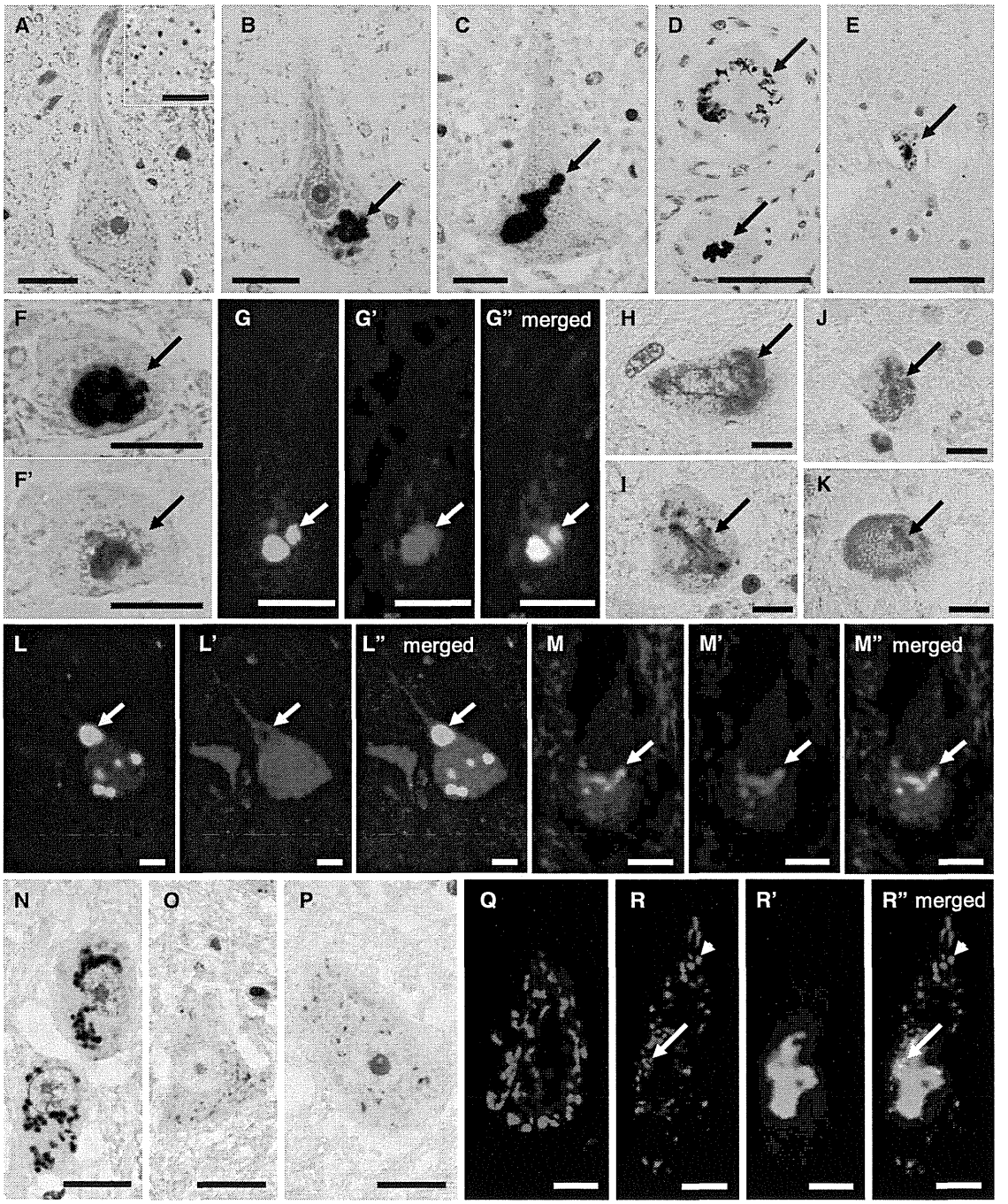

Figure 4. TFG-Related Neuropathological Findings

(A) TFG immunostaining (with hematoxylin counterstaining) of a motor neuron in the spinal cord of a neurologically normal control. A high-power magnified photomicrograph (inset) shows fine granular staining of TFG in the cytoplasm. The scale bars represent 20 μm (main panel) and 10 μm (inset).

(B–E) TFG-immunopositive inclusions of the neurons (with hematoxylin counterstaining) in the hypoglossal nucleus (B), anterior horn of the spinal cord (C), dorsal root ganglion (D, arrows), and motor cortex (E, arrow) of the patient with the *TFG* mutation. The scale bars represent 20 μm (B–D) and 50 μm (E).

(F and F′) Serial section analysis of the facial nucleus motor neuron showing an inclusion body colabeled for TFG (F) and ubiquitin (F′). The scale bars represent 20 μm.

(G–G″) Double immunofluorescence microscopy confirming colocalization of TFG (green) and ubiquitin (red) in an inclusion body of a motor neuron in the hypoglossal nucleus. The scale bars represent 20 μm.

(H and I) TDP-43-positive skein-like inclusions in the motor neurons of the abducens nucleus (H) and anterior horn of the lumbar cord (I). The scale bars represent 20 μm.

(J and K) Phosporylated TDP-43-positive inclusion bodies in the cervical anterior horn (J) and Clarke's nucleus (K). The scale bars represent 20 μm.

(L–L″) Round inclusions (arrows) positive for TFG (green) but negative for TDP-43 (red). The scale bars represent 20 μm.

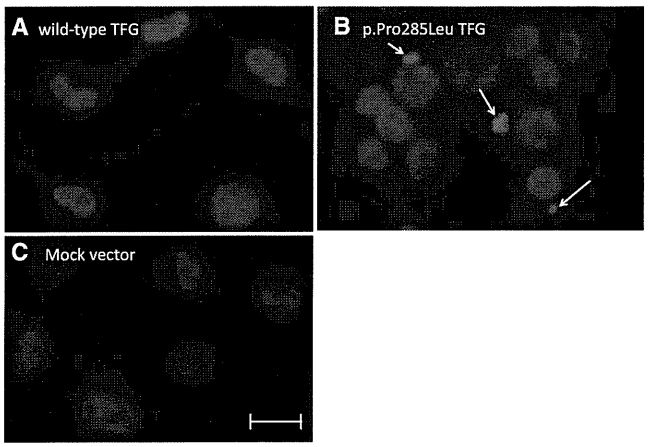

Figure 5. Formation of Cytoplasmic TDP-43 Aggregation Bodies in Cells Stably Expressing Mutant p.Pro285Leu TFG
The coding sequence of *TFG* cDNA was subcloned into pBluescript (Stratagene). After site-directed mutagenesis with a primer pair shown in Table S9, the mutant cDNAs were cloned into the BamHI and XhoI sites of pcDNA3 (Life Technologies). Stable cell lines were established by Lipofectamine (Life Technologies) transfection according to the manufacturer's instructions. Established cell lines were cultured under the ordinary cell-culture conditions (37°C and 5% CO_2) for 5–6 days and were subjected to immunocytochemical analyses. Neuro-2a cells stably expressing wild-type TFG (A), mutant TFG (p.Pro285Leu) (B), and a mock vector (C) are shown. TDP-43-immunopositive cytoplasmic inclusions are absent in the cells stably expressing wild-type TFG or the mock vector (A and C); however, TDP-43-immunopositive cytoplasmic inclusions were exclusively demonstrated in cells stably expressing mutant TFG (p.Pro285Leu), as indicated by arrows (B). Similar results were obtained with HEK 293 cells (not shown). Scale bars represent 10 μm.

a TGN46 antibody. It revealed that the Golgi apparatus was fragmented in approximately 70% of the remaining motor neurons in the lumbar anterior horn. The fragmentation of the Golgi apparatus was prominent near TFG-positive inclusion bodies (Figures 4N–4R). In summary, we found abnormal TDP-43-immunopositive inclusions in the cytoplasm of motor neurons, as well as fragmentation of the Golgi apparatus in HMSN-P, confirming the overlapping neuropathological features between HMSN-P and sporadic ALS.

To further investigate the effect of mutant TFG in cultured cells, stable cell lines expressing wild-type and mutant TFG (p.Pro285Leu) were established from neuro-2a and human embryonic kidney (HEK) 293 cells as previously described.[18] Established cell lines were cultured under the ordinary cell-culture conditions (37°C and 5% CO_2) for 5–6 days and were subjected to immunocytochemical analyses. The neuro-2a cells stably expressing wild-type or mutant TFG demonstrated no distinct difference in the distribution of endogenous TFG, FUS, or OPTN (data not shown). In contrast, cytoplasmic inclusions containing endogenous TDP-43 were exclusively observed in the neuro-2a cells stably expressing untagged mutant TFG, but not in those expressing wild-type TFG (Figure 5). Similar data were obtained from HEK 293 cells (data not shown). Thus, the expression of mutant TFG leads to mislocalization and inclusion-body formation of TDP-43 in cultured cells.

TFG was originally identified as a part of fusion oncoproteins (NTRK1-T3 in papillary thyroid carcinoma,[19] TFG-ALK in anaplastic large cell lymphoma,[20] and TFG/NOR1 in extraskeletal myxoid chondrosarcoma[21]), where the N-terminal portions of TFG are fused to the C terminus of tyrosine kinases or a superfamily of steroid-thyroid hormone-retinoid receptors acting as a transcriptional activator leading to the formation of oncogenic products. Very recently, TFG-1, a homolog of TFG in *Caenorhabditis elegans*, and TFG have been discovered to localize in endoplasmic-reticulum exit sites. TFG-1 acts in a hexameric form that binds the scaffolding protein Sec16 complex assembly and plays an important role in protein secretion with COPII-coated vesicles.[22] It is noteworthy that mutations in genes involved in vesicle trafficking[23,24] (such genes include *VAPB*, *CHMP2B*, *alsin*, *FIG4*, *VPS33B*, *PIP5K1C*, and *ERBB3*) cause motor neuron diseases, emphasizing the role of vesicle trafficking in motor neuron diseases. Thus, altered vesicle trafficking due to the *TFG* mutation might be involved in the motor neuron degeneration in HMSN-P. The presence of TFG-immunopositive inclusions in motor neurons raises the possibility that mutant TFG results in the misfolding and formation of cytoplasmic aggregate bodies, as well as altered vesicle trafficking.

An intriguing neuropathological finding is TDP-43-positive cytoplasmic inclusions in the motor neurons; these inclusions have recently been established as the fundamental neuropathological findings in ALS.[13,14] Of note, expression of mutant, but not wild-type, TFG in cultured cells led to the formation of TDP-43-containing cytoplasmic aggregation. These observations are similar

(M–M″) An inclusion immunopositive for both TFG (green) and TDP-43 (red) is observed in a small number of neurons. The scale bars represent 20 μm.
(N) Normal Golgi apparatus in the neurons of the intact thoracic intermediolateral nucleus. The scale bar represents 20 μm.
(O and P) Fragmentation of the Golgi apparatus with small, round, and disconnected profiles in the affected motor neurons of the lumbar anterior horn. The scale bars represent 20 μm.
(Q–R″) Immunohistochemical observations of the Golgi apparatus and TFG-immunopositive inclusions employing antibodies against TGN46 (red) and TFG (green), respectively. The scale bars represent 10 μm.
(Q) Normal size and distribution (red) in a motor neuron without inclusions.
(R–R″) The Golgi apparatus was fragmented into various sizes and reduced in number in the lumbar anterior horn motor neuron with TFG-positive inclusions (green). The fragmentation predominates near the inclusion (arrow), whereas the Golgi apparatuses distant from the inclusion showed nearly normal patterns (arrow head).

to what has been described for ALS, where TDP-43 is mislocalized from the normally localized nucleus to the cytoplasm with concomitant cytoplasmic inclusions. Cytoplasmic TDP-43 accumulation and inclusion formation have also been observed in motor neurons in familial ALS with mutations in *VAPB* (MIM 608627) or *CHMP2B* (MIM 600795).[25,26] Furthermore, TDP-43 pathology has been demonstrated in transgenic mice expressing mutant VAPB.[27] Although the mechanisms of mislocalization of TDP-43 remain to be elucidated, these observations suggest connections between alteration of vesicle trafficking and mislocalization of TDP-43. Thus, common pathophysiologic mechanisms might underlie motor neuron degenerations involving vesicle trafficking including TFG, as well as VAPB and CHMP2B. Because TDP-43 is an RNA-binding protein, RNA dysregulation has been suggested to play important roles in the TDP43-mediated neurodegeneration.[28] Furthermore, recent discovery of hexanucleotide repeat expansions in *C9ORF72* in familial and sporadic ALS/FTD (MIM 105550)[29,30] emphasizes the RNA-mediated toxicities as the causal mechanisms of neurodegeneration. Observations of TDP-43-positive cytoplasmic inclusions in the motor neurons of the patient with HMSN-P raise the possibility that RNA-mediated mechanisms might also be involved in motor neuron degeneration in HMSN-P.

In summary, we have found that *TFG* mutations cause HMSN-P. The presence of TFG/ubiquitin- and/or TDP-43-immunopositive cytoplasmic inclusions in motor neurons and cytosolic aggregation composed of TDP-43 in cultured cells expressing mutant TFG indicate a novel pathway of motor neuron death.

Supplemental Data

Supplemental Data include three figures and nine tables and can be found with this article online at http://www.cell.com/AJHG/.

Acknowledgments

The authors thank the families for participating in the study. We also thank the doctors who obtained clinical information of the patients. This work was supported in part by Grants-in-Aid for Scientific Research on Innovative Areas (22129002); the Global Centers of Excellence Program; the Integrated Database Project; Scientific Research (A) (B21406026) and Challenging Exploratory Research (23659458) from the Ministry of Education, Culture, Sports, Science, and Technology of Japan; a Grant-in-Aid for Research on Intractable Diseases and Comprehensive Research on Disability Health and Welfare from the Ministry of Health, Labour, and Welfare, Japan; Grants-in-Aid from the Research Committee of CNS Degenerative Diseases; the Ministry of Health, Labour, and Welfare of Japan; the Charcot-Marie-Tooth Association; and the National Medical Research Council of Australia. H.I. was supported by a Research Fellowship from the Japan Society for the Promotion of Science for Young Scientists. We also thank S. Ogawa (Cancer Genomics Project, The University of Tokyo) for his kind help in the analyses employing GAIIx and SOLiD4.

Received: April 16, 2012
Revised: May 27, 2012
Accepted: July 2, 2012
Published online: August 9, 2012

Web Resources

The URLs for data presented herein are as follows.

1000 Genomes Project Database, http://www.1000genomes.org/
dbSNP, http://www.ncbi.nlm.nih.gov/projects/SNP/
HapMap, http://hapmap.ncbi.nlm.nih.gov/
NHLBI GO Exome Sequencing Project, https://esp.gs.washington.edu/drupal/
Online Mendelian Inheritance in Man (OMIM), http://www.omim.org
PolyPhen, http://genetics.bwh.harvard.edu/pph/
RefSeq, http://www.ncbi.nlm.nih.gov/projects/RefSeq/
UCSC Human Genome Browser, http://genome.ucsc.edu/

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Neurobiology of Disease 45 (2012) 862–870

Contents lists available at SciVerse ScienceDirect

Neurobiology of Disease

journal homepage: www.elsevier.com/locate/ynbdi

Oxidative stress induced by glutathione depletion reproduces pathological modifications of TDP-43 linked to TDP-43 proteinopathies

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ARTICLE INFO

Article history:
Received 30 March 2011
Revised 29 August 2011
Accepted 4 December 2011
Available online 13 December 2011

Keywords:
TAR DNA-binding protein 43 kDa (TDP-43)
TDP-43 proteinopathy
Oxidative stress
Glutathione depletion
Post-translational modification
Protein phosphorylation

ABSTRACT

TAR DNA-binding protein 43 (TDP-43) is a major component of ubiquitin-positive inclusion of TDP-43 proteinopathies including amyotrophic lateral sclerosis and frontotemporal lobar degeneration with ubiquitinated inclusions, which is now referred to as FTLD-TDP. TDP-43 in the aberrant inclusion is known to be hyperphosphorylated at C-terminal sites, to be truncated at the N-terminal region, and to re-distribute from nucleus to cytoplasm or neurite. The pathogenic role of these modifications, however, has not been clarified. Furthermore, there is no evidence about the initial cause of these modifications. Herein we show that ethacrynic acid (EA), which is able to increase cellular oxidative stress through glutathione depletion, induces TDP-43 C-terminal phosphorylation at serine 403/404 and 409/410, insolubilization, C-terminal fragmentation, and cytoplasmic distribution in NSC34 cells and primary cortical neurons. In the investigation using a nonphosphorylable mutant of TDP-43, there was no evidence that C-terminal phosphorylation of TDP-43 contributes to its solubility or distribution under EA induction. Our findings suggest that oxidative stress induced by glutathione depletion is associated with the process of the pathological TDP-43 modifications and provide new insight for TDP-43 proteinopathies.

Introduction

TAR DNA-binding protein 43 (TDP-43) is a major component of ubiquitin-positive inclusion, a pathological hallmark of TDP-43 proteinopathies including amyotrophic lateral sclerosis (ALS) and frontotemporal lobar degeneration with ubiquitinated inclusions, which is now referred to as FTLD-TDP (Arai et al., 2006; Neumann et al., 2006). Both diseases occur in sporadic or familial forms, and are characterized by late-onset progressive deterioration of motor and/or cognitive function. TDP-43 is a heterogeneous nuclear ribonucleoprotein (hnRNP), which is known to regulate gene transcription and exon splicing through interactions with RNA, hnRNPs, and nuclear bodies (Ayala et al., 2005; Buratti et al., 2005; Wang et al., 2002, 2004). In addition, this protein has also been reported to stabilize human low molecular weight neurofilament (hNFL) mRNA through direct interaction with its 3'UTR (Strong et al., 2007), regulate retinoblastoma protein phosphorylation through the repression of cyclin-dependent kinase 6 (Cdk6) expression (Ayala et al., 2008), regulate activity of Rho family GTPases (Iguchi et al., 2009), and alter the expression of selected microRNAs, such as let-7b and miR-663 (Buratti et al., 2010). Furthermore, very recent works using cross-linking immunoprecipitation sequencing show that multiple RNAs interact with TDP-43 (Polymenidou et al., 2011; Sephton et al., 2011; Tollervey et al., 2011).

Although it mostly localizes in the nucleus under normal conditions, TDP-43 is distributed from nucleus to cytoplasm or neurite, and forms aggregates consisting mainly of C-terminal fragments in affected neurons of patients with TDP-43 proteinopathies. In addition, TDP-43 in the aberrant aggregation is hyperphosphorylated at multiple C-terminal sites (Hasegawa et al., 2008). However, neither the pathogenic role nor the initial cause of these abnormal modifications of TDP-43 has been elucidated. The fact that the majority of patients with TDP-43 proteinopathies are sporadic suggests that exogenous factors induce post-translational modifications of TDP-43 that are seen in the disease. Furthermore, TDP-43 inclusions have also been observed in Alzheimer disease (AD), Parkinson disease (PD),

Abbreviations: TDP-43, TAR DNA-binding protein of 43 kDa; ALS, amyotrophic lateral sclerosis; hnRNP, heterogeneous nuclear ribonucleoprotein; hNFL, human low molecular weight neurofilament; Cdk6, cyclin-dependent kinase 6; ROS, reactive oxygen species; EA, ethacrynic acid; NAC, N-acetylcysteine; CK1, casein kinase 1; CK2, casein kinase 2; WT-TDP-43, wild type TDP-43; SA-TDP-43, nonphosphorylable TDP-43.

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Available online on ScienceDirect (www.sciencedirect.com).

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doi:10.1016/j.nbd.2011.12.002

dementia with Lewy bodies (DLB), and Huntington disease (HD), argyrophilic grain disease, suggesting that the aggregation of this protein may be a secondary feature of neurodegeneration (Amador-Ortiz et al., 2007; Arai et al., 2009, 2010; Geser et al., 2008; Hasegawa et al., 2007). These findings complicate understanding of the pathogenic role of TDP-43. On the other hand, there is considerable evidence that reactive oxygen species (ROS) and oxidative stress are associated with many neurodegenerative conditions including ALS (Abe et al., 1995, 1997; Beal et al., 1997; Butterfield et al., 2007; Ferrante et al., 1997; Lovell and Markesbery, 2007; Nunomura et al., 2002; Shaw et al., 1995). Herein we show that oxidative stress induced by glutathione depletion reproduces the pathological modifications of TDP-43, that are seen in TDP-43 proteinopathies, in motor neuron-like cells and primary cortical neurons.

Materials and methods

Cell culture and treatment

Mouse NSC34 motor neuron-like cells (a kind gift of N.R. Cashman, University of British Columbia, Vancouver, Canada) were cultured in a humidified atmosphere of 95% air-5% CO2 in a 37 °C incubator in Dulbecco's Modified Eagle's Medium (DMEM) supplemented with 10% fetal bovine serum (FBS). To differentiate the cells, the medium was changed to DMEM containing 1% FBS and 1% NEAA, and was cultured for 24 h. For the interventions, the cells were then incubated with ethacrynic acid (EA) (Sigma-Aldrich, St. Louis, MO), with or without N-acetylcysteine (NAC) (Sigma-Aldrich), casein kinase 1 (CK1) inhibitor (D4476), or casein kinase 2 (CK2) inhibitor (TBCA) (Sigma-Aldrich). Primary cultures of mouse embryonic cortical neurons that were dissociated from embryonic cortex of embryonic day 15 (E15) C57BL/6 J pregnant mice were plated onto poly-L-lysine-coated plates or glass bottom dishes, and maintained in neuron culture medium (Sumilon, Osaka, Japan). Five days after the incubation, the indicated interventions were performed. In both NSC34 cells and primary cortical neurons, the transfections of the intended plasmids were performed using Lipofectamine 2000 (Invitrogen, Eugene, OR), according to the manufacturer's instructions.

DNA constructs

Human wild type TDP-43 (WT-TDP-43) (accession number NM 007375) cDNA was amplified by PCR from cDNA of human spinal cord using the following primers: 5′-CACCATGTCTGAATATATTCGGGTAAC-3′ and 5′-CTACATTCCCCAGCCAGAAGACTTAGAAT-3′. The PCR product was cloned into the pENTR/D-TOPO vector (Invitrogen). For nonphosphorylable TDP-43 (SA-TDP-43) vector, primers containing the mutant substitution of TDP-43 serine 403/404 and 409/410 to alanine were used to mutagenize WT-TDP-43 (KOD-Plus-Mutagenesis kit; Toyobo, Osaka, Japan). The entry vector of WT- or SA-TDP-43 was transferred into pcDNA6.2/N-EmGFP-DEST Vector or pcDNA3.1/nV5-DEST using Gateway LR Clonase II enzyme mix (Invitrogen). The sequences of all constructs were verified using CEQ 8000 genetic analysis system (Beckman Coulter, Brea, CA).

Immunoblot analysis

For whole lysate analysis, NSC34 cells and primary cortical neurons were lysed in 2% SDS sample buffer. For analysis of protein solubility, cells cultured in 6-well plates were lysed in 100 μl of Tris (TS) buffer (50 mM Tris–HCl buffer, pH 7.5, 0.15 M NaCl, 5 mM EDTA, 5 mM EGTA, protein phosphatase inhibitors, and protease inhibitor cocktail). Lysates were sonicated and centrifuged at 100,000 ×*g* for 15 min. To prevent carryover, the pellets were washed with TS buffer, followed by sonication and centrifugation. TS-insoluble pellets were lysed in 50 μl of Triton-X100 (TX) buffer (TS buffer containing 1% Triton X-100), sonicated, and centrifuged at 100,000 *g* for 15 min. The pellets were washed with TX buffer, followed by sonication and centrifuge. TX-insoluble pellets were lysed in 50 μl of Sarkosyl (Sar) buffer (TS buffer containing 1% Sarkosyl), sonicated and centrifuged at 100,000 × g for 15 min. Sar-insoluble pellets were lysed in 25 μl of SDS sample buffer. After denaturation, 3 μl of each cell lysate was separated by SDS-PAGE (5%–20% gradient gel) and analyzed by western blotting with ECL Plus detection reagents (GE Healthcare, Buckinghamshire, UK). Primary antibodies used were as follows: anti-TDP-43 rabbit polyclonal antibody (1:1000, ProteinTech, Chicago, IL), anti-TDP-43 (405–414) rabbit polyclonal antibody (1:1000, Cosmo Bio Co. Ltd., Tokyo, Japan), anti-TDP-43 (phospho Ser403/404, Cosmo Bio) rabbit polyclonal antibody (1:1000, Cosmo Bio), anti-TDP-43 (phospho Ser409/410, Cosmo Bio) rabbit polyclonal antibody (1:1000, Cosmo Bio), anti-GAPDH mouse monoclonal antibody (1:2000, Temecula, CA), anti-GFP mouse monoclonal antibody (1:2000, MBL, Nagoya, Japan), and anti-V5 mouse monoclonal antibody (1:2000, Invitrogen).

Assay of ROS production

NSC34 cells to be treated with intended agents were incubated in 96-well plates with 5-(and-6)-chloromethyl-2′,7′-dichlorodihydro fluoresceindiacetate acetyl ester (CM-H2DCFDA) (Molecular Probes, Eugene, OR, USA) for 1 h. Oxidation in the cells was then measured in a multiple-plate reader (PowerscanHT, Dainippon Pharmaceutical, Japan) at excitation and emission wavelengths of 485 nm and 530 nm, respectively. The assays were carried out in 6 wells for each condition.

Immunocytochemistry

NSC34 cells and primary cortical neurons were fixed with 4% paraformaldehyde, incubated with PBS containing 0.2% Triton X-100 for 5 min, blocked, and incubated overnight with anti-TDP-43 rabbit polyclonal antibody (1:1000, ProteinTech), anti-TDP-43 (phospho Ser409/410) mouse monoclonal antibody (1:2000, Cosmo Bio) and anti-TIAR mouse monoclonal antibody (1:1000, BD Transduction Laboratories, Milan, Italy). After washing, samples were incubated with Alexa-488-conjugated goat anti-rabbit IgG (1:1000, Invitrogen) and Alexa-564-conjugated goat anti-mouse IgG (1:1000, Invitrogen) for 30 min, mounted with (Vector Laboratories, Inc. Burlingame, CA), then imaged with a laser conforcal microscope (Nikon A1, Nikon, Tokyo, Japan).

Time lapse analysis

NSC34 cells or mouse primary cortical neurons were grown on glass base dishes, transfected with GFP-WT-TDP-43, and treated with EA. GFP and phase contrast imaging was done every 10 min using a 40X objective lens on a laser scanning confocal microscope.

Cell viability analysis

The 3-(4,5-dimethylthiazol-2-yl)-5-(3-caboxymethoxyphenyl)-2-(4-sulfophenyl)-2H -tetrazolium (MTS)-based cell proliferation assay (MTS assay) was carried out using the CellTiter 96 Aqueous One Solution Cell Proliferation Assay (Promega, Madison, WI), according to the manufacturer's instructions. Absorbance at 490 nm was measured in a multiple-plate reader (PowerscanHT, Dainippon Pharmaceutical, Japan). The assays were carried out in 6 wells for each condition.

Statistical analysis

Statistical differences were analyzed by ANOVA and Bonferroni post hoc analyses for three group comparisons (SPSS version 15.0, SPSS Inc., Chicago, IL). Two-tailed $p<0.05$ was regarded as statistically significant.

Results

EA-mediated oxidative stress induces TDP-43 phosphorylation in NSC34 cells

To investigate the effect of oxidative stress on endogenous TDP-43, NSC34 cells were incubated for 12 h with EA, which is able to increase cellular oxidative stress through depletion of glutathione, (Keelan et al., 2001; Rizzardini et al., 2003). Immunoblots showed abnormal TDP-43-immunoreactive bands at 45 kDa, which suggests hyperphosphorylation of TDP-43, at EA concentration greater than 50 μM EA (Fig. 1A). The bands were immunopositive for phospho-TDP-43-specific (pTDP-43) antibodies at serine 403/404 and serine 409/410 (S403/404 and S409/410), that are seen in TDP-43 proteinopathies as pathological phosphorylation (Hasegawa et al., 2008) (Fig. 1A). In addition, phosphorylation of these TDP-43 sites was prevented by co-treatment with 2 mM NAC, a precursor of glutathione. Quantification of CM-H2DCFDA oxidation, a measure of ROS formation, showed that ROS productions was increased by EA treatment in a dose-dependent manner and was prevented by NAC (Fig. 1B). Since TDP-43 phosphorylation at S403/404 and S409/410 is exerted by CK1 and CK2 (Hasegawa et al., 2008), the effect of treatment with these inhibitors in combination with EA was examined. Both inhibitors prevented serine phosphorylation of TDP-43 in a dose-dependent manner, although CK1 inhibitor was more effective than CK2 inhibitor (Fig. 1C).

EA induces TDP-43 insolubilization and C-terminal fragmentation

To investigate the effect of oxidative stress on endogenous TDP-43 solubility, cells treated with 70 μM EA were extracted sequentially. In the immunoblots, the amount of TDP-43 in TS and TX fractions were significantly decreased, but the amount in Sar and SDS fractions were increased in a time-dependent manner (Fig. 2A). These phenomena were prevented in the presence of 2 mM NAC. Phosphorylated TDP-43 was increased in Sar fractions in a time-dependent manner and was detectable in SDS fractions 5 h after EA induction (Fig. 2A). In addition, long exposure of immunoblots with anti-TDP-43 antibody demonstrated that ~25 kDa C-terminal fragment (CTF) of TDP-43 in Sar and SDS fractions appeared evidently by EA induction, and the amount of TDP-43 CTF in SDS fraction was significantly increased at 5 h after EA induction compared with control (Fig. 2A, B).

EA induces cytoplasmic distribution of TDP-43

Immunocytochemistry showed that endogenous TDP-43 disappeared from the nucleus, translocated to the cytoplasm, and became phosphorylated at least in some population of NSC34 cells treated with 70 μM EA for 5 h, whereas this protein was localized in the nucleus and was not phosphorylated in untreated cells (Fig. 3A). Although the majority of cytoplasmic TDP-43 was diffusely distributed under EA treatment, it was also localized in stress granules (SGs), which were labeled with TIAR (Fig. 3A). The time lapse analysis of NSC43 cells expressing GFP-WT-TDP-43 demonstrated cytoplasmic distribution of TDP-43 in the majority of the cells treated with 70 μM EA, but TDP-43 consistently localized in the nucleus of cells co-treated with 2 mM NAC (Fig. 3B, C).

H_2O_2 induces C-terminal phosphorylation, C-terminal fragmentation, insolubilization, and cytoplasmic distribution of TDP-43

To confirm that the TDP-43 modifications are not induced by the specific toxicity of EA, we investigated the effects of H_2O_2, another

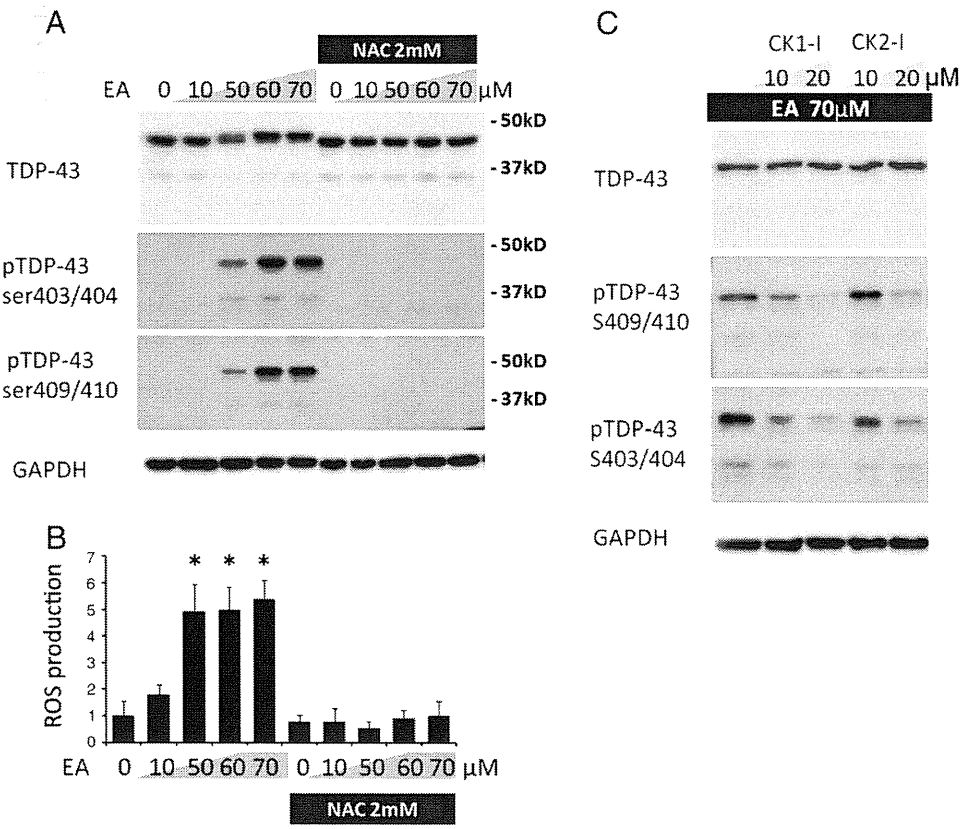

Fig. 1. TDP-43 phosphorylation induced by EA. (A) Immunoblots of NSC34 cells. EA induced TDP-43 C-terminal phosphorylation at S403/404 and S409/410 in a dose-dependent manner. The phosphorylation was prevented by 2 mM NAC. (B) Quantification of ROS by CM-H2DCFDA oxidative assay. The values relative to those of controls are shown. ROS production was increased by EA induction and suppressed by 2 mM NAC. Asterisk denotes significant difference from control ($p<0.0001$, $n=6$). Error bars indicate SD. (C) Immunoblots of NSC34 cells treated with 70 μM of EA. Casein kinase 1 and 2 inhibitors (CK1-I and CK2-I) both prevented the phosphorylation of TDP-43 in a dose-dependent manner.

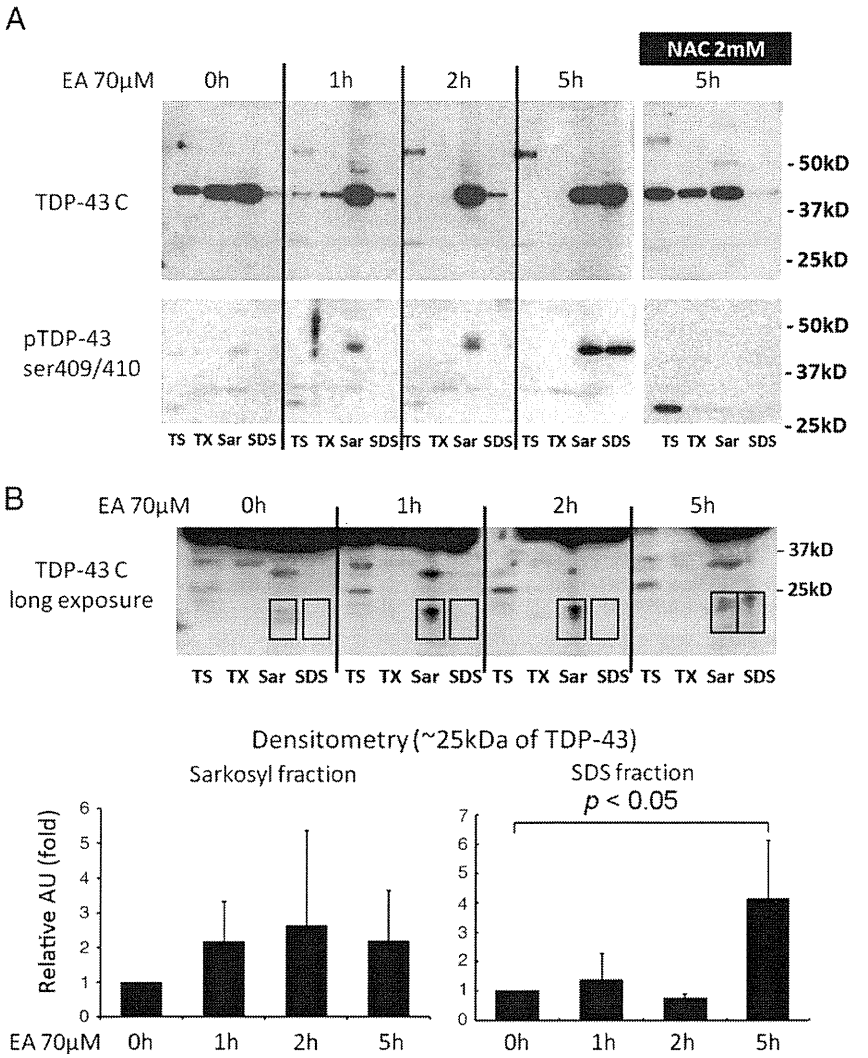

Fig. 2. Analysis of TDP-43 solubility under EA treatment. (A) Sequential extraction analysis using Tris (TS), Triton X100 (TX), Sarkosyl (Sar), and SDS buffers. The amount of TDP-43 in TS and TX fractions was decreased by 70 μM EA in a time-dependent manner, while the amount of TDP-43 in Sar and SDS fractions was increased by the treatment. These phenomena were prevented by 2 mM NAC. Phosphorylated TDP-43 (S409/410) was increased in Sar and SDS fractions in a time-dependent manner. (B) Densitometric quantitation of TDP-43C-terminal fragment (CTF). The relative intensities to controls are shown in arbitrary units (AU). Long exposure of immunoblots with anti-TDP-43 antibody (405–414) (TDP-43C) showed ~25 kDa C-terminal fragment (CTF) in Sar and SDS fractions. The amount of TDP-43 CTF was significantly increased in the SDS fraction at 5 h after EA induction (n = 3). Error bars indicate SD.

inducer of oxidative stress, on the modifications of TDP-43. Immunoblots of NSC34 cells showed that 10 mM H_2O_2 induced C-terminal phosphorylation and C-terminal fragmentation of TDP-43 (Fig. S4A). In the sequential extraction analysis of NSC34 cells, the amount of TDP-43 in TS and TX fractions was decreased by 10 mM H_2O_2, while that of TDP-43 in SDS fraction was increased by the treatment (Fig. S4B). The time lapse analysis of NSC34 cells expressing GFP-WT-TDP-43 showed that 10 mM H_2O_2 induced cytoplasmic distribution of TDP-43 (Fig. S4C).

EA induces C-terminal phosphorylation and cytoplasmic distribution of TDP-43 in primary cortical neurons

To investigate the effect of oxidative stress in neurons, 5-day in vivo (5 DIV) mouse primary cortical neurons were treated with EA for 5 h. Immunoblots showed that EA induced TDP-43 phosphorylation at S403/404 and S409/410 in a dose-dependent manner, and 2 mM NAC prevented the phosphorylation (Fig. 4A). In the time lapse analysis of neurons expressing GFP-WT-TDP-43, TDP-43 was distributed in the cytoplasm in the presence of 30 μM EA (Fig. 4B).

C-terminal phosphorylation of TDP-43 is not mandatory for its insolubilization or cytoplasmic distribution under EA

Since C-terminal phosphorylation of TDP-43 was accompanied by insolubilization and distribution to the cytoplasm in response to oxidative stress, we investigated the effect of C-terminal phosphorylation of TDP-43 using a nonphosphorylable TDP-43 (SA-TDP-43) mutant which contains serine to alanine substitutions at 403/404 and 409/410 (Fig. 5A). We used N-terminal tagged TDP-43, since C-terminal tagged TDP-43 was not detected by anti-pTDP-43 antibody in the immunoblots even under conditions of oxidative stress sufficient to phosphorylate endogenous TDP-43 (Fig. S1). As was seen with WT-TDP-43 under normal conditions, GFP-tagged and V5-tagged SA-TDP-43 were located in the nucleus (Fig. S2). In the immunoblots, endogenous and GFP-WT-TDP-43 were phosphorylated in the presence of 70 μM EA, but GFP-SA-TDP-43 was not phosphorylated even at an EA concentration of 70 μM (Fig. 5B). The time lapse analysis of NSC34 cells demonstrated that GFP-SA-TDP-43 translocated to the cytoplasm (Fig. 6A). The proportion of the cells with cytoplasmic distribution of TDP-43 under oxidative stress was not

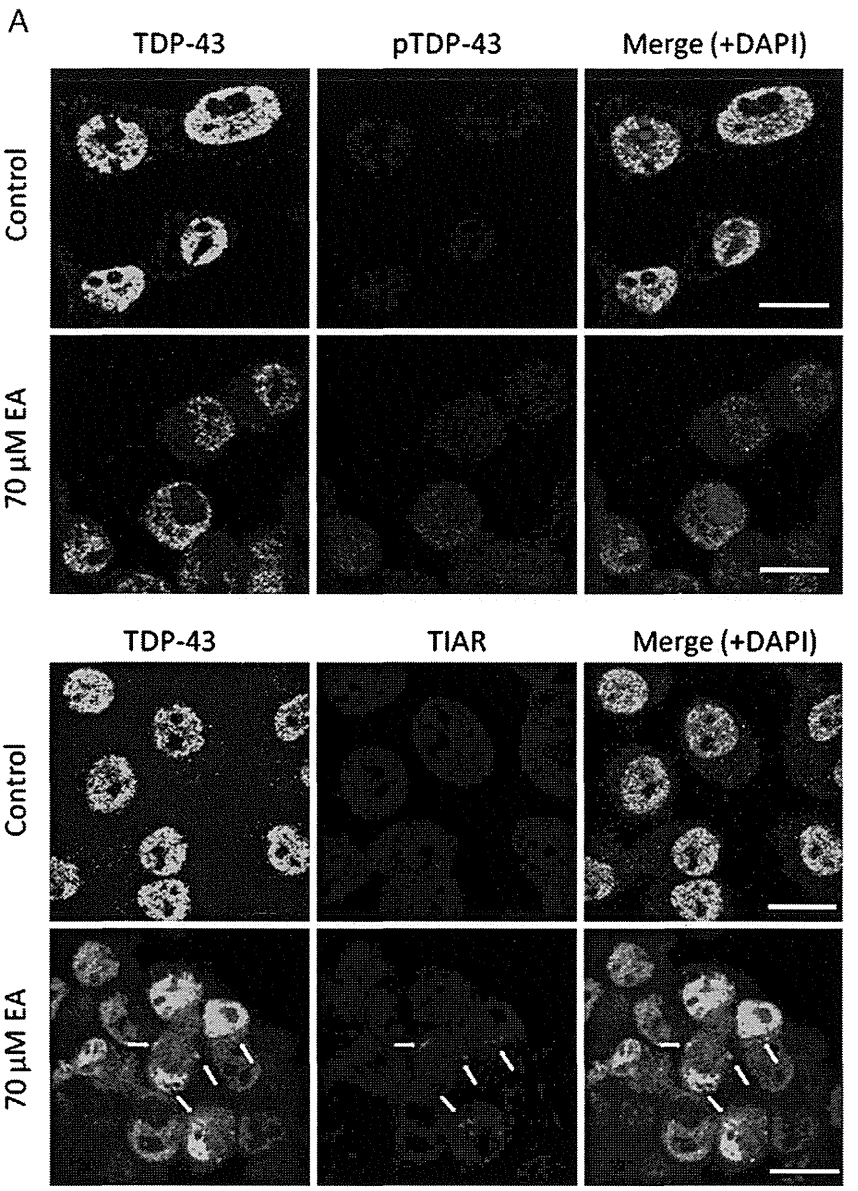

Fig. 3. Cytoplasmic distribution of TDP-43 induced by EA. (A) Immunocytochemistry of NSC34 cells. Cells were stained with anti-TDP-43 antibody (green), anti-phospho-specific TDP-43 (pTDP-43) (S409/410) or anti-TIAR antibody (red), and DAPI (blue). EA treatment (70 μM, 5 h) induced translocation of TDP-43 from the nucleus to the cytoplasm in NSC34 cells. Cytoplasmic TDP-43 was immunopositive for pTDP-43 antibody. In the control cells TDP-43 localized in the nucleus without phosphorylation. TDP-43 co-localized with stress granule marker, TIAR under EA treatment, although the majority of cytoplasmic TDP-43 was diffusely distributed. Arrows indicate stress granules. Scale bars represent 10 μm. (B) Time lapse analysis of NSC43 cells expressing GFP-WT-TDP-43. GFP and phase contrast images showed that TDP-43 was distributed to the cytoplasm when exposed to 70 μM EA, but this distribution was prevented by 2 mM of NAC. (C) The proportion of cells with cytoplasmic distribution of TDP-43 (cells with cyto-TDP) in the GFP-TDP-43 expressing cells 0 h or 5 h after EA induction without or with NAC treatment. Three areas per sample were measured. Error bars indicate SD.

different between WT- and SA-TDP-43 (Fig. 6B). Sequential extraction of NSC34 cells was performed using V5-tagged TDP-43 vectors, since the Sar-insoluble fraction of GFP-TDP-43 was abundant even in the absence of oxidative stress (data not shown). The amount of Sar-insoluble fraction of SA-TDP-43 detected was the same as was seen with WT-TDP-43. (Fig. 7A, B). These findings indicate that phosphorylation is not necessary for oxidative-stress mediated insolubilization and cytoplasmic distribution of TDP-43. Next, we performed MTS assay of NSC34 cells to investigate the effect of TDP-43 and its modifications on the cell viability. The results showed that no significant difference in the viability among the cells expressing GFP-mock, GFP-WT- and GFP-SA-TDP-43, either 0 h or 5 h after EA induction (Fig. S3).

Discussion

Post-translational modifications of TDP-43 such as C-terminal phosphorylation, insolubilization, C-terminal fragmentation, and cytoplasmic distribution are pathological hallmarks of TDP-43 proteinopathies (Arai et al., 2006; Hasegawa et al., 2008; Neumann et al., 2006). TDP-43 with defective nuclear localization signal (NLS) was shown to promote cytoplasmic aggregation, C-terminal phosphorylation, and C-terminal fragmentation of TDP-43 in cell-based studies (Nonaka et al., 2009a; Winton et al., 2008). In addition, overexpression of TDP-43 CTF lead to phosphorylation and formation of cytoplasmic aggregates (Igaz et al., 2009; Nonaka et al., 2009b). Although these observations suggest that the cytoplasmic localization

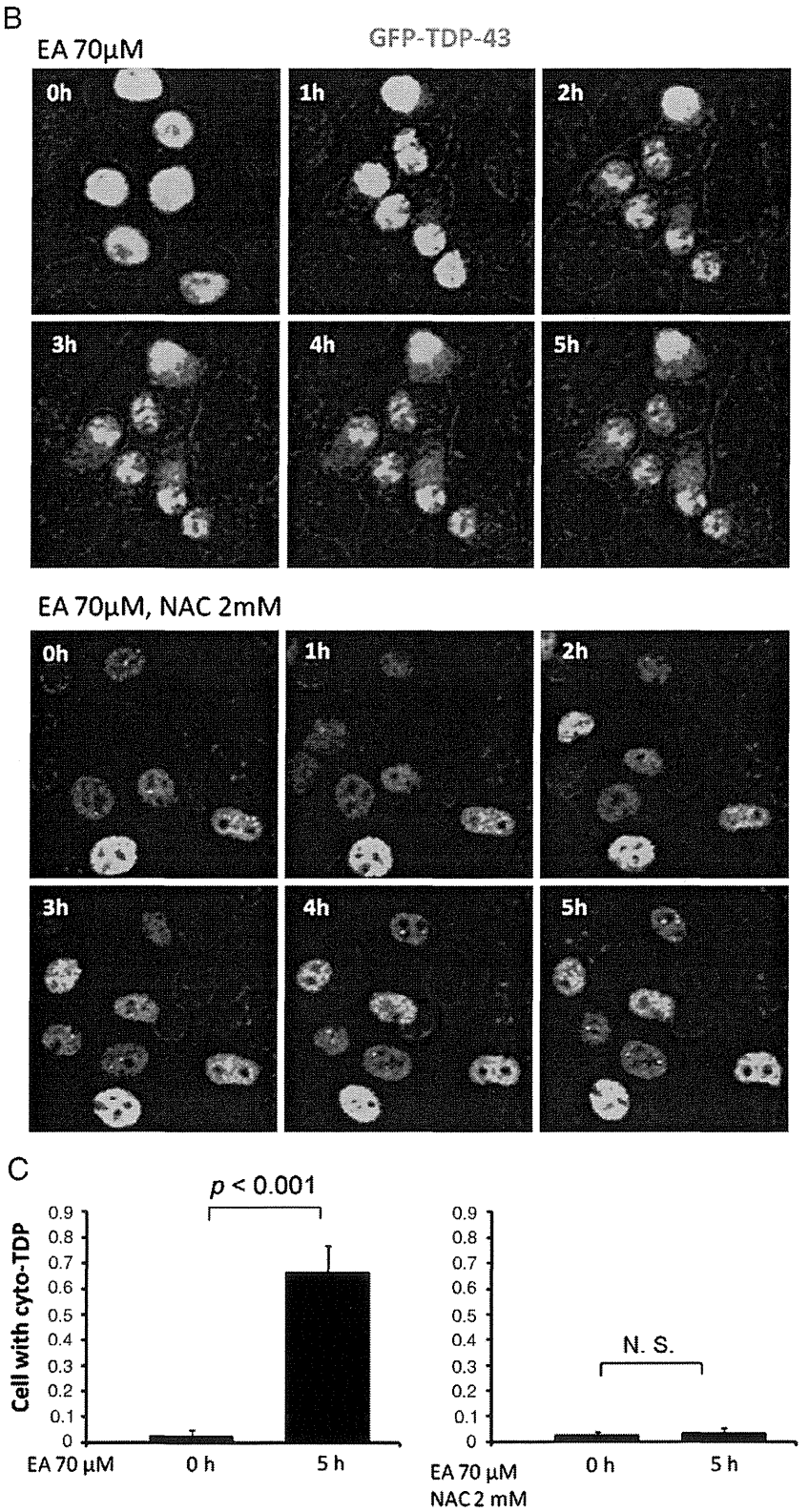

Fig. 3 (*continued*).

or fragmentation of TDP-43 facilitates its pathological modification such as aggregation and phosphorylation, the initial cause of these modifications in TDP-43 proteinopathies has not been fully elucidated. Some studies have demonstrated that artificial axonal damage induces transient cytoplasmic distribution of TDP-43 in motor neurons (Moisse et al., 2009; Sato et al., 2009), indicating that the pathological distribution of TDP-43 may result from the cellular response to neuronal injury or axonal obstruction. However, in these affected neurons, aggregation, C-terminal fragmentation and phosphorylation of TDP-43 were not observed. Furthermore, zinc-induced nuclear

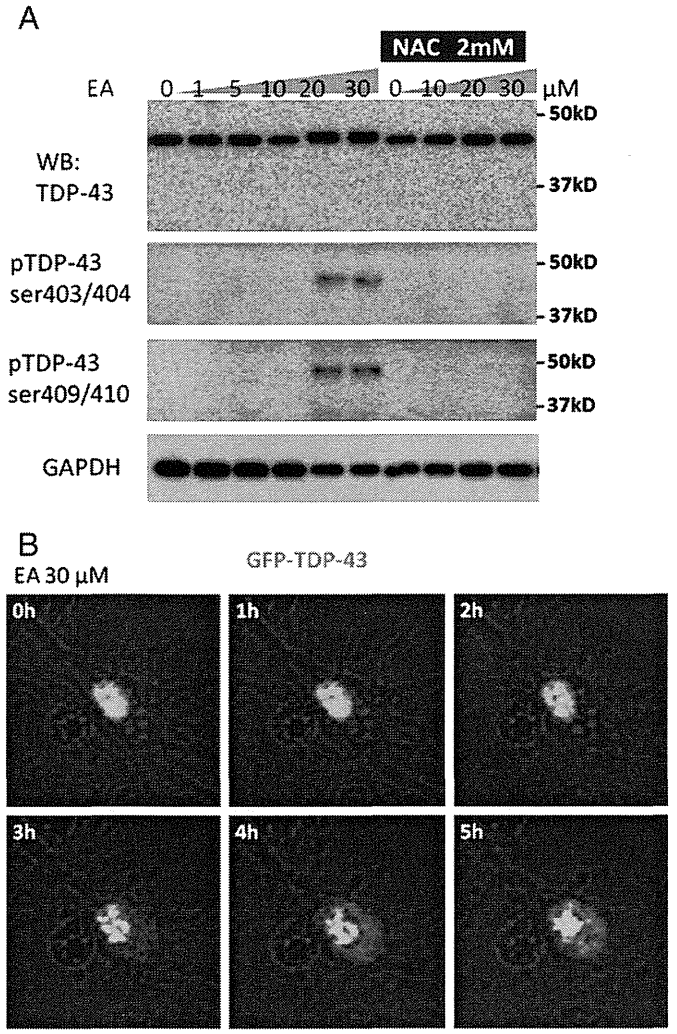

Fig. 4. TDP-43 modification induced by EA in primary cortical neuron. (A) Immunoblots of primary cortical neurons. EA induced TDP-43 phosphorylation at S403/404 and S409/410 in a dose-dependent manner, and this was prevented by 2 mM NAC. (B) Time lapse analysis of neurons expressing GFP-WT-TDP-43. TDP-43 in primary cultures was distributed to the cytoplasm in the presence of 30 μM EA.

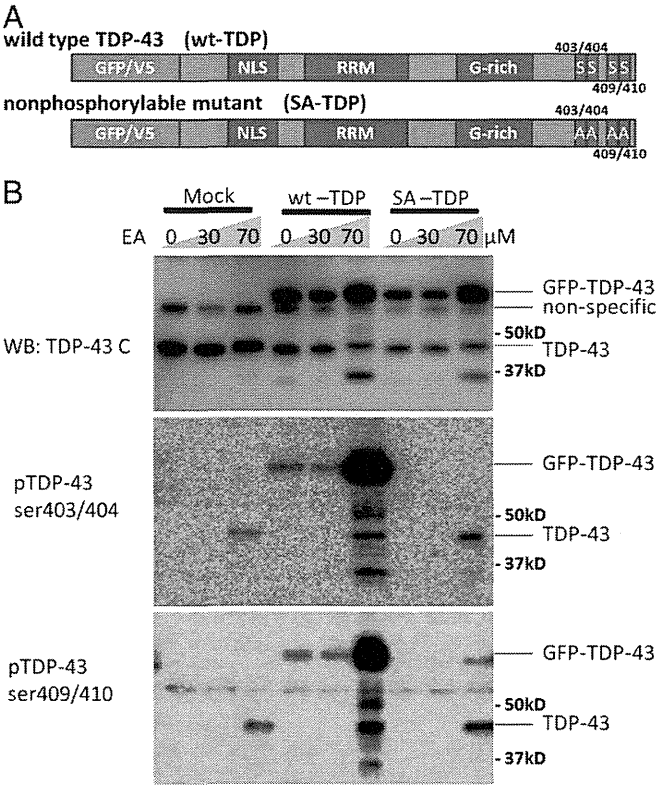

Fig. 5. Nonphosphorylable mutant of TDP-43. (A) Structures of WT- and SA-TDP-43 vectors. SA-TDP-43 contains serine to alanine substitutions at 403/404 and 409/410. (B) Immunoblots of NSC34 cells expressing GFP-WT- or GFP-SA-TDP-43. Endogenous and GFP-WT-TDP-43 were phosphorylated at both 403/404 and 409/410 by 70 μM EA, but GFP-SA-TDP-43 was not phosphorylated by the treatment.

inclusion formations have also been observed in SY5Y cells, but not C-terminal fragmentation or phosphorylation of TDP-43 (Caragounis et al., 2010).

In the present study, we demonstrated that a compound that induces cellular glutathione depletion, EA induced C-terminal phosphorylation of TPD-43 at S403/404 and S409/410 in NSC34 cells and mouse primary cortical neurons, and that NAC completely prevented this phosphorylation. In addition, inhibitors of both CK1 and CK2 also prevented the phosphorylation in a dose-dependent manner. These findings indicate that C-terminal phosphorylation of TDP-43 occurs as a consequence of oxidative stress induced by glutathione depletion and is mediated by CK1 and CK2. Furthermore, the sequential extract analysis showed that EA reduced the solubility of TDP43 and increased the amount of ~25 kDa CTF in the Sar-insoluble fraction. Additionally, EA also induced cytoplasmic distribution of TDP-43 in NSC34 cells and primary cortical neurons. The time lapse analysis showed that cytoplasmic distribution of TDP-43 was seen in the majority of NSC34 cells. Although the immunocytochemistry of TDP-43 demonstrated that cytoplasmic distribution of TDP-43 were observed only in a certain population of NSC34 cells treated with EA, this is likely due to the fact that most of damaged cells could not stay adherent to the plate during the fixation. Previous reports indicated that severe level of oxidative stress may result in apoptotic cell death, and that caspase activation induces C-terminal fragmentation of TDP-43 (Dormann et al., 2009; Zhang et al., 2007). These observations do not exclude the possibility that caspase activation contributes to TDP-43 modifications that were observed under EA treatment. The results of the present study demonstrated that H_2O_2, another inducer of oxidative stress, also causes C-terminal phosphorylation, fragmentation, insolubilization, and cytoplasmic distribution of TDP-43 as observed under EA exposure. These data suggest that oxidative stress is involved in the process of the pathological TDP-43 modifications seen in TDP-43 proteinopathies. The facts that oxidative stress is associated with aging-related disorders (Frederickson et al., 2005; Migliore, 2005) and that TDP-43 proteinopathies are aging process-related diseases may support our assumption that oxidative stress possibly mediates TDP-43 modification. A high frequency of abnormal TDP-43 pathology such as C-terminal phosphorylation has been found not only in patients with TDP-43 proteinopathies but also in patients with other neurodegenerative disease such as AD, DLB, and HD (Arai et al., 2010). Since numerous studies have demonstrated increased oxidative cellular damage in these conditions (Butterfield et al., 2007; Lovell and Markesbery, 2007; Nunomura et al., 2002), oxidative stress may be a cause of pathological TDP-43 modification in various neurodegenerative disorders.

Several studies demonstrated that TDP-43 is involved in SGs under cellular stresses including arsenite treatment and heat shock (Colombrita et al., 2009; Liu-Yesucevitz et al., 2010; McDonald et al., 2011; Nishimoto et al., 2010). Although TDP-43 was seen as a component of SGs under EA treatment, majority of cytoplasmic TDP-43 was independent of SGs and was diffusely distributed. These findings suggest that there is SG-independent mechanism for cytoplasmic distribution of TDP-43 under oxidative stress induced by glutathione depletion.

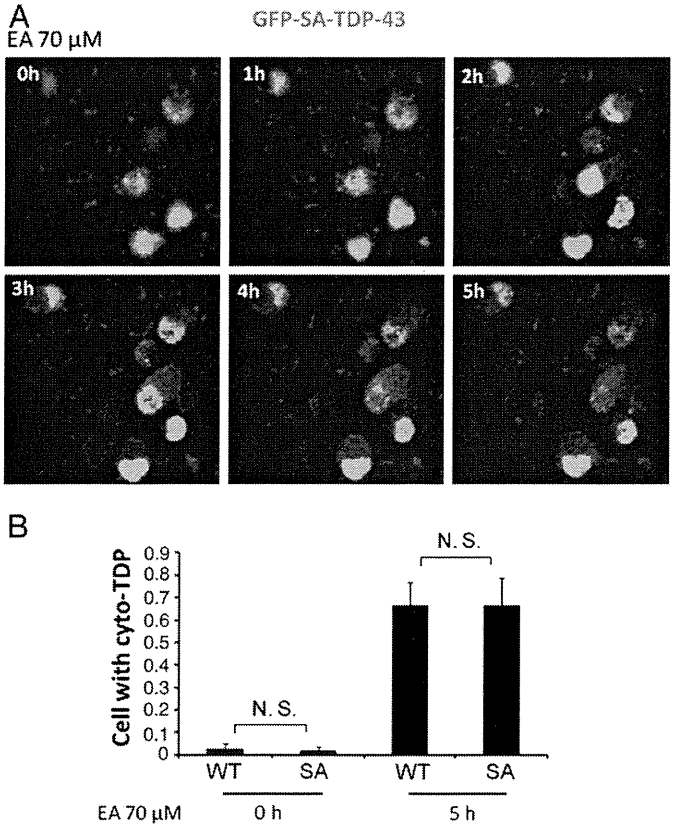

Fig. 6. The effect of C-terminal phosphorylation on TDP-43 distribution. (A) Time lapse analysis of NSC34 cells expressing GFP-SA-TDP-43. GFP-SA-TDP-43 was distributed to the cytoplasm by 70 μM of EA. (B) The proportion of cells with cytoplasmic distribution of TDP-43 (cells with cyto-TDP) in the GFP-TDP-43 expressing cells. The proportion of cells with cyto-TDP was not different between WT- and SA-TDP-43, either 0 h or 5 h after EA induction. Three areas per sample were measured. Error bars indicate SD.

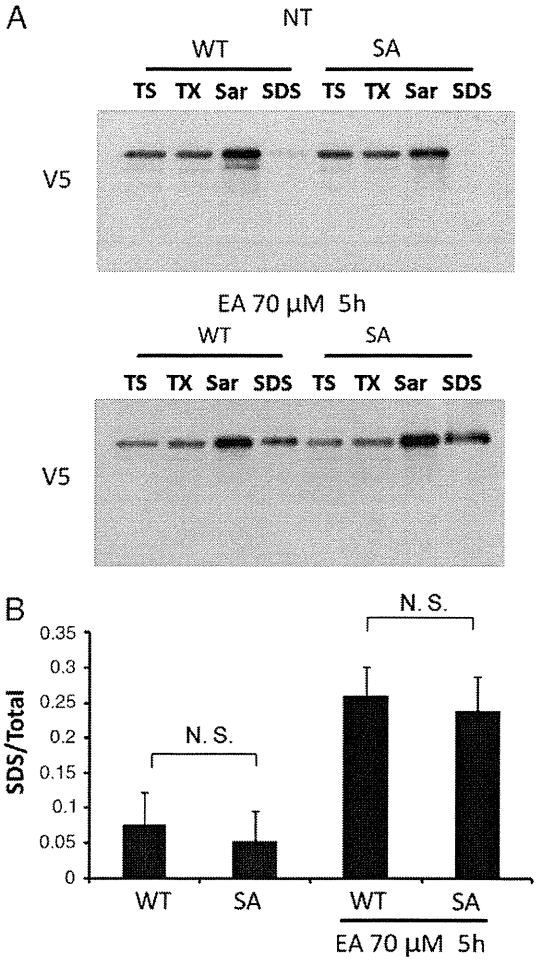

Fig. 7. The effect of C-terminal phosphorylation on TDP-43 solubility. (A) Sequential extraction of NSC34 cells expressing V5-WT- or V5-SA-TDP-43. (B) Densitometric quantitation of Sar-insoluble V5-TDP-43. Ratio of Sar-insoluble fraction from the whole fraction did not differ between WT- and SA-TDP-43 with or without 70 μM EA. Three independent experiments were performed. Error bars indicate SD.

In the present study, S403/404 and S409/410 of TDP-43 were phosphorylated together with insolubilization and cytoplasimic distribution of the protein. The hyperphosphorylation of disease marker proteins is a common feature of neurodegenerative disorders, and its relation to the pathogenesis has been intensively investigated: Tau in AD; huntingtin in HD; and alfa-synuclein in PD and DLB (Ballatore et al., 2007; Fujiwara et al., 2002; Gu et al., 2009). A number of studies have demonstrated that disease-specific phosphorylation of these marker proteins modulates aggregation and potentially influences disease pathogenesis (Azeredo da Silveira et al., 2009; Gu et al., 2009). In the present study, there was no difference between wild type and non-phosphorylable TDP-43 in the degree of insolubilization and cytoplasmic translocation under oxidative stress conditions, suggesting that C-terminal phosphorylation of TDP-43 is not mandatory for aggregation or abnormal intracellular distribution. In support with our findings, there is a study demonstrating that C-terminal phosphorylation of TDP-43 is not substantially required for the cytoplasmic aggregation (Brady et al., 2010). In addition, our results show that C-terminal tags interfere with the detection of TDP-43 phosphorylation, providing a cautionary note for cell-based and animal studies of TDP-43 with a C-terminal tag.

We further examined whether the pathological modifications of TDP-43 contribute to cell vulnerability to glutathione depletion. In the analysis of MTS assay, the viabilities of NSC34 cells were decreased by EA treatment. Although GFP-WT-TDP-43 was fully phosphorylated, insolubilized and distributed to cytoplasm in the cells treated with EA, there was no significant difference in the viability between the cells expressing GFP-mock and GFP-WT-TDP-43. In addition, the viability of NSC34 cells expressing GFP-SA-TDP-43 was not different from that of the cells expressing GFP-WT-TDP-43. These findings suggest that TDP-43 modification may not affect cell viability under oxidative stress induced by glutathione depletion.

In conclusion, we demonstrated that oxidative stress induced by glutathione depletion instigated TDP-43 modifications including C-terminal phosphorylation, insolubilization, C-terminal fragmentation and cytoplasmic distribution, and that these changes reproduce the pathological features of TDP-43 proteinopathies and other neurodegenerative diseases such as AD.

Supplementary materials related to this article can be found online at doi:10.1016/j.nbd.2011.12.002.

Funding

Funding: This work was supported by a Center-of-Excellence (COE) grant, a Grant-in-Aid for Scientific Research on Innovated Areas "Foundation of Synapse and Neurocircuit Pathology," and Grant-in-Aids from Ministry of Education, Culture, Sports, Science, and Technology of Japan; grants from the Ministry of Health, Labor and Welfare of Japan; and Core Research for Evolutional Science and Technology (CREST) of the Japan Science and Technology Agency (JST).

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Neurobiology of Aging 33 (2012) 2527.e11–2527.e16

NEUROBIOLOGY OF AGING

www.elsevier.com/locate/neuaging

Brief communication

Analysis of *C9orf72* repeat expansion in 563 Japanese patients with amyotrophic lateral sclerosis

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Received 25 March 2012; received in revised form 20 May 2012; accepted 20 May 2012

Abstract

Recently, a hexanucleotide repeat expansion in *C9orf72* was identified as the most common cause of both sporadic and familial amyotrophic lateral sclerosis (ALS) and frontotemporal dementia in Western populations. We analyzed 563 Japanese patients with ALS (552 sporadic and 11 familial) using fluorescent fragment-length analysis of *C9orf72* and repeat-primed polymerase chain reaction analysis. Haplotype analysis was performed for 42 single nucleotide polymorphisms in patients with *C9orf72* repeat expansion. *C9orf72* repeat expansion was found in 2 patients with sporadic ALS (2/552 = 0.4%) and no patients with familial ALS (0/11 = 0%). In the probands' families, 1 primary progressive aphasia patient and 1 asymptomatic 76-year-old individual exhibited *C9orf72* repeat expansion. All of the patients with the *C9orf72* repeat expansion carried the 20-single nucleotide polymorphism consensus risk haplotype. The frequency of the *C9orf72* repeat expansion among Japanese patients is much lower than in Western populations. The existence of a 76-year-old asymptomatic carrier supported the notion of incomplete penetrance. The *C9orf72* mutation should be analyzed in sporadic ALS patients after determining their family histories not only of frontotemporal dementia but also of primary progressive aphasia.

Keywords: Amyotrophic lateral sclerosis; *C9orf72*; Incomplete penetrance; Sporadic; Aphasia; Frontotemporal dementia

1. Introduction

Amyotrophic lateral sclerosis (ALS) is a neurodegenerative disorder that primarily affects motor neurons in the spinal cord, brain stem, and cerebral cortex, typically leading to death within a few years. Five to ten percent of ALS cases are familial, and the remaining cases are believed to be sporadic (Valdmanis et al., 2009). A number of genes causing ALS with a dominant mode of inheritance have

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0197-4580/$ – see front matter
http://dx.doi.org/10.1016/j.neurobiolaging.2012.05.011

been discovered, such as *SOD1*, *TARDBP*, *FUS*, *VAPB*, *ANG*, *VCP*, *OPTN* (Ticozzi et al., 2011), and *UBQLN2* (Deng et al., 2011). Moreover, there is increasing clinical and pathological evidence for the hypothesis that ALS and frontotemporal dementia (FTD) constitute an overlapping continuum of diseases (Lomen-Hoerth et al., 2002; Neumann et al., 2006). Recently, the expansion of a noncoding GGGGCC hexanucleotide repeat in the *C9orf72* gene has been reported to be a major cause of both ALS and FTD (DeJesus-Hernandez et al., 2011; Gijselinck et al., 2012; Renton et al., 2011) and the most common genetic abnormality in familial and sporadic forms of both ALS and FTD, particularly in Western populations (Chiò et al., 2012; DeJesus-Hernandez et al., 2011; Gijselinck et al., 2012; Renton et al., 2011; Sabatelli et al., 2012; Stewart et al., 2012). In the present study, we describe the incidence and demographic and clinical features associated with the *C9orf72* mutation in a large cohort of Japanese ALS patients. We also perform haplotype analysis to investigate whether Japanese patients have the same risk haplotype as European patients (Gijselinck et al., 2012; Laaksovirta et al., 2010; Mok et al., 2012).

2. Methods

2.1. Subjects

We obtained a total of 760 DNA samples from the Japanese Consortium for Amyotrophic Lateral Sclerosis Research (JaCALS; Appendix A). A total of 563 (11 familial and 552 sporadic) patients were diagnosed with ALS according to the El Escorial revised criteria (Brooks et al., 2000) and classified as bulbar-onset, spinal-onset, FTD-ALS, or other (see Supplementary Table 1 for details). We had determined the family histories of ALS but not FTD or primary progressive aphasia (PPA) in all of the patients when they were enrolled as patients with sporadic ALS (SALS). We recruited 197 control subjects, none of whom had a medical or family history of neurodegenerative disorders. The mean age at onset of the patients with ALS was 60.4 ± 11.7 years (range 20–86), and the mean age at sampling of the controls was 60.6 ± 10.3 years (range 26–83). All of the subjects were unrelated Japanese individuals. Written informed consent was obtained from all of the subjects. The ethical committees at the participating institutions approved this study.

2.2. Fluorescent fragment-length analysis of C9orf72 and repeat-primed PCR analysis

The normal repeat number of the GGGGCC hexanucleotide was determined in all of the patients and control subjects using genotyping primers, as previously described (DeJesus-Hernandez et al., 2011). To provide a qualitative assessment of the presence of *C9orf72* repeat expansions, we performed repeat-primed polymerase chain reaction (PCR), as previously described (DeJesus-Hernandez et al., 2011).

2.3. Haplotype analysis

We genotyped 42 single nucleotide polymorphisms (SNPs) across 232 kilobase of Chromosome 9p21, which were first described as the founder haplotype in the Finnish ALS population (Laaksovirta et al., 2010), using primers (Supplementary Table 2) to determine whether our Japanese patients carried the haplotype associated with a risk of ALS. These 42 SNPs included the 20-SNP consensus risk allele that had recently been detected in genome-wide association studies in several populations (Mok et al., 2012). We also performed haplotype analysis with 4 microsatellites (D9S1121, D9S169, D9S270, and D9S104) flanking the *C9orf72* GGGGCC repeat, as previously described (Gijselinck et al., 2012) (Fig. 1).

3. Results

3.1. Detection of C9orf72 repeat expansion

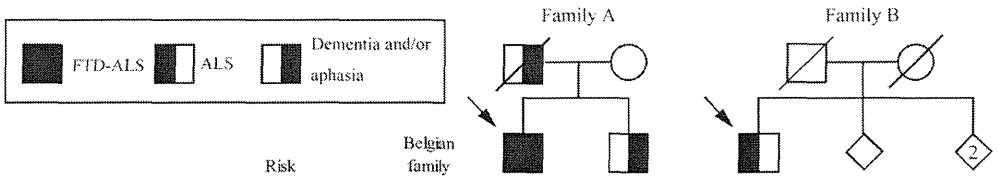
The *C9orf72* repeat expansion was found in 2 of 522 Japanese patients (2/552 = 0.4%) with SALS and none of the 11 patients (0/11 = 0%) with familial ALS (FALS) using repeat-primed PCR (Table 1). Patient A-I with a *C9orf72* mutation was classified as SALS in this study, but after detecting the mutation, we found that patient A-II (a brother of patient A-I) developed aphasia and dementia and had a *C9orf72* mutation (Fig. 1). The average repeat number based on fluorescent fragment-length analysis was 3.65 ± 2.43 (range 2–13 repeats) in 561 ALS patients without the *C9orf72* mutation. A subsequent analysis of 197 healthy controls did not detect any *C9orf72* mutation. The average repeat number was 3.69 ± 2.46 (range 2–14 repeats) in the 197 controls. The mean age at disease onset in patients with *C9orf72* mutation, including patient A-II, was 64.7 ± 6.1 years (range 57–72). The genotypes of all individuals with the *C9orf72* mutation were detected for the 20 SNPs spanning a 140-kilobase segment concordant with the recently identified risk haplotype on chromosome 9p (Mok et al., 2012) and 24 or 25 consecutive SNPs in the 42-SNP Finish risk haplotype (Laaksovirta et al., 2010) (Fig. 1, Supplementary Table 3).

3.2. Clinical presentations of individuals with C9orf72 mutation

3.2.1. Patient A-I (family A)

Patient A-I was a 65-year-old man who reported weakness in the left leg. The weakness progressed, and he developed fasciculation. At age 66, a neurological examination revealed dementia. His Mini Mental State Examination score was 23/30, and his Frontal Assessment Battery score was 13/18. He also exhibited dysarthria and weakness, atrophy, and fasciculation in the tongue and all 4 modalities. His tendon reflexes were diminished, and the plantar re-

A)



B)

Marker	Position	Risk allele	Freq JPT	Belgian family DR14	Patient A-I	Patient A-II	Patient B-I	Subject B-II
rs725804	27458939	A	A=0.081		C/C	C/C	C/C	C/C
rs10511816	27468461	T	T=0.105		T/G	T/G	G/G	G/G
rs1444533	27477874	A	A=0.553		A/A	A/A	A/G	A/G
rs1822723*	27478052	C	C=0.669		C/C	C/C	C/C	C/C
rs4879515*	27482235	T	T=0.645		T/T	T/T	T/T	T/T
rs895023	27483959	T	T=1.000		T/T	T/T	T/T	T/T
rs868856*	27489251	T	T=0.247		T/T	T/T	T/T	T/T
rs7046653*	27490967	A	A=0.250		A/A	A/A	A/A	A/A
rs2440622	27495418	A	A=0.988		A/A	A/A	A/A	A/A
rs1977661 *	27502986	C	C=0.651		C/C	C/C	C/C	C/C
rs903603*	27529316	C	C=0.341		C/C	C/C	C/T	C/T
rs10812610*	27533984	C	A=0.680		C/C	C/C	C/A	C/A
rs2814707*	27536397	A	A=0.058		A/A	A/A	A/G	A/G
rs3849942*	27543281	A	A=0.076		A/A	A/A	A/G	A/G
C9orf72	27546544..27573842			mutation	mutation	mutation	mutation	mutation
rs12349820	27553876	T	T=0.890		T/T	T/T	T/T	T/T
rs10122902*	27556780	G	G=0.738		G/G	G/G	G/G	G/G
rs10757665*	27557919	T	T=0.890		T/T	T/T	T/T	T/T
rs1565948*	27559733	G	G=0.600		G/G	G/G	G/G	G/G
rs774359*	27561049	C	C=0.070		C/C	C/C	C/T	C/T
rs2282241*	27572255	G	G=0.326		G/G	G/G	G/T	G/T
rs1948522*	27575785	C	C=0.837		C/C	C/C	C/C	C/C
rs1982915*	27579560	G	G=0.238		G/G	G/G	G/A	G/A
rs2453556*	27586162	G	G=0.448		G/G	G/G	G/A	G/A
rs702231*	27588731	A	A=0.634		A/A	A/A	A/A	A/A
rs696826*	27589657	G	G=0.983		G/G	G/G	G/G	G/G
rs2477518*	27599746	T	T=0.820		T/T	T/T	T/T	T/T
D9S270	28404862 .. 28404948			327	327/325	327/325	323/323	323/323
D9S104	28771379 .. 28771576			168	158/158	158/158	158/171	158/171

Fig. 1. (A) The pedigrees of the 2 families with *C9orf72* repeat expansion. To maintain confidentiality, several unaffected individuals who died early in families A and B are not shown. Probands are indicated by arrows. (B) The genotyping data of the single nucleotide polymorphisms (SNPs) and microsatellites. Twenty SNPs, which comprised a recently identified consensus risk haplotype (Mok et al., 2012), are shown with an asterisk. See Supplementary Table 3 for details of the analyses of 42 SNPs (Laaksovirta et al., 2010) and microsatellites (Gijselinck et al., 2012). Alleles possibly shared between our subjects and patients in Western populations are shown in bold. The genotypes of all 4 subjects with respect to the 20 SNPs were found to be concordant with the risk haplotype (Mok et al., 2012). All of the positions of SNPs and microsatellites were from NC_000009.11. Abbreviations: ALS, amyotrophic lateral sclerosis; Freq JPT, Frequency in Japanese in Tokyo from International HapMap project (International HapMap Consortium, 2003); FTD, frontotemporal dementia.

sponse was extensor on the left. He had neither dysphagia nor dyspnea. No sensory abnormalities were noted. Extensive screening for causes of motor neuropathy was negative. The diagnosis was clinically probable ALS-laboratory supported (Brooks et al., 2000) and FTD-ALS.

3.2.2. *Patient A-II (family A)*

This patient was a 57-year-old man who presented with difficulty speaking. He was believed to have suffered from a mental disease after being imprisoned because of his involvement in a fatal car accident. At age 64, he was severely dysfluent and could barely speak. Logoclonia was particularly prominent. However, he did not exhibit any violent behavior or other behavioral abnormalities. He also did not display any clinical features of motor neuron disease. Brain magnetic resonance imaging revealed severe frontotemporal lobar atrophy. PPA was considered the most likely diagnosis.

3.2.3. *Patient B-I (family B)*

Patient B-I was a 72-year-old man who presented with gait disturbance and weakness in the proximal lower extremity muscle. His family history was negative for motor neuron disease and dementia (Fig. 1). The muscle weakness and atrophy progressed and spread to the other parts of his body despite treatment with intravenous gamma globulin. At age 74, he could not roll over while sleeping. A neurological examination showed marked muscle atrophy in his arms and shoulders and prominent fasciculation in his legs. The deep tendon reflexes were decreased in his limbs, and he had no pathological reflexes. Sensations in all 4 modalities were intact. At age 75, he developed dyspnea and dysphagia and started noninvasive positive pressure ventilation and intravenous hyperalimentation. He died of respiratory insufficiency at age 76. An autopsy was not performed. The diagnosis was clinically suspected ALS (Brooks et al., 2000).

Table 1
Frequencies of ALS patients with *C9orf72* and *SOD1* mutations in different countries

Study	Population	*C9orf72*			*SOD1*	
		Familial ALS	Sporadic ALS	Mean AAO (range), years	Familial ALS	Sporadic ALS
This study, 2012	Japanese (JaCALS)	0% (0/11)	0.4% (2/552)	64.7 (57–72)	NA	NA
Akimoto et al. (2011)	Japanese (JaCALS)	NA	NA	NA	NA	1.6% (4/255)
DeJesus-Hernandez et al. (2011)	Mixed[a]	23.5% (8/34)	4.1% (8/195)***	54.5 (41–72)	11.8% (4/34)	0% (0/195)
Renton et al. (2011)	Finish	46.4% (52/112)**	21.0% (61/290)***	53 (30–71)	NA	NA
Gijselinck et al. (2012)	Flanders-Belgian	46.7% (7/15)*	4.9% (6/122)***	54.5 (38–64)	0% (0/16)	0% (0/125)
Stewart et al. (2012)	Unknown[b]	27.4% (17/62)	3.6% (6/169)**	58.2 (39–82)	Total 8.2% (19/231)	
Byrne et al. (2012)	Ireland	40.8% (20/49)*	4.9% (19/386)***	56.3 (NA)	Total 0% (0/191)	
Cooper-Knock et al. (2012)	Northern England	42.9% (27/63)*	7.0% (35/500)***	57.3 (27–74)	Total 2.5% (14/563)	
Chiò et al. (2012)	Italian	37.5% (45/120)*	NA	59.0 (NA-80)	0% (0/141)	NA
	Sardinian	57.1% (12/21)**	NA	60.4 (NA)	NA	NA
	German	22.0% (9/41)	NA	56.4 (NA)	NA	NA
Majounie et al. (2012)	England	45.9% (45/98)**	6.8% (62/916)***	NA	NA	NA
	German	21.7% (15/69)	5.2% (22/421)***	NA	NA	NA
	Italian	37.8% (34/90)*	4.1% (19/465)***	NA	NA	NA
	Sardinian	57.9% (11/19)**	7.8% (10/129)***	NA	NA	NA
	USA White	US total 36.2% (59/163)*	5.4% (48/890)***	NA	NA	NA
	USA Hispanic		8.3% (6/72)***	NA	NA	NA
	USA Black		4.1% (2/49)	NA	NA	NA
	Australian	NA	5.3% (14/263)***	NA	NA	NA
	Israeli	21.4% (3/14)	NA	NA	NA	NA
	Indian	NA	0% (0/31)	NA	NA	NA
	Asian	5.0% (1/20)	0% (0/238)	NA	NA	NA
	Pacific islander/Guam	NA	0% (0/90)	NA	NA	NA
Sabatelli et al. (2012)	Italian	NA	3.7% (60/1624)***	58.6 (49–65)	NA	NA
	Sardinian	NA	6.8% (9/133)***	62.9 (58–63)	NA	NA

Key: AAO, age at onset; ALS, amyotrophic lateral sclerosis; JaCALS, Japanese Consortium of Amyotrophic Lateral Sclerosis Research; NA, not available.
[a] Mixed included 229 ALS patients from Mayo Clinic, Florida: White (212), Asian (1), Pacific Islander (1), and Black or African American (15).
[b] Unknown included 231 ALS patients from the ALS Clinic of Vancouver Coastal Health and the University of British Columbia (Vancouver General Hospital and GF Strong Rehabilitation Centre sites).
* $p < 0.05$, compared with our results (2-tailed, Yates's χ^2 test).
** $p < 0.01$, compared with our results (2-tailed, Yates's χ^2 test).
***$p < 0.001$ compared with our results (2-tailed, Yates's χ^2 test).

3.2.4. Subject B-II (family B)

Subject B-II, a sibling of Patient B-I, had a *C9orf72* mutation but did not have symptoms of dementia or motor neuron disease until age 76 (Fig. 1).

4. Discussion

We began this study considering patients without family histories of ALS to be SALS because our cohort included only family histories of ALS but not FTD or PPA. Although it may be difficult to describe the real frequency in SALS because 1 of the SALS patients had a family member who developed PPA, the frequencies of the *C9orf72* mutation in Japanese patients were 0.4% (2/552) in SALS and 0% (0/11) in FALS according to this classification. In contrast, the frequencies of the *C9orf72* mutation fall within the ranges of 21%–57% in FALS and 3%–21% in SALS in Western populations (Table 1), and the *C9orf72* mutation has been reported as the most common genetic cause of FALS and SALS in Western populations (Byrne et al., 2012; Chiò et al., 2012; Cooper-Knock et al., 2012; DeJesus-Hernandez et al., 2011; Gijselinck et al., 2012; Majounie et al., 2012; Renton et al., 2011; Sabatelli et al., 2012; Stewart et al., 2012). However, the *C9orf72* mutation in this study was not more frequent than the *SOD1* mutation in Japanese SALS patients (0.4% and 1.6%, Table 1) (Akimoto et al., 2011). Considering these data, the *C9orf72* mutation is more common than the *SOD1* mutation in Western populations but not in Japan, suggesting different genetic backgrounds. Our results may explain the association study of rs2814707 on 9p21.2, which was reported to be the most significantly associated SNP with SALS in Caucasian but not in Japanese and Chinese populations (Iida et al., 2011). A recent report revealed that the rate of expansion in Asian FALS and SALS was 5% (1/20) and 0% (0/238), respectively (Majounie et al., 2012). An analysis of the SNPs on chromosome 9p revealed that all 4 subjects with the *C9orf72* mutation and another Japanese subject from the previously mentioned report (Majounie et al., 2012) share a shorter region of the risk haplotype

than Western populations. Thus, the haplotype bearing the *C9orf72* mutation was only shared in a narrow region between Western and Asian populations, suggesting that the *C9orf72* mutation may be an old mutation in human migration history from Western to East Asia. This mutation was estimated to be approximately 1500 years old (Majounie et al., 2012).

Bulbar onset and cognitive impairment have been reported to be more common in ALS patients with the *C9orf72* repeat expansion (Chiò et al., 2012; Cooper-Knock et al., 2012; DeJesus-Hernandez et al., 2011; Sabatelli et al., 2012; Stewart et al., 2012). We did not find any patients with bulbar onset, but we identified 2 patients with dementia. Although the age at onset has been known to be lower in SALS patients with the *C9orf72* mutation than in those without this mutation (Sabatelli et al., 2012), our patients exhibited a relatively older age at onset (Table 1).

Although apparently sporadic patients with *C9orf72* mutation have been detected worldwide (Byrne et al., 2012; Cooper-Knock et al., 2012; Sabatelli et al., 2012), it was not known whether this phenomenon was due to incomplete penetrance or to spontaneous expansion of the GGGGCC hexanucleotide repeat from a nonpathogenic parental form (ie, a de novo expansion). In this study, we found a 76-year-old healthy individual with a *C9orf72* mutation (Subject B-II), as described in previous studies (Majounie et al., 2012; Renton et al., 2011). This discovery suggests not de novo expansion but incomplete penetrance, which explains the existence of apparently sporadic patients with the *C9orf72* mutation. Although it has been reported that the penetrance of the *C9orf72* mutation is almost full by 80 years by Kaplan–Meier analysis of 603 mutant gene carriers and 5 neurologically healthy individuals, further studies of family members of patients with the *C9orf72* mutation will be required to calculate the true penetrance and to improve genetic counseling.

Finally, we found a PPA patient with the *C9orf72* mutation after detecting the mutation in a SALS patient, suggesting the importance of collecting information regarding whether SALS patients have a family history of dementia or aphasia. Therefore, the possibility of *C9orf72* mutation should be investigated when clinicians meet with SALS patients after determining their family histories of FTD or PPA. Furthermore, our data supported Byrne and colleagues' suggestion that a family history of FTD should also be included in the revised definition of FALS (Byrne et al., 2012).

Disclosure statement

All of the authors disclose no conflicts of interest. The study was approved by the ethical committees of the participating centers. All participants gave written informed consent.

Acknowledgements

The authors thank all of the participants in this study. The authors also thank Dr. Mariely DeJesus-Hernandez, Dr. Ilse Gijselinck, Dr. Marc Cruts, and Dr. Christine Van Broeckhoven for technical advice. This work was supported by the Ministry of Education, Culture, Sports, Science and Technology of Japan (21229011, 21390272, 21591098, 22790817, 22790829, and 23659452), the Ministry of Welfare, Health and Labor of Japan (20261501, 22140501, 22140901, and CCT-B-1701), the Japan Science and Technology Agency, Core Research for Evolutional Science and Technology, and the Inochinoiro Foundation of Japan.

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Appendix B. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.neurobiolaging.2012.05.011.

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CROSS-SECTIONAL AND LONGITUDINAL ANALYSIS OF AN OXIDATIVE STRESS BIOMARKER FOR SPINAL AND BULBAR MUSCULAR ATROPHY

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Accepted 6 April 2012

ABSTRACT: *Introduction:* Spinal and bulbar muscular atrophy (SBMA) is an adult-onset motor neuron disease caused by a CAG repeat expansion in the androgen receptor gene. The aim of this study was to verify whether urinary 8-hydroxydeoxyguanosine (8-OHdG), an oxidative stress marker, is a biomarker for SBMA. *Methods:* We measured the levels of urinary 8-OHdG in 33 genetically confirmed SBMA patients and 32 age-matched controls over a 24-month period at 6-month intervals. *Results:* Urinary 8-OHdG levels in SBMA patients were significantly elevated compared with those of controls and correlated well with motor function scores. During the follow-up period, urinary 8-OHdG levels increased and correlated with motor function at each time-point. In addition, urinary 8-OHdG levels at baseline were correlated with changes in the 6-minute walk test during 24 months. *Conclusions:* Urinary 8-OHdG is a biomarker for SBMA, reflecting the severity and possibly predicting the deterioration of motor function.

Muscle Nerve **46:** 692–697, 2012

Spinal and bulbar muscular atrophy (SBMA) is an hereditary, adult-onset, lower motor neuron disease. It is caused by aberrant elongation of a trinucleotide CAG repeat, which encodes a polyglutamine tract in the first exon of the androgen receptor (AR) gene.[1–3] The main symptoms are slowly progressive muscle weakness and atrophy of the bulbar, facial, and limb muscles. In general, the interval between the onset of weakness and death is 10–20 years.[4] An expanded CAG repeat has been identified as the cause of several neurodegenerative disorders, including SBMA, Huntington disease (HD), and several forms of spinocerebellar ataxia.[5] Although the causative genes show little homology other than the presence of a CAG repeat, these polyglutamine-mediated disorders share common pathways of molecular pathogenesis, such as transcriptional dysregulation, axonal transport defects, and mitochondrial dysfunction.[6,7]

Although animal studies have indicated the beneficial effects of androgen deprivation for SBMA, the results of clinical trials were inconclusive.[8–10] This is likely attributable to the difficulties in evaluating the disease-modifying effects of the tested drugs due to the slow progression of the neurological symptoms in SBMA. Therefore, appropriate surrogate endpoints are needed to facilitate the proof-of-concept of potential therapies for this disease. In this regard, it is important to identify biomarkers for SBMA that reflect the pathogenic processes and can be used as indicators of therapeutic efficacy. Although the nuclear accumulation of mutant AR protein in the scrotal skin has been shown to be a candidate histopathological biomarker, its practical use is limited due to the invasive nature of the procedure.[11,12] Conversely, non-invasive serum or urinary markers to evaluate disease severity have not been established for SBMA.

Oxidative stress resulting from mitochondrial dysfunction has been implicated in aging and neurodegeneration.[13] Pathogenic huntingtin, the causative protein of HD, induces oxidative stress through its direct association with mitochondria and downregulation of mitochondrial transcriptional regulators.[14,15] In a cellular model of SBMA, the expression of pathogenic AR is associated with depolarization of the mitochondrial membrane and an increase in the levels of reactive oxygen species (ROS), which is attenuated by the antioxidants coenzyme Q10 and idebenone.[16] ROS, such as hydroxyl radicals and H_2O_2, react with guanine residues in DNA and produce 8-hydroxydeoxyguanosine (8-OHdG), which is excreted in the urine, thereby serving as a biomarker of oxidative DNA damage.[17]

The aim of this study was to evaluate the validity of urinary 8-OHdG as a biomarker for SBMA. In particular, we investigated whether the urinary levels of 8-OHdG reflect the disease severity of SBMA patients. We also investigated the natural history of this parameter in order to determine whether it can be used to monitor disease progression.

METHODS

Participants. We studied 33 patients with SBMA and 32 age-matched, normal controls (Table 1). The inclusion criteria were: a clinical diagnosis of

Abbreviations: 6MWT, 6-minute walk test; 8-OHdG, 8-hydroxydeoxyguanosine; ALS, amyotrophic lateral sclerosis; ALSFRS-R, ALS Functional Rating Scale-revised; AR, androgen receptor; BMI, body mass index; HbA_{1c}, glycated hemoglobin; HD, Huntington disease; LNS, limb Norris score; NBS, Norris bulbar score; PCR, polymerase chain reaction; ROS, reactive oxygen species; SBMA, spinal and bulbar muscular atrophy

Key words: androgen receptor, biomarker, motor neuron, oxidative stress, spinal and bulbar muscular atrophy

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Published online 31 August 2012 in Wiley Online Library (wileyonlinelibrary.com). DOI 10.1002/mus.23413