Association of less common cystic fibrosis mutations with a mild phenotype

A Curtis, R Nelson, M Porteous, J Burn, S S Bhattacharya

Abstract
A majority of cystic fibrosis (CF) genes (70 to 75%) share a single mutation, but the remaining 25 to 30% of defects are accounted for by more than 20 different mutations. One of the less frequent mutations, G551D, has been identified in the CF genes of two sibs and one unrelated adult patient. The adult patient also has a second rare mutation, ΔF507. All three subjects exhibit a less severe phenotype than that normally associated with CF. This supports a hypothesis that the common mutation (ΔF508) is responsible for the severe form of the disorder, and the minority of patients with a milder form tend to have mutations at other sites in the CF gene.

A deletion of three base pairs in exon 10 of the gene has been shown to be the primary genetic mutation in 68% of chromosomes carrying a defective cystic fibrosis (CF) gene in North America. This mutation is likely to represent more than 75% of CF mutations in the British population. The deleted triplet (ΔF508) results in the removal of a phenylalanine residue at amino acid position 508, which resides in the putative ATP binding region of the 1480 amino acid CF gene product, the cystic fibrosis transmembrane conductance regulator (CFTR). It was estimated from linkage disequilibrium and haplotype data that a small number of further mutations must exist to account for the remaining 25 to 30% of defective CF loci in Britain and North America. However, a further 20 mutations have currently been found which together make up no more than a few percent of the remaining defective chromosomes.

One of the less common mutations (G551D), initially described by Cutting et al., results in the creation of an MboI recognition site at codon 551 in the CFTR gene. A further mutation, ΔI507, first described by Schwarz et al., is the result of a three base pair deletion adjacent to the ΔF508 site at codon 507.

A minority (approximately 15%) of persons affected with cystic fibrosis exhibit a milder phenotype than that usually associated with the disorder. These cases often survive into adulthood, the females reproduce, and are pancreatic sufficient. Many of the severely affected patients, being pancreatic insufficient and approximately 10% having a history of meconium ileus, have been found to be homozygous for the ΔF508 mutation. Those with an apparently less severe form of the disease are predominantly compound heterozygotes at the CF locus. They either have a single mutation at the ΔF508 position and are, therefore, presumed to carry one of the other mutations on the other chromosomes, or do not have the ΔF508 deletion at all and therefore probably carry two of the rarer mutations.

In this study we describe, first, a family with two children who have very mild CF-like symptoms in which the G551D mutation is segregating and, secondly, an unrelated adult CF female who is a compound heterozygote for G551D and ΔI507.

Materials and methods
DNA was extracted by standard methods from EDTA blood samples collected from the parents and three children of a family in which two of the children had very mild CF-like symptoms, and from a 24 year old female CF patient.

The adult patient, diagnosed as having CF in childhood, had recently married. She was pancreatic sufficient and only attended the clinic intermittently. The two sibs with a mild CF phenotype also had normal exocrine pancreatic function. II·1 (fig 1) is 14 years old. He had severe bronchopneumonia at the age of 4 years and his respiratory tract has had recurrent Staphylococcus aureus and Haemophilus influenzae infections. Sweat chloride values of a test carried out during a recent admission to hospital were
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Figure 1 Detecation of G551D mutation. PAGE of PCR amplified DNA samples using primers which flank the G551D mutant site from members of a mild CF family and a mild CF adult patient. The 420 bp amplified fragment is cut into two fragments of 245 bp and 177 bp by MboI when the mutation is present, as shown in II-1, I-1, II-2, and the adult patient.

hybridisation with specific oligonucleotides whose sequences are shown in table 1, or by polyacrylamide gel electrophoresis (PAGE). Hybridisation of dot blots was carried out at 50°C in 4×SSC, 5× Denhardt's solution, and 10% dextran sulphate for four hours. Filters were washed for 15 minutes each at 48°C in 1×SSC, 0·1% SDS, 0·1% sodium pyrophosphate, and then in 0·1 × SSC, 0·1% SDS, 0·1% sodium pyrophosphate.

The ΔI507 mutation was detected by PAGE. Samples for electrophoreses were prepared in 5% sucrose, 0·06% orange G. Polyacrylamide gels were prepared from 10% Acrylogel 5 (BDH) in 1 × TBE and electrophoresis was at 75V for 15 hours. Gels were analysed by visualisation under UV light following ethidium bromide staining. The presence of ΔF508 and ΔI507 was identified by comparison with known controls. The G551 substitution was identified after digestion of 10 μl of the PCR amplified DNA with two units of MboI (using the manufacturer's recommended procedure) and electrophoresis on Hydrolink–dsDNA gels (AT Biochem) at 50V for 15 hours.

Results
The presence or absence of the mutations at the ΔF508, ΔI507, and G551D positions of the CF gene in the six amplified DNA samples is shown in table 2. The ΔF508 deletion was not detected in any of those tested as shown by dot blot hybridisation (fig 2) and PAGE (fig 3).

Table 2 Results of the mutations detected in the CF genes of the six subjects tested. The family pedigree is shown in fig 1.

<table>
<thead>
<tr>
<th>Source of DNA</th>
<th>ΔF508</th>
<th>ΔI507</th>
<th>G551D</th>
<th>CF genotype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father I-1</td>
<td>N/N</td>
<td>N/N</td>
<td>N/X</td>
<td>N/G551D</td>
</tr>
<tr>
<td>Mother I-2</td>
<td>N/N</td>
<td>N/N</td>
<td>N/N</td>
<td>N/N*</td>
</tr>
<tr>
<td>Son I-1</td>
<td>N/N</td>
<td>N/N</td>
<td>N/X</td>
<td>N/G551D</td>
</tr>
<tr>
<td>Daughter II-2</td>
<td>N/N</td>
<td>N/N</td>
<td>N/X</td>
<td>N/G551D</td>
</tr>
<tr>
<td>Daughter II-3</td>
<td>N/N</td>
<td>N/N</td>
<td>N/N</td>
<td>N/N*</td>
</tr>
<tr>
<td>Unrelated adult patient</td>
<td>N/N</td>
<td>N/X</td>
<td>N/X</td>
<td>ΔI507/G551D</td>
</tr>
</tbody>
</table>

N= presence of a non-mutant sequence and X= the presence of a mutant sequence. Indicates that an unidentified CF mutation may be present in these subjects.

Table 1 Sequences of the forward (F) and reverse (R) primers used in the PCR amplification of the mutant sites, ΔF508, ΔI507, and G551D, and of the hybridisation probes used specifically to detect the ΔF508 deletion and its normal homologue.

<table>
<thead>
<tr>
<th>Oligonucleotide function</th>
<th>Mutant site</th>
<th>Sequence</th>
</tr>
</thead>
</table>
| PCR primer               | ΔF508/ΔI507 | F: 5'GTTTTTCTGAGTATTAGCTGGCAC  
                          |             | R: 5'GTGCGCTTGTTGAGGCTTTC  
                          |             | 48| 5'TGGTGGATCTTCCGATACGAC  
                          |             | R: 5'CACAGATTCTGAGTACCATATAAC  |
| PCR primer               | G551D       | 5'CACCAAAAGATGATATTTTTC  
                          |             | Mutant allele: AACACACATGATATTTTCTT |
| Dot blot hybridisation   | ΔF508       | Normal allele: AACACCAATGATATTTTCTT |
| probe                    |             |          |
Figure 2  Detection of ΔF508 mutation. The normal oligonucleotide probe (upper row) and ΔF508 allele specific oligonucleotide probe (lower row) were hybridised to duplicate dot blots of PCR amplified DNA from members of a mild CF family (lanes 1 to 5) and a normal CF adult patient (lane 6). Control ΔF508/ΔF508, lane 7. Control N/N, lane 8. Control ΔF508/N, lane 9. Control ΔI507/N, lane 10.

Figure 3  Detection of ΔF508 and ΔI507 mutations. PAGE of PCR amplified DNA samples using primers which flank the ΔF508 and ΔI507 mutant sites. Lanes 1 to 5 are members of a mild CF family and lane 6 is a normal CF adult patient. Control ΔF508/ΔF508 showing a 95 bp fragment, lane 7. Control N/N showing a 98 bp fragment, lane 8. Control ΔF508/N showing both 98 and 95 bp fragments and two characteristic slow running heteroduplex bands, lane 9. Control ΔI507/N showing both 98 and 95 bp fragments and a single heteroduplex band, lane 10.

As shown in fig 3, three members of the family were heterozygous for the G551D mutation. These were the father (I-1), son (II-1), and older daughter (II-2). However, the mother (I-2) and younger daughter (II-3) had normal alleles at all three of the possible mutant sites tested.

The unrelated CF affected female had a single G551D mutation as shown in fig 1, and was also heterozygous for the ΔI507 deletion (fig 3). Owing to some cross reaction with the ΔF508 hybridisation oligonucleotide (fig 2), it is possible to misinterpret the ΔI507 mutation as ΔF508. However, as shown in fig 3, when compared with the controls on a polyacrylamide gel, the pattern of the amplified DNA from this patient is clearly that of a ΔI507 and not a ΔF508 heterozygote.

Discussion
A large combined European study has shown that the major CF mutation, ΔF508, is present on 70% of defective CF chromosomes. However, the frequency of ΔF508 increases in a south-east to north-west direction. Lower frequencies are observed in southern populations, with a minimum value of 27% in Turkey which rises to a maximum of 88% in Denmark. The British contribution to this study from several centres indicates a frequency for ΔF508 of 75% in this country.

The family with one normal child and two children with an apparently mild CF-like phenotype were referred to the Northern Region Genetic Advisory Service for DNA studies as a possible method of explaining the phenotype and thus confirming the diagnosis. As shown in fig 2, it was impossible to make this confirmation based on the initial screen for the presence of the ΔF508 deletion in this family, even though the expectation was to detect it on at least one chromosome 7 in 90% of CF patients.

A summary of the combined European data shows that 50% of CF patients suffering from pancreatic insufficiency are homozygous for ΔF508 and a further 36% are heterozygous for the deletion at this site. Of those patients with a history of meconium ileus, 58% are homozygous and a further 29% are heterozygous for this common mutation. This suggests that about 85% of severely affected subjects have the ΔF508 mutation on at least one of their two defective CF chromosomes.

The possible phenotypic effect of the non-ΔF508 mutations must also be considered. Ninety percent of patients who are pancreatic sufficient have at least one of the less frequent mutations: 43% are compound heterozygotes ΔF508/non-ΔF508 and 47% do not have the ΔF508 deletion at all.

These figures would support the model proposed by Kerem et al which suggests that ΔF508 is a severe allele which is recessive to all mild alleles, and that a second severe allele must exist to account for severely affected patients who have a single copy, or no copies, of the ΔF508 deletion. However, the model also predicts that there should be no mild cases in the ΔF508/ΔF508 category. To account for the small number of patients in the latter category, the authors of the European study suggest possible misdiagnosis, though the emerging situation is complex and may remain so with the identification of more mutant alleles and correlation with various phenotypes.

Further detailed studies on the family described here detected the less frequent G551D mutation to be present in the two CF-like children (II-1 and II-2) but not in the normal child (II-3). This defective allele has been inherited from the father (I-1). Therefore, the children, II-1 and II-2, do have at least one defective CF gene and appear to be suffering from a mild form of cystic fibrosis which may be specifically
related to a particular combination of non-ΔF508 mutations. If this is the case, then they will be compound heterozygotes for an as yet unidentified mutation inherited from their mother (I-2). An alternative explanation is that G551D gives rise to a more severe form of the disorder, perhaps lethal at a very early developmental stage when homozygous, such that these two cases are manifesting CF carriers. However, the apparent lack of CF symptoms in the father (I-1) would tend to argue against this hypothesis, and against the hypothesis that G551D could sometimes manifest itself as a dominant CF mutation.

In addition, the unrelated adult female CF patient described here has been shown to have two defective CF genes, one with the G551D mutation and one with ΔI507, and she also shows mild symptoms. The apparent association of ΔI507 with a mild phenotype further illustrates the precise influence different mutations in the CF gene may have on the functioning of the CFTR protein. ΔF508 and ΔI507 are at adjacent sites suggesting that removal of phenylalanine disrupts the ATP binding domain to a greater extent than the removal of isoleucine.

We are grateful to Drs M Schwartz and G Cutting for information regarding ΔI507 and G551D mutations before publication of their results.

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