation of the generation of the androgenetic/biparental mosaicism. Polar bodies are not shown.

one blastomere containing a paternally derived pronucleus and in the formation of the normal cell lineage by union of paternally and maternally derived pronuclei (Figure 2). This model has been proposed for androgenetic/biparental mosaicism generated after fertilization between a single ovum and a single sperm.[5,15,16] The normal methylation pattern of the *XIST*-DMR is explained by assuming that the two X chromosomes in the androgenetic cell lineage undergo random X-inactivation, as in the normal cell lineage. Furthermore, the results of microsatellite analysis imply that the androgenetic cells were more prevalent in leukocytes than in tongue and tonsil tissues.

A somatic androgenetic cell lineage has been identified in seven liveborn patients including this patient (Supplementary Table 1).[3–7] In this context, leukocytes are preferentially utilized for genetic analyses in human patients, and detailed examinations such as analyses of plural DMRs are necessary to detect an androgenetic cell lineage. Thus, the hitherto identified patients would be limited to those who had androgenetic cells as a predominant cell lineage in leukocytes probably because of a stochastic event and received detailed molecular studies. If so, an androgenetic cell lineage may not be so rare, and could be revealed by detailed analyses as well as examinations of additional tissues in patients with relatively complex phenotypes, as observed in the present patient.

Phenotypic features in androgenetic/biparental mosaicism would be determined by several factors. They include (1) the ratio of two cell lineages in various tissues/organs, (2) the number of imprinted domains relevant to specific features (for example, dysregulation of the imprinted domains on 11p15.5 and 14q32.2 is involved in placentomegaly[9,17]), (3) the degree of clinical effects of dysregulated imprinted domains (an (epi)dominant effect has been assumed for the 11p15.5 imprinted domains[18]), (4) expression levels of imprinted genes in androgenetic cells (although *SNRPN* expression of this patient was consistent with androgenetic cells being predominant in leukocytes, complicated expression patterns have been identified for several imprinted genes in both androgenetic and parthenogenetic fetal mice, probably because of perturbed *cis*- and *trans*-acting regulatory mechanisms[19]) and (5) unmasking of possible paternally inherited recessive mutation(s) in androgenetic cells. Thus, in this patient, it appears that the extent of overall (epi)genetic aberrations exceeded the threshold level for the development of BWS-like and upd(14)pat-like body and placental phenotypes, but remained below the threshold level for the occurrence of other imprinting disorders or recessive Mendelian disorders.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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ORIGINAL

GATA3 abnormalities in six patients with HDR syndrome

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Abstract. *GATA3* mutations cause HDR (*h*ypoparathyroidism, sensorineural *d*eafness, and *r*enal dysplasia) syndrome and, consistent with the presence of the second DiGeorge syndrome locus (*DGS2*) proximal to *GATA3*, distal 10p deletions often leads to HDR and DiGeorge syndromes. Here, we report on six Japanese patients with *GATA3* abnormalities. Cases 1–5 had a normal karyotype, and case 6 had a 46,XX,del(10)(p15) karyotype. Cases 1–6 had two or three of the HDR triad features. Case 6 had no DiGeorge syndrome phenotype except for hypoparathyroidism common to HDR and DiGeorge syndromes. Mutation analysis showed heterozygous *GATA3* mutations in cases 1–5, i.e., c.404–405insC (p.P135fsX303) in case 1, c.700T>C & c.708–709insC (p.F234L & p.S237fsX303) on the same allele in case 2, c.737-738insG (p.G246fsX303) in case 3, c.824G>T (p.W275L) in case 4, and IVS5+1G>C (splice error) in case 5. Deletion analysis of chromosome 10p revealed loss of *GATA3* and preservation of *D10S547* in case 6. The results are consistent with the previous finding that *GATA3* mutations are usually identified in patients with two or three of the HDR triad features, and provide supportive data for the mapping of *DGS2* in the region proximal to *D10S547*.

Key words: HDR syndrome, *GATA3*, DiGeorge syndrome, *DGS2*, Phenotypic spectrum

HDR (*h*ypoparathyroidism, sensorineural *d*eafness, and *r*enal dysplasia) syndrome is an autosomal dominant disorder first reported by Bilous *et al.* [1]. This condition is primarily caused by haploinsufficiency of *GATA3* on chromosome 10p15, although *GATA3* mutations have not been identified in a small portion of patients with clinical features compatible with HDR syndrome [2, 3]. *GATA3* consists of six exons, and encodes a transcription factor with two transactivating domains and two zinc finger domains on exons 2–6 [2]. *GATA3* is expressed in the developing parathyroid glands, inner ears, and kidneys, together with thymus and central nervous system (CNS) [4, 5].

Distal 10p deletions involving *GATA3* often lead to DiGeorge syndrome associated with hypoplastic thymus, T-cell immunodeficiency, hypoparathyroidism, congenital cardiac defects, and facial dysmorphism, in addition to HDR syndrome [6, 7]. Thus, deletion mappings have been performed, localizing the second DiGeorge syndrome locus (*DGS2*) to a ~1 cM region proximal to *D10S547* (the locus order: 10pter–*GATA3*–*D10S547*–*DGS2*–10cen) [6, 7].

Here, we report clinical and molecular findings in five patients with intragenic *GATA3* mutations and one patient with distal 10p deletion involving *GATA3*, and discuss the clinical features in *GATA3* mutation posi-

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Table 1 Summary of six patients with *GATA3* mutation or deletion

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
Present age	40 years	39 years	4 years	31 years	17 years	4 years
Sex	Female	Female	Male	Female	Male	Female
Karyotype	46,XX	46,XX	46,XY	46,XX	46,XY	46,XX,del(10)(p15)
Hypoparathyroidism	Yes	Yes	Yes	Yes	Yes	Yes
Symptom	Convulsion	Tetany	No[b]	Convulsion	Convulsion	Convulsion
Ca (mg/dL)	3.4	3.4	2.7	4.3	3.0	4.7
P (mg/dL)	8.0	7.9	8.1	7.9	8.7	8.6
Intact PTH (pg/mL)	Undetected	Undetected	14	Undetected	Undetected	15
Age at diagnosis	10 years	13 years	17 months	3 years	17 months	2 weeks
Sensorineural deafness	Yes	Yes	No	Yes	Yes	Yes
Hearing level (dB)[a]	50 (B)	>70 (B)	Normal	60 (B)	50 (B)	90 (B)
Age at diagnosis	13 years	6 years		11 years	12 months	6 months
Renal lesion	Yes	Yes	Yes	Equivocal[c]	Yes	Yes
Malformation	RH (L)	PCD (B)	PD (R)	Absent	RH (L)	VUR (B)
Age at diagnosis	9 years	27 years	17 months		17 months	2 months

Abbreviations: PTH, parathyroid hormone; dB, decibel; B, bilateral; L, left; R, right; RH, renal hypoplasia; PCD, pelvicalyceal deformity; PD, pelvic duplication; and VUR, vesicoureteral reflux.
[a] Degree of hearing loss: normal, <25 dB; mild 26–40 dB; moderate 41–55 dB; moderately severe, 56–70 dB; and profound, >90 dB.
[b] Hypocalcemia was revealed by routine biochemical studies, when this boy was admitted because of bronchopneumonia.
[c] Renal malformation was absent, but renal dysfunction with increased serum creatinine was noticed during pregnancy.
Normal reference data: Ca: 8.84–10.44 mg/dL; P: 4.5–6.5 mg/dL; and intact PTH: 10–65 pg/mL.

tive patients and the chromosomal location of *DGS2*.

Patients and Methods

Patients

We studied six hitherto unreported Japanese patients (cases 1–6) with two or three HDR triad features. Cases 1–5 had a normal karyotype, and case 6 had a 46,XX,del(10)(p15) karyotype. Cases 1–4 and 6 were apparently sporadic cases, whereas case 5 was a possible familial case: the father received renal dialysis due to chronic renal failure from his twenties, and the paternal grandmother had unilateral renal hypoplasia, although they lacked clinical features suggestive of hypoparathyroidism and hearing difficulty.

Clinical phenotypes of the HDR triad features are summarized in Table 1. Hypoparathyroidism was noticed by convulsion in cases 1 and 4–6 and by tetany in case 2; in case 3, it was incidentally found by biochemical examinations at the time of admission due to bronchopneumonia. After confirming parathyroid hormone deficiency, 1α(OH) vitamin D therapy was started, successfully normalizing serum calcium and phosphate values in cases 1–6. Sensorineural deafness was demonstrated in cases 1, 2, and 4–6 by auditory brainstem response or audiometry, and they required hearing aids in their daily life. Case 3 had no hearing difficulty with normal auditory brainstem response. Renal lesion was radiologically confirmed in cases 1–3, 5, and 6. Although case 4 had no discernible renal malformation, she manifested renal dysfunction during pregnancy. In addition, case 6 exhibited developmental delay but lacked hypoplastic thymus, T-cell immunodeficiency, congenital cardiac defects, and facial dysmorphism characteristic of DiGeorge syndrome.

Mutation analysis of GATA3

This study was approved by the Institutional Review Board Committee at National Center for Child Health and Development. After obtaining informed consent, leukocyte genomic DNA samples of cases 1–6 were amplified by PCR for the coding regions on exons 2–6 and their flanking splice sites, and the PCR products were subjected to direct sequencing from both directions on a CEQ 8000 autosequencer (Beckman Coulter, Fullerton, CA). The primer sequences and the PCR conditions were as described previously [2, 3]. To confirm a heterozygous mutation, the corresponding PCR products were subcloned with a TOPO TA Cloning Kit (Life Technologies, Carlsbad, CA), and normal and mutant alleles were sequenced separately.

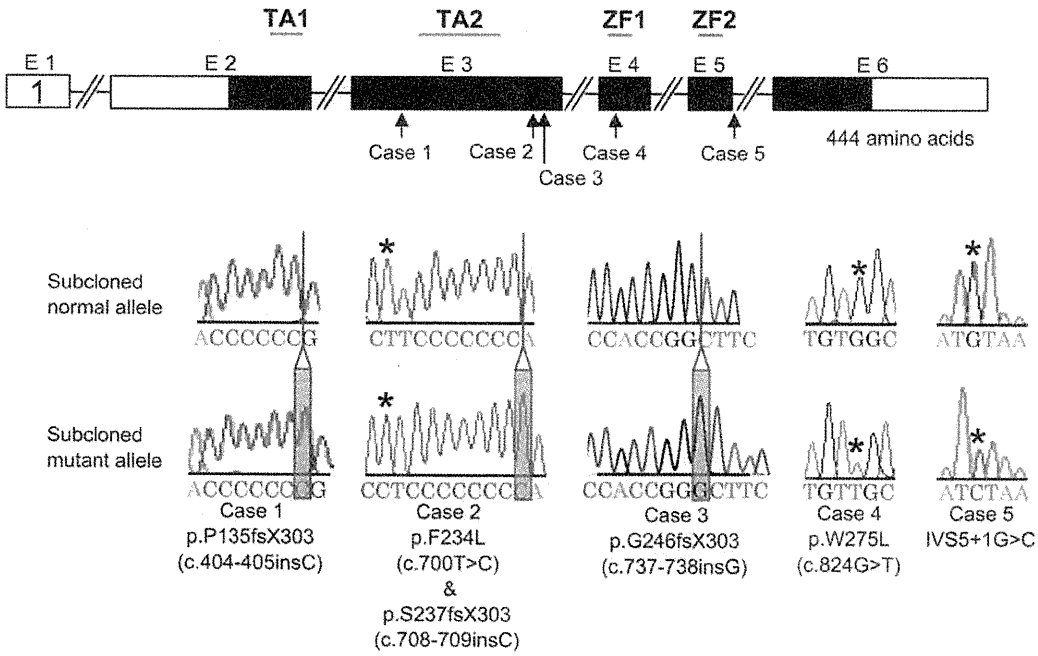

Fig. 1 Mutation analysis of *GATA3*.
Upper part: The structure of *GATA3* and the position of the mutations identified in cases 1–5. *GATA3* consists of exons 1–6 (E1–E6) and encodes two transactivating domains (TA1 and TA2) and two zinc finger domains (ZF1 and ZF2). The black and white boxes denote the coding regions and the untranslated regions, respectively.
Lower part: Electrochromatograms showing the subcloned normal and mutant sequences in cases 1–5.

Deletion analysis of 10p

To indicate an extent of the 10p deletion in case 6, oligoarray comparative genomic hybridization (CGH) was carried out with 1x244K Human Genome Array (catalog No. G4411B) (Agilent Technologies, Palo Alto, CA), according to the manufacturer's protocol. Furthermore, fluorescence *in situ* hybridization (FISH) was performed with an RP11-554F11 BAC probe containing the whole *GATA3* gene [3] and an RP11-17E09 BAC probe containing *D10S547* (BACPAC Resources Center, Oakland, CA), together with a CEP 10 probe for *D10Z1* (Abbott, Chicago, IL) utilized as an internal control. The two BAC probes were labeled with digoxigenin and detected by rhodamine anti-digoxigenin, and the control probe was detected according to the manufacturer's protocol.

Results

Mutation analysis of GATA3

Direct sequencing identified heterozygous *GATA3* mutations in cases 1–5, i.e., a frameshift mutation (c.404–405insC, p.P135fsX303) in case 1, a missense mutation (c.700T>C, p.F234L) and a frameshift mutation (c.708–709insC, p.S237fsX303) on the same allele in case 2, a frameshift mutation (c.737-738insG, p.G246fsX303) in case 3, a missense mutation (c.824G>T, p.W275L) in case 4, and a splice donor site mutation (IVS5+1G>C) in case 5 (Fig. 1). Unfortunately, the renal phenotype positive father and paternal grandmother of case 5 were not examined. These mutations were absent from 200 control subjects. No intragenic mutation was identified in case 6 with distal 10p deletion.

Deletion analysis of 10p

CGH revealed a ~10 Mb terminal deletion from chromosome 10p of case 6 (Fig. 2). FISH analysis showed that the 10p deletion chromosome was missing *GATA3* and retained *D10S547*.

Discussion

Cases 1–6 had two or three of the HDR triad features and heterozygous *GATA3* abnormalities. This is consistent with the previous notion that *GATA3* mutations

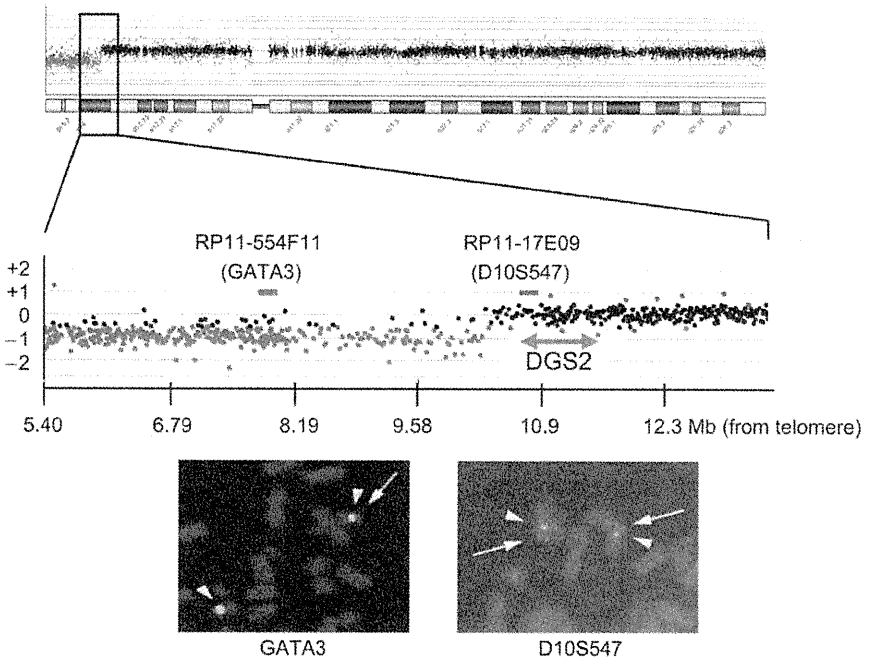

Fig. 2 Deletion analysis of 10p. The green and black signals in CGH indicate the deleted and preserved regions on the 10p deleted chromosome, respectively. The critical region for *DGS2* is indicated. The RP11-554F11 probe containing *GATA3* detects only a single signal (an arrow), whereas the RP11-17E09 probe containing *D10S547* identifies two signals (arrows). The arrowheads indicate *D10Z1* detected by a control CEP 10 probe.

are usually identified in patients with two or three of the HDR triad features [8, 9]. However, this would more or less be due to an ascertainment bias that *GATA3* are usually examined in patients diagnosed as having HDR syndrome. Indeed, familial studies of probands with typical HDR syndrome have identified *GATA3* mutations in subjects with apparently deafness only phenotype [3, 10], although there has been no report documenting apparently normal phenotype in individuals with *GATA3* mutations. It is possible, therefore, that *GATA3* mutations are associated with a relatively wide penetrance and expressivity of the HDR triad features. In this context, it is notable that the father and the paternal grandmother of case 5 had renal abnormalities as the sole discernible clinical phenotype. This suggests that *GATA3* mutations may cause renal abnormalities alone in exceptional patients, although mutations analysis could not be performed for the father and the grandmother.

Case 6 lacked T-cell immunodeficiency, congenital cardiac defects, and abnormal facial appearance characteristic of DiGeorge syndrome. While case 6 had hypoparathyroidism, this is explained by loss of *GATA3*. In addition, developmental delay is ascribed to chromosome aberration. Thus, genotype-phenotype correlation in case 6 is consistent with the previous mapping of *DGS2* to a region proximal to *D10S547* [6, 7].

Acknowledgements

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Proximal Promoter of the Cytochrome P450 Oxidoreductase Gene: Identification of Microdeletions Involving the Untranslated Exon 1 and Critical Function of the SP1 Binding Sites

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Context: *POR* (cytochrome P450 oxidoreductase) is a ubiquitously expressed gene encoding an electron donor to all microsomal P450 enzymes and several non-P450 enzymes. *POR* mutations cause an autosomal recessive disorder characterized by skeletal dysplasia, adrenal dysfunction, and disorders of sex development. Although recent studies have indicated the presence of a CpG-rich region characteristic of housekeeping genes around the untranslated exon 1 (exon 1U) and a tropic effect of thyroid hormone on *POR* expression via thyroid hormone receptor-β, detailed regulatory mechanisms for the *POR* expression remain to be clarified.

Objective: Our objective was to report a pivotal element of the proximal promoter of *POR*.

Results: We first studied three patients (cases 1–3) with POR deficiency due to compound heterozygosity with an p.R457H mutation and transcription failure of an apparently normal allele, by oligoarray comparative genomic hybridization and serial direct sequencing of the deletion fusion points. Consequently, a 2,487-bp microdeletion involving exon 1U was identified in case 1 and an identical 49,604-bp deletion involving exon 1U and exon 1 was found in cases 2 and 3. We next analyzed the 2,487-bp region commonly deleted in cases 1–3 by *in silico* analysis, DNA binding analysis, luciferase assays, and methylation analysis. The results showed a critical function of the evolutionally conserved SP1 binding sites just upstream of exon 1U, especially the binding site at the position −26/−17, in the transcription of *POR*.

Conclusions: The results suggest that the SP1 binding sites constitute an essential element of the *POR* proximal promoter. **(*J Clin Endocrinol Metab* 96: E1881–E1887, 2011)**

Cytochrome P450 (CYP) oxidoreductase (POR) deficiency (PORD) is a rare autosomal recessive disorder caused by mutations in the gene encoding a flavoprotein that functions as an electron donor to all microsomal P450 enzymes and several non-P450 enzymes (1–3). Salient clinical features of PORD include skeletal dysplasia referred to as Antley-Bixler syndrome, adrenal dysfunction, 46,XY and 46,XX disorders of sex development (DSD), and maternal virilization during pregnancy (1–4). Such features are primarily explained by impaired activities of POR-

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Abbreviations: CGH, Comparative genomic hybridization; CYP, cytochrome P450; DSD, disorders of sex development; exon 1U, untranslated exon 1; HEK, human embryonic kidney; POR, CYP oxidoreductase; PORD, POR deficiency; SL2, Schneider line 2.

dependent CYP51A1 and squalene epoxidase involved in cholesterologenesis and CYP17A1, CYP21A2, and CYP19A1 involved in steroidogenesis (1–4). Anorectal and urinary anomalies are also occasionally observed in PORD, probably due to decreased activity of CYP26 relevant to retinoic acid metabolism (5). The complete absence of POR activity is assumed to be lethal (4), and consistent with this, all the patients identified to date have at least one missense mutation that is likely to preserve some residual activity (1, 2, 6, 7). In addition, heterozygosity with one apparently normal allele has been reported in approximately 12% of PORD patients (4).

The *POR/Por* gene is transcribed ubiquitously with more or less variable expression levels among different tissues (8, 9). Consistent with the ubiquitous expression pattern, rat *Por* is known to be associated with a CpG-rich region (CpG islands) (9) characteristic of housekeeping genes (10). Similarly, human *POR* consists of a single untranslated exon 1 (exon 1U) and coding exons 1–15, and the region around exon 1U harbors a CpG-rich region (11). In addition, the SP1 binding sites as a potential proximal promoter element reside in the CpG-rich region of rat *Por* (9), whereas they have not yet been reported in the CpG-rich region of human *POR*. Furthermore, Tee *et al.* (12) have recently studied the approximately 300-bp proximal promoter region just upstream of exon 1U of human *POR*, showing that thyroid hormone exerts a major trophic effect on *POR* expression primarily via thyroid hormone receptor-β, with thyroid hormone receptor-α, estrogen receptor-α, Smad3, and Smad4 exerting lesser modulatory effects. However, the detailed regulatory mechanisms for the transcription of human *POR* remain to be clarified.

Here, we report two types of microdeletions, one involving exon 1U alone and the other involving exon 1U and exon 1, in patients with PORD and suggest a pivotal role of the SP1 binding sites in the transcriptional regulation of *POR*. The results, in conjunction with the previous data (12), provide significant progress in the clarification of the regulatory machinery for the expression of *POR*.

Patients and Methods

Patients

We examined three nonconsanguineous patients (case 1 with 46,XY and cases 2 and 3 with 46,XX) reported in our previous paper describing 35 patients with PORD (7); cases 1, 2, and 3 in this report correspond to cases 18, 26, and 27 in the previous paper, respectively. Cases 1–3 manifested Antley-Bixler syndrome-compatible skeletal features, adrenal dysfunction with

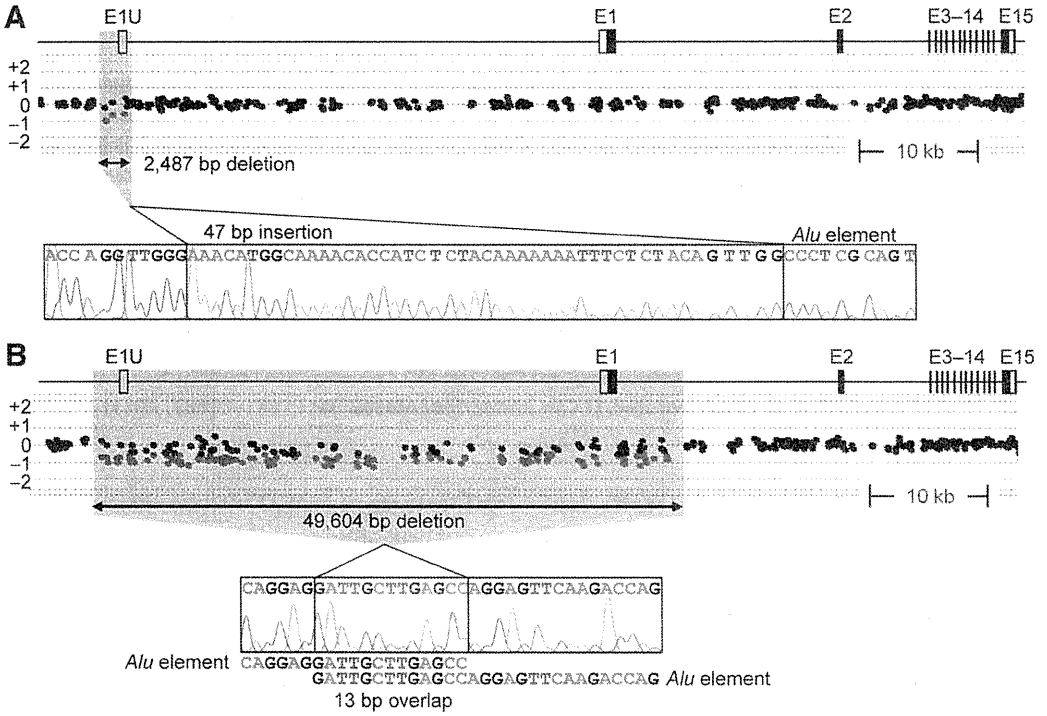

FIG. 1. Identification and characterization of the microdeletions in case 1 (panel A) and cases 2 and 3 (panel B) by CGH analysis and direct sequencing of the deletion junctions. The position of *POR* exons (E1U–E15) is shown on the CGH findings; the *black and white boxes* denote the coding regions and the untranslated regions, respectively. In the CGH results, the *black and green dots* denote signals indicative of the normal and the decreased (<−0.5) copy numbers, respectively. In the direct sequencing findings, the 47-bp segment inserted into the fusion point in case 1 is *highlighted* with *light yellow*, and the 13-bp overlapping sequence at the fusion point in cases 2 and 3 is *highlighted* with *light blue*. The *Alu* elements are indicated with *light blue bars*.

drastically compromised cortisol response to ACTH stimulation, and DSD (bilateral cryptorchidism in case 1, partial labial fusion in case 2, and mild clitoromegaly in case 3). Cases 2 and 3 also experienced adrenal crisis, whereas maternal virilization during pregnancy was not identified in cases 1–3. In addition, case 2 had right vesicoureteral reflux, and case 3 manifested imperforated anus. In cases 1–3, direct sequencing for leukocyte genomic DNA indicated apparent heterozygosity for the Japanese founder mutation p.R457H, and that for leukocyte cDNA demonstrated transcription failure of an apparently normal allele (7). Thus, although cases 1–3 were found to have compound heterozygosity for p.R457H and transcription failure, the cause of transcription failure remained to be clarified.

Primer and probe

The primers and probes used in the present study are shown in Supplemental Table 1 (published on The Endocrine Society's Journals Online web site at http://endo.endojournals.org).

Genome structure analysis

Oligoarray comparative genomic hybridization (CGH) was performed for leukocyte genomic DNA, using a custom-build oligo-microarray containing 39,169 probes for an approximately 8-Mb region around *POR* and 26,662 reference probes for a different genomic interval (2x105K format, design ID 022431) (Agilent Technologies, Palo Alto, CA). The procedure was as described in the manufacturer's instructions. To determine the deletion size and the junction structure, serial direct sequencing was performed for long PCR products obtained with primer pairs flanking the deleted region, and the obtained junction sequence was compared with the reference sequence at the NCBI Database (NT_007933.15). The presence or absence of repeat sequences around the breakpoints was examined with Repeatmasker (http://www.repeatmasker.org).

In silico analysis

In silico analysis was performed for CpG islands, evolutionally conserved sequences, and promoter-associated histone marks, using UCSC genome browser (http://genome.ucsc.edu/). Putative transcription factor binding sites were searched by TFSEARCH (http://mbs.cbrc.jp/research/db/TFSEARCH.html). In addition, because animal *Por* has been well studied in rats (9), conservation status of identified sites was examined using rat data. The transcription start site of *POR* exon 1U (+1) was determined on the basis of the *POR* cDNA sequence (NM_000941) obtained from the NCBI database.

Luciferase assays

A series of promoter-reporter constructs were generated by inserting PCR-amplified DNA fragments into PGL3-enhancer vector or pGL3-basic vector (Promega, Madison, WI). Deletion mutants were created by site-directed mutagenesis. Transient transfection was carried out using human embryonic kidney (HEK) 293 cells with endogenous SP families, because of their stable transfection efficiency and usefulness in *in vitro* functional studies for SP1 binding sites (13). HEK 293 cells were cultured in DMEM at 37 C, seeded in 12-well dishes, and transfected using Lipofectamine 2000 (Life Technologies, Carlsbad, CA) with 0.6 μg of the reporter plasmids. As an internal control for the transfection, 20 ng pRL-CMV vector (Promega) was used. In addition, transient transfection was also performed using *Drosophila* Schneider line 2 (SL2) cells (CRL-1963; American Type Culture Collection, Manassas, VA) that lack endogenous SP families. SL2 cells were grown in Schneider's medium at 25 C, seeded in six-well dishes, and transfected using calcium phosphate (14) with 1.0 μg of the reporter plasmid and a total of 50 ng of various combinations of the SP1 expression vector (pPAC-SP1) and an empty pPAC vector, as well as 50 ng of the SP3 expression vector (pPAC-SP3). As an internal control for the transfection, 50 ng pPAC-β-galactosidase vector was used. For both experiments using HEK 293 cells and SL2 cells, luciferase activities were determined at 48 h after the transfections.

Transfections were performed in triplicate within a single experiment, and the experiments were repeated three times. The results are expressed as mean ± SEM, and statistical significance was examined by the *t* test. $P < 0.05$ was considered significant.

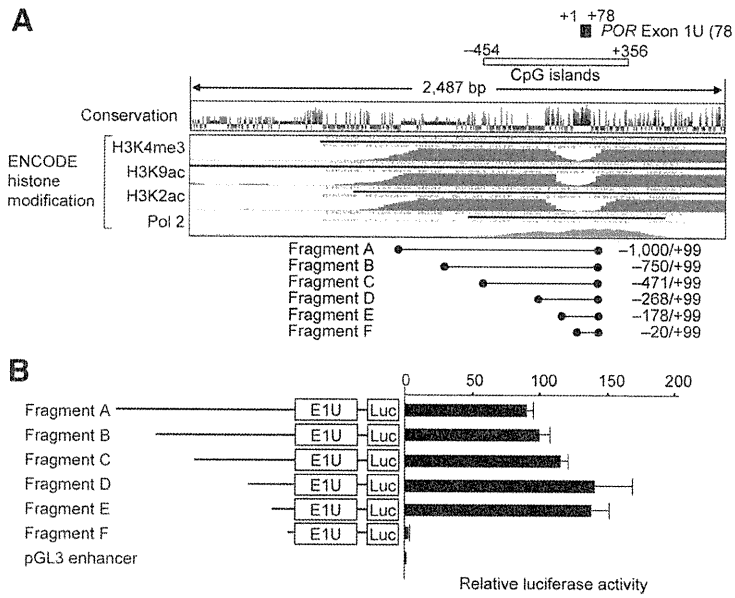

FIG. 2. Localization of the promoter region to a 178-bp segment just upstream of exon 1U. Panel A, *In silico* analysis in search of the promoter-compatible sequences. The transcription start site of *POR* exon 1U (+1) is based on the *POR* cDNA sequence at the NCBI database (NM_000941). The CpG-rich region spans from −454 to +356 bp. The ENCODE histone modification analysis indicates the presence of a highly conserved promoter-compatible sequence just upstream of exon 1U. The fragments A–F denote the DNA sequences used for the luciferase assays. Panel B, Luciferase reporter assays using the fragments A–F. The results are expressed as fold-change of the target vectors over the empty pGL3 enhancer vector (mean ± SEM). Transfections were performed in triplicate within a single experiment, and the experiments were repeated three times. Although the increase in the relative luciferase activity is significant for fragment A (92.6 ± 5.2, $P = 0.0006$), fragment B (101.6 ± 5.8, $P = 0.0006$), fragment C (106.0 ± 5.5, $P = 0.0004$), fragment D (137.7 ± 29.0, $P = 0.0009$), and fragment E (131.3 ± 13.4, $P = 0.0006$), it is not significant for fragment F (2.6 ± 1.1, $P = 0.25$).

DNA binding analysis

EMSA was performed as described previously (15). In brief, 10 μg of nuclear extracts of HEK 293 cells were incubated with ^{32}P-labeled oligonucleotides and unlabeled polydeoxyinosinic-deoxycytidylic acids and subjected to polyacrylamide gel electrophoresis (4%). For a competition experiment, a 200-fold molar excess of unlabeled competitor DNA was added. Supershift assay was performed by preincubating the nuclear extracts with anti-SP1 antisera (PEP2) and/or anti-SP3 antisera (D-20) (Santa Cruz Biotechnology, Santa Cruz, CA).

Methylation analysis

Bisulfite sequencing was performed for human leukocyte- and HEK 293-derived genomic DNA samples treated with the EZ DNA Methylation Kit (Zymo Research, Orange, CA) that converts all the cytosines except for methylated cytosines at the CpG dinucleotides into uracils and subsequently thymines. A 282-bp CpG-rich region containing SP1 binding sites just upstream of exon 1U was amplified with primer sets that hybridize to both methylated and unmethylated alleles because of absent CpG dinucleotides within the primer sequences. Subsequently, the PCR products were subcloned with the TOPO TA Cloning Kit (Life Technologies), and multiple clones were subjected to direct sequencing on the CEQ 8000 autosequencer (Beckman Coulter, Fullerton, CA).

Results

Identification and characterization of microdeletions in cases 1–3

Oligoarray CGH analysis indicated cryptic heterozygous deletions in cases 1–3 (Fig. 1). Furthermore, sequencing of the long PCR products harboring the fusion points revealed a 2,487-bp microdeletion (13,575,403–13,577,889 bp) encompassing exon 1U in case 1 and an identical 49,604-bp deletion (13,571,326–13,620,929 bp) involving exon 1U and exon 1 in cases 2 and 3. Thus, the 2,487-bp microdeletion on the noncoding upstream region was common to cases 1–3. The microdeletion in case

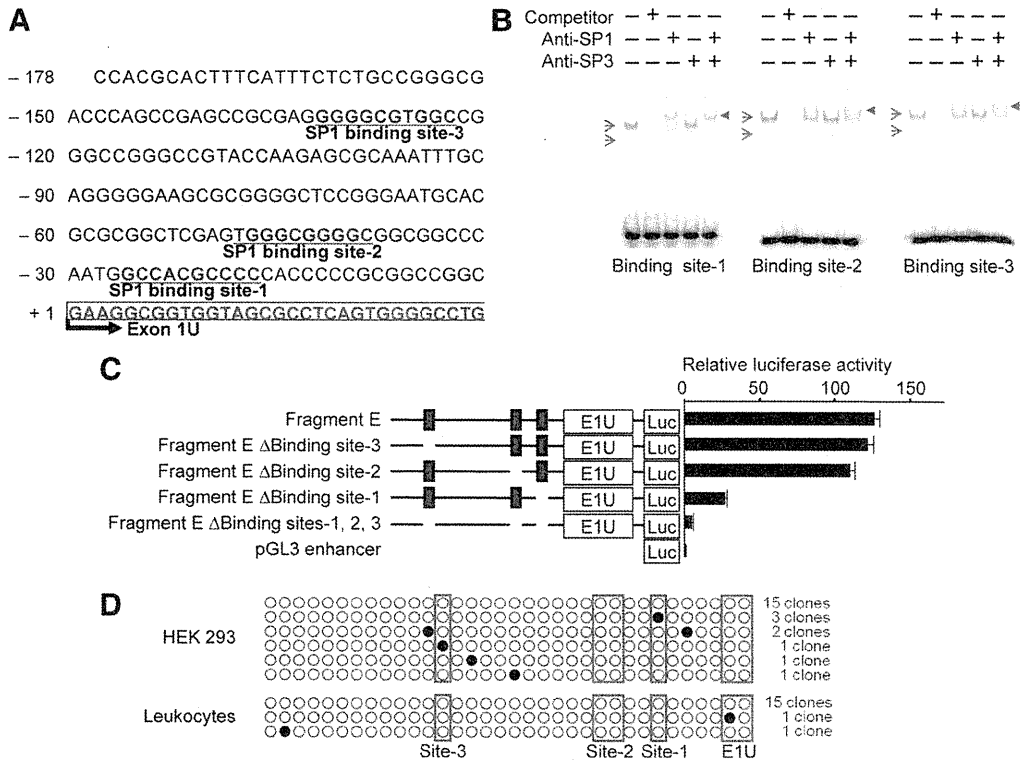

FIG. 3. Functional studies of the SP1 binding sites. Panel A, The three potential SP1 binding sites 1–3 at the position just upstream of exon 1U. The transcription start site of *POR* exon 1U (+1) is based on the *POR* cDNA sequence at the NCBI database (NM_000941). Panel B, EMSA showing positive bindings of SP1 and SP3 proteins to the SP1 binding sites 1–3. The *red arrows* indicate the strong bands derived from the SP1 protein binding to the probes containing the SP1 binding sites. These bands become weak, and supershifted bands (*red arrowheads*) are seen by adding anti-SP1. In addition, the *blue arrows* denote specific bands derived from the SP3 protein binding to the same probes. These bands become very weak by adding anti-SP3; the extremely faint supershifted bands are not visible in this figure. The band shift pattern is more obvious for SP1 protein than for SP3 protein. Panel C, Luciferase reporter assays using fragment E and its deletion mutants. The results are expressed as fold change of the target vectors over the empty pGL3 enhancer vector (mean ± SEM). Transfections were performed in triplicate within a single experiment, and the experiments were repeated three times. Although the relative luciferase activity is similar between Fragment E (121.8 ± 3.4) and ΔBinding site-3 (117.8 ± 3.1) ($P = 0.22$), it is significantly different between Fragment E and ΔBinding site-2 (105.7 ± 3.5) ($P = 0.015$), ΔBinding site-1 (25.8 ± 1.2) ($P = 0.0007$), and ΔBinding site-1, -2, and -3 (5.2 ± 0.5) ($P = 0.0004$). Panel D, Methylation analysis of the CpG-rich region. Each *circle* denotes a CpG island, and *filled* and *open circles* represent methylated and unmethylated cytosines, respectively. The CpG dinucleotides within the exon 1U are surrounded by *blue squares*, and those within the SP1 binding sites 1, 2, and 3 by *red squares*.

1 occurred between an *Alu* element and a nonrepeat sequence and was associated with an addition of a 47-bp segment of unknown origin, whereas that in cases 2 and 3 occurred between two *Alu* elements with an overlap of a 13-bp segment.

Critical function of the SP1 binding sites

In silico analysis for the noncoding 2,487-bp region showed an 810-bp long CpG-rich region involving exon 1U, an approximately 350-bp long evolutionally conserved sequence-rich region encompassing exon 1U, and an approximately 1.3-kb region with promoter-associated histone marks (Fig. 2A). The TATA box was not identified. Thus, relative luciferase activity was examined for fragments A–F with various lengths of the candidate promoter region, localizing a critical sequence for the *POR* promoter to a 178-bp segment defined by fragment E and fragment F (Fig. 2B).

The 178-bp segment was found to harbor three SP1 binding sites, *i.e.* site 1 at the position −26/−17, site 2 at the position −48/−39, and site 3 at the position −132/−123 (Fig. 3A). The three binding sites were well conserved in rats. EMSA indicated specific binding of SP1 and SP3 proteins to the three binding sites, with the band shift pattern being more obvious for SP1 protein than for SP3 protein (Fig. 3B). Deletion of the binding site 1 and the binding site 2 significantly reduced the relative luciferase activity (by ~80 and ~15%, respectively), although deletion of the binding site 3 had no significant effect on the relative luciferase activity; furthermore, loss of the binding sites 1–3 virtually abolished the relative luciferase activity (Fig. 3C). The 282-bp segment containing the three SP1 binding sites was almost completely unmethylated (Fig. 3D).

Furthermore, relative luciferase activity was examined for a 170-bp fragment (−120/+50) harboring the SP1 binding site 1 and the SP1 binding site 2, using SL2 cells devoid of endogenous SP families. Relative luciferase activity was clearly increased in a dose-dependent manner by adding the *SP1* expression vector but was barely elevated by adding the *SP3* expression vector (Fig. 4).

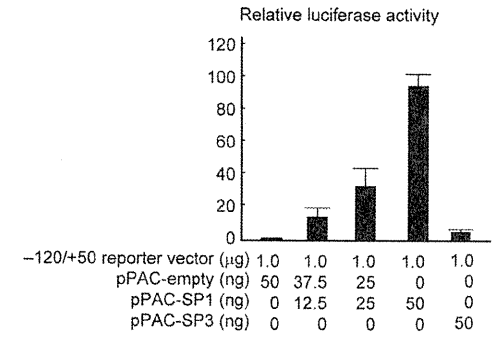

FIG. 4. Luciferase assays of a fragment containing the SP1 binding sites 1 and 2, using SL2 cells lacking endogenous SP families. The results are expressed as fold change of the target vectors over the empty pPAC vector (mean ± SEM). Transfections were performed in triplicate within a single experiment, and the experiments were repeated three times. The relative luciferase activity is significantly increased by adding the *SP1* expression vector of 12.5 ng (14.7 ± 4.4) ($P = 0.037$), 25.0 ng (31.8 ± 7.6) ($P = 0.035$), and 50 ng (95.8 ± 7.1) ($P = 0.0002$), although it is barely elevated by adding the *SP3* expression vector of 50 ng (5.2 ± 1.5) ($P = 0.054$).

Discussion

We identified two types of cryptic deletions, one involving exon 1U alone and the other encompassing exon 1U and exon 1, in three cases with PORD. The microdeletion in case 1 is explained by nonhomologous end joining that occurs between nonhomologous sequences and is frequently accompanied by an insertion of a short segment at the fusion point (16). The microdeletion in cases 2 and 3 is compatible with a repeat sequence mediated nonallelic intrachromosomal or interchromosomal recombination (16). Although cases 2 and 3 were apparently nonconsanguineous, it would not be unexpected that the same repeat-mediated genomic rearrangement took place in unrelated individuals. Notably, because the apparently normal allele in cases 1–3 was not transcribed (7), this implies that the 2,487-bp microdeletion common to cases 1–3 has affected the promoter function for *POR*. In this context, because approximately 12% of patients with PORD are known to be heterozygotes with one apparently normal *POR* allele (4), it might be possible that some, if not all, of them have similar microdeletions or other genetic aberrations affecting the *POR* transcription.

The present study revealed a pivotal role of the SP1 binding sites, especially the binding site 1, in the transcription of *POR*. This implies that the SP1 binding sites constitute an essential element of the *POR* proximal promoter. Indeed, SP1 binding sites as well as other noncore promoter elements are usually located in multiple copies within the proximal promoter region (~250 bp upstream of the transcription initiation site) of a ubiquitously expressed gene like *POR* (10). In this regard, several findings are noteworthy. First, the TATA box was apparently absent from the *POR* promoter region. This is compatible with the ubiquitous expression of *POR*, because the TATA box is usually identified in genes with a tissue-specific expression pattern (10). Second, the SP1 binding sites were highly conserved between the human and the rat. This finding, in conjunction with the previous data indicating absence of polymorphism for the three SP1 binding sites in 842 individuals (17), implies that the wild-type sequences of the SP1 binding sites are indispensable for the regulation of *POR* transcription. Third, the functional

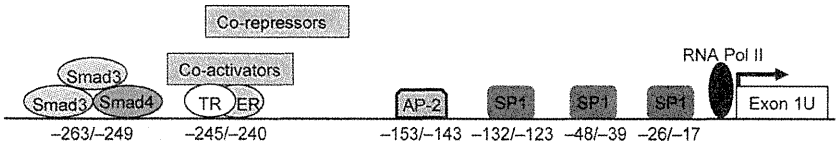

FIG. 5. Schematic representation indicating the binding sites for various factors in the proximal promoter region of *POR*. The diagram of the promoter upstream of −143 has been taken from Tee *et al.* (12). ER, Estrogen receptor; Pol II, polymerase II; TR, thyroid hormone receptor; AP-2, activator protein 2.

data using SL2 cells indicated a major role of SP1, rather than SP3, in the *POR* transcription. This is consistent with the notion that although both SP1 and SP3 can bind to the same cognate SP1 binding site, the DNA binding properties and regulatory functions are quite different between SP1 and SP3, depending on the promoter context and the cell type (18). Lastly, the SP1 binding sites were almost completely unmethylated. This argues for a transcriptionally active status of *POR*, because SP1 protein binding is known to be reduced when the CpG-rich region around the SP1 binding sites is methylated (19).

The proximal promoter region of *POR* has been studied previously (11, 12). Scott *et al.* (11) analyzed the 5′ region of *POR* coding exons by means of comparative genomics and characterized human *POR* exon 1U and its flanking sequences. Subsequently, Tee *et al.* (12) examined a 361-bp region around the transcription start site of exon 1U (−325/+36) using adrenal NCI-H295A and liver Hep-G2 cells and found a major trophic effect of thyroid hormone on *POR* expression primarily via thyroid hormone receptor-β as well as modulatory effects of thyroid hormone receptor-α, estrogen receptor-α, Smad3, and Smad4 on *POR* expression. The binding sites for these factors reside in a −263/−240 region upstream of the SP1 binding sites (Fig. 5). Furthermore, Tee *et al.* (12) screened functional alterations of polymorphisms within the 325-bp region, suggesting that the common −152C→A polymorphism may play a certain role in the genetic variation of steroid biosynthesis and drug metabolism. In this regard, whereas the −152C→A polymorphism resides on the AP-2 (activator protein 2) binding site, the functional difference of the polymorphism is obviously independent of the recruit of AP-2 (12). Thus, the underlying factors for the reduced activity of the −152A allele remain to be clarified.

Taken together, multiple regulatory elements have been identified in the proximal promoter region of *POR* (Fig. 5). Although the regulatory machinery has not yet been fully elucidated, we suggest that the presence of the SP1 binding sites has permitted the ubiquitous expression of *POR* and that the presence of other sites including thyroid hormone receptors is relevant to the variability in *POR* expression level among different tissues. In this regard, although the present study failed to identify the effects of the −263/−240 regulatory sequence identified by Tee *et al.* (12) (fragment D *vs.* fragment E in Fig. 2), this may be due to the difference in the cell type and/or in the promoter-luciferase construct used in the study by Tee *et al.* (+36) and in this study (+99). In addition, the hormonal effects on the *POR* transcription have not been examined in this study.

Finally, it would be useful to refer to clinical phenotypes of cases 1–3. In this context, we have previously compared clinical phenotype between Japanese PORD patients with homozygosity for the hypomorphic p.R457H mutation (group A) and those with compound heterozygosity for p.R457H and one apparently null mutation including nonsense and frameshift mutations (group B) and found that skeletal features are definitely more severe and adrenal dysfunction and 46,XY DSD are somewhat more severe in group B than in group A, whereas 46,XX DSD, maternal virilization during pregnancy, and anorectal and urinary anomalies are similarly identified in the two groups (5, 7). It is likely, therefore, that the residual POR activity reflected by the p.R457H dosage constitutes the underlying factor for clinical variability in some features but not in other features, probably due to the simplicity and complexity of POR-dependent metabolic pathways relevant to each phenotype. The clinical features of cases 1–3 are quite comparable to those of group B patients and, therefore, are consistent with transcription failure of one allele being a null mutation.

In summary, we identified microdeletions involving exon 1U and its upstream region in PORD patients, and revealed the critical function of the SP1 binding sites in the transcription of *POR*. Additional studies will permit to elucidate the regulatory machinery for *POR* expression.

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RESEARCH ARTICLE

AMERICAN JOURNAL OF medical genetics PART A

Submicroscopic Deletion in 7q31 Encompassing *CADPS2* and *TSPAN12* in a Child With Autism Spectrum Disorder and PHPV

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We performed array comparative genomic hybridization utilizing a whole genome oligonucleotide microarray in a patient with the autism spectrum disorders (ASDs) and persistent hyperplastic primary vitreous (PHPV). Submicroscopic deletions in 7q31 encompassing *CADPS2* (Ca^{2+}-dependent activator protein for secretion 2) and *TSPAN12* (one of the members of the tetraspanin superfamily) were confirmed. The *CADPS2* plays important roles in the release of neurotrophin-3 and brain-derived neurotrophic factor. Mutations in *TSPAN12* are a relatively frequent cause of familial exudative vitreoretinopathy. We speculate that haploinsufficiency of *CADPS2* and *TSPAN12* contributes to ASDs and PHPV, respectively.

Key words: *CADPS2*; *TSPAN12*; autism; PHPV; CGH

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INTRODUCTION

Autism spectrum disorders (ASDs OMIM %209850) are complex neurodevelopmental conditions characterized by social communication disabilities, no or delayed language development, and stereotyped and repetitive behaviors. A number of studies have confirmed that genetic factors play an important role in ASDs.

About 10% of ASDs are associated with a Mendelian syndrome (e.g., fragile X syndrome, tuberous sclerosis and Timothy syndrome). Cytogenetic approaches revealed a high frequency of large chromosomal abnormalities (3–7% of patients), including the most frequently observed maternal 15q11-13 duplication (1–3% of patients). Association studies and mutation analysis of candidate genes have implicated the synaptic genes *NLGN3*(Neuroligin3 OMIM*300336), *NLGN4* (OMIM*300427) [Jamain et al., 2003], *SHANK3* (OMIM*606230)[Durand et al., 2007; Moessner et al., 2007], *NRXN1*(Neurexin1 MIM + 600565) [Kim et al., 2008], *SHANK2* (OMIM*603290) [Berkel et al., 2010], and *CNTNAP2* (MIM*604569) [Alarcón et al., 2008; Arking et al., 2008] in ASDs. There is increasing evidence that the *SHANK3-NLGN4-NRNX1* postsynaptic density genes play important roles in the pathogenesis of ASDs.

Recently, on association between de novo copy number variation (CNV) and ASDs was revealed. Sebat et al. [2007] performed comparative genomic hybridization (CGH) on the genomic DNA from ASD patients and unaffected subjects to detect de novo CNV. As a result, they identified CNV in 12 out of 118 (10%) patients with sporadic ASD and confirmed de novo CNV were significantly associated with ASDs. Marshall et al. [2008] performed a genome-wide search for structural abnormalities in 427 unrelated ASD patients using SNP microarray analysis and karyotyping. De novo CNV were found in approximately 7% and approximately 2% of idiopathic families with one ASD child, or two or more ASD siblings, respectively. These authors discovered a CNV at 16p11.2 with an approximate frequency of 1%. Glessner et al. [2009] reported the results from a whole-genome CNV study of many European ASD patients and controls and found several new susceptibility genes encoding neuronal cell-adhesion molecules, including *NLGN1* and *ASTN2*, and genes involved in the ubiquitin pathways, including *UBE3A*, *PARK2*, *RFWD2*, and *FBXO40*. The investigators suggested that two gene networks, neuronal cell-

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adhesion and ubiquitin degradation, that are expressed within the central nervous system contribute to the genetic susceptibility of ASDs.

The International Molecular Genetic Study of Autism Consortium [1998] previously identified linkage loci on chromosomes 7 and 2, which were termed AUTS1 and AUTS5, respectively. Further genetic studies have provided evidence for AUTS1 being located on chromosome 7q [The International Molecular Genetic Study of Autism Consortium 2001]. Screening for mutations in six genes mapping to 7q, *CUTL1*, *SRPK2*, *SYPL*, *LAMB1*, *NRCAM*, and *PTPRZ1* in 48 unrelated individuals with autism led to the identification of several new coding variants in the *CUTL1*, *LAMB1*, and *PTPRZ1*genes [Bonora et al., 2005].

The human Ca^{2+}-dependent activator protein for secretion 2 (*CADPS2*: OMIM*609978) is also located on chromosome 7q31, which is within the AUTS1 locus [Cisternas et al., 2003]. It is a member of the CAPS/CADPS protein family that regulates the secretion of dense-core vesicles, which are abundant in the parallel fiber terminals of granule cells in the cerebellum and play important roles in the release of neurotrophin-3 (NT-3) and brain-derived neurotrophic factor (BDNF) [Sadakata et al., 2007a,b,c]. BDNF is indispensable for brain development and function, including the formation of synapses. Cisternas et al. [2003] studied *CADPS2* mutations in 90 unrelated autistic individuals, but identified no disease-specific variants. However, Sadakata et al. [2007a] reported that an aberrant, alternatively spliced *CADPS2* mRNA that lacks exon 3 (*CADPS2* Delta exon3) is detected in some patients with ASD.

Persistent hyperplastic primary vitreous (PHPV) is an ocular malformation caused by the presence of a retrolental fibrovascular membrane and the persistence of the posterior portion of the tunica vasculosa lentis and the hyaloid artery. It is often accompanied by microphthalmos, cataracts, and glaucoma. *NDP* (OMIM *300658, X-linked) and *FZD4* (OMIM *604579, dominant) were found to be mutated in unilateral and bilateral PHPV [Shastry, 2009]. These genes also cause Norrie disease and familial exudative vitreoretinopathy (FEVR), which share some clinical features with PHPV. FEVR is a genetically heterogeneous retinal disorder characterized by abnormal vascularization of the peripheral retina, which is often accompanied by retinal detachment. Mutations in the genes encoding *LRP5* (OMIM *603506, dominant and recessive) also cause FEVR. Junge et al. [2009] showed that *Tetraspanin12* (*Tspan12*) is expressed in the retinal vasculature, and loss of *Tspan12* phenocopies defects are seen in Fzd4, *Lrp5*, and *Norrin* mutant mice. *TSPAN12* is one of the members of the tetraspanin superfamily, characterized by the presence of four transmembrane domains. It constitutes large membrane complexes with other molecules. Nikopoulos et al. [2010] applied next-generation sequencing and found a mutation in *TSPAN12* (MIM*613168). Poulter et al. [2010] described seven mutations that were identified in a cohort of 70 FEVR patients without mutations in three known genes. Mutations in *TSPAN12*, which is at 7q31, are a relatively frequent cause of FEVR.

We performed array comparative genomic hybridization (array-CGH) utilizing a 44K whole genome oligonucleotide microarray in a patient with the ASDs and PHPV. Submicroscopic deletions in 7q31 encompassing *CADPS2* and *TSPAN12* were confirmed. We speculate that haploinsufficiency of *CADPS2* and *TSPAN12* contributes to ASD and PHPV, respectively.

CLINICAL REPORT

The patient, a 3-year-old boy, was born to nonconsanguineous healthy Japanese parents. His family history was unremarkable. He was born at 40 weeks' of gestation, his birth weight was 3,100 g, and his birth length was 50.0 cm. After birth, congenital nystagmus was noted, and he did not pursuit objects. An ophthalmological examination revealed bilateral PHPV. Cataract, glaucoma, and FEVR were not present. His gross motor development was normal, and his verbal development was delayed.

At 3 years of age, he came to our hospital for evaluation because of developmental delay. On examination dysmorphic features included a round face, low-set ears, broad eyebrows, apparent hypertelorism, blepharophimosis, hypoplastic alae nasi, a long philtrum, and a small mouth. His visual acuity was low, but he could perform daily activities with some support. In addition, impairment of social interaction, poor social skills, and strict adherence to routine behaviors were noted. He showed stereotypic movements and hyperactivity in his day care room. He was diagnosed as having an ASD according to the DSM-VI criteria. His DQ was 76 according to standard Japanese method. At 3 years and 8 months of age, his height, weight, and head circumference were 88.6 cm (−2.4 SD), 11.7 kg (−1.8 SD), and 46.8 cm (−2.4 S.D), respectively.

The results of routine laboratory tests were unremarkable. G-banded karyotype analysis revealed the following karyotype: 46,XY,inv(4)(p14;q21). Electroencephalography (EEG) showed occipital epileptic discharges. He was free from epileptic seizures.

Ultrasound evaluation revealed echogenic bands in the posterior segments of both globes. Magnetic resonance brain imaging also showed bilateral fibrous intraocular tissue (Fig. 1). However, no specific findings were found in the CNS including the cerebellum.

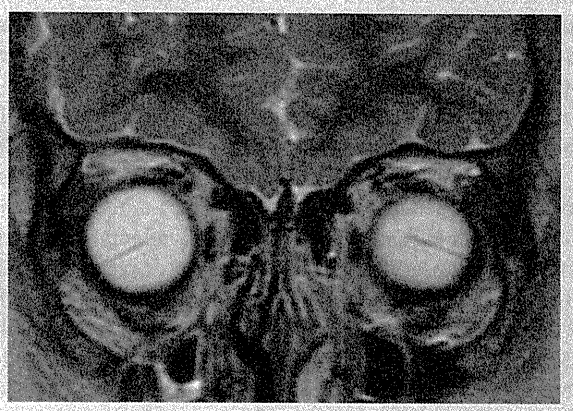

FIG. 1. MR coronal image, T2-weighted. Magnetic resonance imaging also showed fibrous intraocular tissue in the eye. [Color figure can be seen in the online version of this article, available at http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1552-4833]

MATERIALS AND METHODS

After obtaining informed consent based on a permission approved by the institution's ethical committee, peripheral blood samples were obtained from the patient and his parents. Genomic DNA was extracted using the QIAquick DNA extraction kit (QIAgen, Valencia, CA).

Array-CGH analysis was performed using the Human Genome CGH Microarray 44K (Agilent Technologies, Santa Clara, CA), as described previously [Shimojima et al., 2009].

Metaphase nuclei were prepared from peripheral blood lymphocytes using standard methods and were used for FISH analysis with human BAC clones selected from the UCSC genome browser (http://www.genome.ucsc.edu), as described elsewhere [Shimojima et al., 2009]. Physical positions refer to the March 2006 human reference sequence (NCBI Build 36.1).

RESULTS

Using array-CGH analysis, genomic copy number loss was identified in the 7q31.31 region (Fig. 2). The deletion was 5.4 Mb in size and included *CADPS2* and *TSPAN12*, but not *FOXP2*. There were no copy number changes in chromosome 4. FISH analyses confirmed the above deletion (Fig. 3). There were no deletions in either parent indicating de novo occurrence.

DISCUSSION

We described a patient with an ASD and PHPV who demonstrated submicroscopic deletion in chromosome 7q31.31. The deletion resides in the AUTS1 locus on chromosome 7q. The deleted region contained about 20 genes including *CADPS2* and *TSPAN12*. Little data are available about the association of other genes with developmental and ophthalmological disorders. We posit that haploinsufficiency of *CADPS2* and *TSPAN12* contributes to ASDs and PHPV, respectively.

Our patient fulfilled the DSM-VI criteria for an ASD. Poor eye contact, impairment of social interaction, poor social skills with strict adherence to routine, stereotypic movements, and hyperactivity were noted. However, his intellectual disability was mild. Ataxic movement was not observed.

There have been several reports of small deletions on chromosome 7q. Lennon et al. [2007] reported a young male with moderate intellectual disability, dysmorphic features, and language delay who had a deletion in the 7q31.1-7q31.31 region, which included the *FOXP2* gene. The patient demonstrated language impairment, including developmental verbal dyspraxia, but did not meet the criteria for autism. Cukier et al. [2009] reported a chromosomal inversion spanning the region from approximately 7q22.1 to 7q31 in autistic siblings. They suggested that an autism susceptibility gene is located in the chromosome 7q22–31 region. Dauwerse et al.

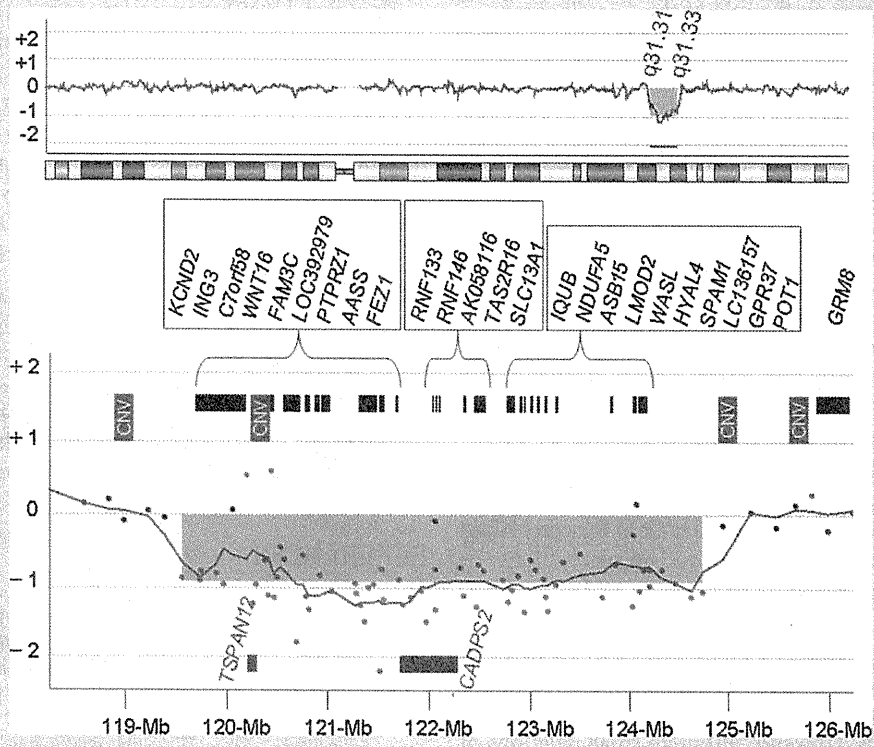

FIG. 2. Array-CGH of the patient. Loss of the genomic copy numbers was identified in the region of 7q31.31. The deletion size was 5.4 Mb and included *CADPS2* and *TSPAN12*.