Perinatal lethal osteogenesis imperfecta

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Abstract
Perinatal lethal osteogenesis imperfecta is the result of heterozygous mutations of the COL1A1 and COL1A2 genes that encode the α1(I) and α2(I) chains of type I collagen, respectively. Point mutations resulting in the substitution of Gly residues in Gly-X-Y amino acid triplets of the triple helical domain of the α1(I) or α2(I) chains are the most frequent mutations. They interrupt the repetitive Gly-X-Y structure that is mandatory for the formation of a stable triple helix. Most babies have their own private de novo mutation. However, the recurrence rate is about 7% owing to germline mosaicism in one parent.

The mutations act in a dominant negative manner as the mutant proα chains are incorporated into type I procollagen molecules that also contain normal proα chains. The abnormal molecules are poorly secreted, more susceptible to degradation, and impair the formation of the extracellular matrix. The collagen fibres are abnormally organised and mineralisation is impaired.

The severity of the clinical phenotype appears to be related to the type of mutation, its location in the α chain, the surrounding amino acid sequences, and the level of expression of the mutant allele.

Osteogenesis imperfecta (OI) is a genetically determined disorder of the connective tissues. The major phenotypic features include bone fragility, dentinogenesis imperfecta, blue sclerae, deafness, and ligamental laxity. It has long been recognised to be clinically heterogeneous with mild, moderate, severe, and lethal phenotypes. The Sillence classification takes these varying phenotypes into account.1
show clinical and radiological heterogeneity which appears to be established early in the pregnancy. The radiographic appearances are used to subclassify OI-II into groups A to C or into groups I to V. The Sillence subclassification will be used here.

**OI-IIA**
The babies are small for the period of gestation. The face is hypoplastic with micrognathia, deep blue-grey sclerae, and a relatively large calvarium, which is moulded and soft. The chest is small and the abdomen protuberant. The limbs are short and bowed. The hips are flexed and abducted. One or more limbs may be held in a severely deformed position. The radiographs show generalised osteopenia. The diaphyses of the long bones and ribs are as wide as their growth plates owing to the lack of metaphyseal remodelling (fig 1). The thin and crumpled cortices give the long bones a continuously beaded appearance. The pelvis and shoulder girdle have a similar appearance. There is generalised platyspondyly. The skull and face are severely porotic. Numerous wormian bones are present in the skull sutures. The babies are usually stillborn or die at birth.

**OI-IIIB**
The ribs are less affected so that respiratory distress is less and babies may survive for months (fig 2). Otherwise the clinical and radiographic features are similar to those of OI-IIA.

**OI-IIIC**
This is the least common subtype. The babies are very small, osteopenia is severe, and the long bones are slender, poorly modelled, and contain numerous fractures (fig 3). The babies are stillborn or die soon after birth.

**Clinical heterogeneity**
Babies are classified as having OI-II if they die in the perinatal period. However, the babies

**Genetic heterogeneity**
Numerous studies have shown that the majority

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*Figure 3* OI-IIIC: radiography showing minimal ossification of the skeleton.

Type I is the common mild form, type II is the perinatal lethal form, type III is a severe form, and type IV is a moderately severe form. We will focus on OI type II (OI-II).

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*Figure 4* Map of glycine substitutions within the triple helical domains of the α1(I) and α2(I) chains of OI-II. Each line represents the triple helical domain of an α chain. The substituting residue is listed on the left. The residue numbers are indicated above each line for the α1(I) chain and below each line for the α2(I) chain. The residues are numbered relative to the first glycine residue of the triple helix.
of babies with OI-II are heterozygous for mutations of the COL1A1 or COL1A2 genes that alter the structure of the triple helical domains or the carboxy-terminal propeptides of the proα1(I) or proα2(I) chains of type I procollagen (fig 4, table). Each procollagen molecule contains two proα1(I) chains and one proα2(I) chain. The propeptides are enzymatically removed outside the cell to produce type I collagen that is laid down in the extracellular matrix of the dermis, bone, dentine, sclera, ligaments, and fascia, the tissues affected in OI.

The first mutation defined in OI-II was a heterozygous deletion within COL1A1 that resulted in the loss of 84 amino acids from the triple helical domain of the α1(I) chain. However, few deletions have subsequently been identified (table). Exon skipping mutations are more common. They usually maintain the translational reading frame and the repetitive Gly-X-Y amino acid triplet structure as the exons encode complete triplets (table).

The majority of mutations in OI-II involve the substitution of Gly residues in Gly-X-Y triplets within the triple helical domain of the α chains. The ability of such mutations to produce the OI-II phenotype was confirmed by reproducing it in transgenic mice bearing a COL1A1 mutation that substituted Cys for Gly 859. Numerous point mutations of the GGN codon for Gly have been identified (fig 4). Substitutions by Ser are the most common while substitutions by Ala and Glu are rare and substitutions by Trp have not been identified to date. Approximately two-thirds of the substitutions involve the α1(I) chain and a similar proportion involve the carboxy-terminal halves of the triple helical domains of the α1(I) and α2(I) chains. The non-uniform nature of the substitutions, α chain involved, and sites within the α chains are unlikely to be the result of ascertainment or technical biases. Similar results were found when all babies born with OI-II in Victoria, Australia were studied. Similar results have also been obtained with modern methods of mutation detection that screen full length α1(I) and α2(I) cDNAs.

Most unrelated babies with OI-II have their own private de novo mutation (fig 4). Exceptions include recurrent substitutions of Gly 352, 415, and 1003 by Ser in the α1(I) chain. These mutations occurred at CpG dinucleotides, in a manner consistent with demethylation of a methylated cytosine residue. However, there do not appear to be any major mutational hot spots in the COL1A1 or COL1A2 genes in babies with OI-II.

A few mutations in the carboxy-propeptide of proα1(I) chains have been identified in OI-II (table). They alter sequences that are important in chain association, disulphide linkage of the chains, and interactions with chaperones.

In many instances, the mutations in OI-II are new dominant mutations, while in the remainder the mutation is inherited from a mosaic parent. Isolated germline mosaicism has not been identified to date. The mosaic parent may appear to be clinically normal or to have a mild or moderate form of OI. However, leucocytes, hair follicles, and dermal fibroblasts contain differing proportions of the normal and mutant alleles. The proportion within the osteoblasts, which is likely to be the most important determinant of the phenotype, is usually unknown. The recurrence risk of OI-II is approximately 7% because of the occurrence of germline mosaicism in one parent.

**Pathogenesis**

All of the mutations that produce OI-II appear to act in a dominant negative manner. The mutant proα chains are incorporated into type I procollagen molecules and produce major abnormalities in collagen metabolism.

Deletions, skipping mutations, and insertions in the triple helical domain produce abnormal alignment of the proα chains. Substitutions of Gly residues interrupt the mandatory repetitive Gly-X-Y structure required for normal formation of the triple helix. They may also produce a bulge or kink as a means of accommodating the bulkier side chains. For example, kinks at the mutant site have been observed in type I collagen molecules containing mutant α1(I) chains bearing substitutions of Gly 718 or 748 by Cys. The lysine residues, particularly on the amino-terminal side of the substitution, are often over-modified by the prolonged action of lysyl
hydroxylase and glycosyl transferases owing to a delay in the zipper-like folding of the collagen molecules.30 The thermal denaturation temperature of the abnormal collagen is often reduced but it is independent of the level of overmodification of the \( \alpha \) chains.31 The variable levels of overmodification and thermal stability of the mutant molecules are likely to reflect regional differences in helix stability and in the propensity for renucleation of the helix beyond the mutation.32-34

As type I collagen molecules contain two \( \alpha_1(I) \) chains it is likely with heterozygous mutations of COL1A1 that 25% of the molecules are normal while 75% of the molecules contain one or two mutant \( \alpha_1(I) \) chains. Conversely, as type I collagen molecules contain one \( \alpha_2(I) \) chain, it is likely with heterozygous mutations of COL1A2 that 50% of the molecules are normal and 50% contain a mutant \( \alpha_2(I) \) chain.27 Procollagen containing one or more mutant pro\( \alpha_1 \) chains is poorly secreted and is excessively degraded by cultured fibroblasts.22 Once secreted, cleavage of the amino propeptides by N-proteinase may be reduced even with mutations distant from the cleavage site.28

Histological and biochemical anomalies have been observed in the dermis from babies with OI-II. The fibroblasts often contain dilated, rough endoplasmic reticulum because of impaired secretion of the mutant type I procollagen molecules.35 The collagen fibrils are smaller than normal. There is a reduced amount of type I collagen which consists of a mixture of normal and mutant type I collagen molecules. The mutant collagen chains are more readily extracted which suggests that the type I collagen molecules containing one or more mutant chains may be degraded before they are incorporated into the more insoluble cross linked extracellular matrix.36

Severe anomalies have also been observed in bone from babies with OI-II. The bone is severely porotic. The normal cortical and trabecular bone pattern is replaced by woven bone.35 37 There is an abundance of plump osteoblasts surrounded by little extracellular matrix. The osteoblasts may also contain dilated rough endoplasmic reticulum.2 The growth plate is normal but cartilage cores persist in the trabeculae.38 The bone matrix contains a reduced amount of type I collagen and increased amounts of type III and V collagens.39 40 The type I collagen includes both normal and mutant molecules.34 40 The levels of some non-collagenous proteins are also abnormal.41 Osteocalcin, \( \alpha_{2} \)-HS glucoprotein, and bone sialoprotein levels are increased, osteonectin is reduced, and decorin levels are normal. There are dramatic changes in the collagen fibrils and mineralisation. The collagen fibrils are thin and do not show the normal spatial arrangement of parallel bundles.42 At the mineralising front, apatite crystallites are not oriented along the collagen fibrils as observed in normal bone. The crystallites are also small and appear to grow by aggregation of new crystallites onto their surfaces.2 38 43

Many of these metabolic findings were also observed in transgenic mouse models of OI-II.94 Expression of COL1A1 constructs encoding a Gly 859 to Cys substitution or an in frame deletion in the triple helical domain of \( \alpha_1(I) \) chains resulted in the incorporation of mutant type I collagen molecules into the tissues.

Mutations of the carboxyl-terminus of the pro\( \alpha_1(I) \) chain can also produce dramatic changes in type I collagen metabolism.64 In one heterozygous baby with OI-II, a codon frameshift mutation produced a truncated pro\( \alpha_1(I) \) chain with other pro\( \alpha_\)'chains.18 The abnormal type I procollagen molecules were not secreted and were degraded within the cell. The type I collagen content of the dermis and bone was reduced to about 20% of normal. This is the amount of normal collagen that would be expected if all of the molecules containing one or two mutant pro\( \alpha_1 \) chains were degraded. In contrast, mutations of the carboxyl-terminus of the pro\( \alpha_1 \) chains that prevent chain association and incorporation of mutant chains into type I procollagen molecules produce one form of mild OI-I.46

Genotype-phenotype relationships

There are two broad categories of genotype-phenotype relationships in osteogenesis imperfecta. The first category includes phenotypes associated with haploinsufficiency of COL1A1 and COL1A2. The second category includes phenotypes associated with dominant negative mutations of COL1A1 and COL1A2. There are rare exceptions, such as some forms of autosomal recessive OI that do not appear to be the result of type I collagen mutations.47

Haploinsufficiency of COL1A1 results in an approximately 50% reduction of type I collagen synthesis and the mild osteogenesis imperfecta type I phenotype with normal teeth, OI-IA.37 Heterozygous Mov-13 mice, in which one COL1A1 allele is inactivated by insertion of a retrovirus, also show the OI-IA phenotype.40 In contrast, homozygous Mov-13 mice die around the twelfth day of gestation as a result of the absence of type I collagen from many tissues.40 A human equivalent has not been identified as yet but would probably produce early death in utero and spontaneous abortion.

A homozygous deficiency of \( \alpha_2(I) \) chains has been reported in a child with moderately severe OI-III.56 The structure of the carboxyl-propeptide of the pro\( \alpha_2 \) chains was altered so that the chains would not associate. The metabolic consequences of the mutation were equivalent to homozygous haploinsufficiency of COL1A2. The heterozygous parents were minimally affected.

The majority of deletions, insertions, and splicing anomalies that alter the triple helical domain of the \( \alpha_1 \) or \( \alpha_2 \) chains produce lethal phenotypes. However, the more common glycine substitutions in the repetitive Gly-X-Y triplets of the triple helix produce mild to lethal phenotypes. The site and type of substitution have been proposed as important factors in determining the severity of the phenotype. For Gly substitutions by
Cys in the α1(I) chain, carboxyl-terminal sites produce lethal phenotypes, mid-helical sites produce moderately severe phenotypes, and amino-terminal sites produce mild phenotypes.4 However, exceptions such as the substitution at Gly 244 by Cys in a baby with OI-II have been observed.31 Gradients of phenotypic severity are less obvious with other Gly substitutions (fig 4). Lethal phenotypes are frequently observed with mid-helical Gly substitutions by Ser and Arg.

There are a few rare instances of unrelated subjects harbouring the same substitutions of glycines in either the α1(I) or α2(I) chain. Somewhat unexpectedly, such people do not always exhibit the same phenotype suggesting the possible involvement of epistatic effects. To illustrate this, an α1(I)-Gly352Ser substitution produces OI-II in one person but OI-IV in two others.20 22 A similar, though less dramatic, effect has also been noted in two subjects with OI-III resulting from an α2(I)-Gly859Ser substitution.52 In contrast, three subjects harbouring an α2(I)-Gly502Ser substitution appear to exhibit exactly the same OI-II phenotype.73 Clearly evidence from more instances is required to resolve the question of epistasis.

Gly substitutions were proposed to be less deleterious in the α2(I) chain as type I collagen molecules only contain one α2(I) chain. However, a similar proportion of Gly substitutions in the α1(I) and α2(I) chains produce lethal phenotypes. The sequences around the Gly substitution may be more important in determining the consequences of the substitution than the α chain involved.23 For example, within the α2(I) chain there are non-lethal domains interspersed with lethal domains.25

The level of expression of the mutant allele has been shown in transgenic mice also to be an important determinant of the severity of the phenotype. A direct relationship was found between the severity of the phenotype and steady state mutant mRNA levels in mice bearing a Gly 859 substitution by Cys in COL1A1.19 These findings indicated that moderate levels of expression of the mutant COL1A1 were sufficient to lead to dramatic dominant negative effects on the incorporation of type I collagen into the extracellular matrix. Similar findings were also observed in transgenic mice that were high expressors of a COL1A1 gene construct containing an in frame deletion.44 However, inbred mice expressing moderate levels of this transgene showed marked phenotypic variability.48 The explanation for this variability was not determined.

Little is known about the levels of expression of the mutant alleles and the levels of incorporation of mutant molecules into the extracellular matrix in human OI-II. However, the collagen content of the dermis and bone is reduced and mutant collagen is detectable in babies with Gly substitutions in the triple helical domain of the α chains.46 In one baby with a substitution of Gly 580 by Asp in the α2(I) chain, the bone matrix was shown to contain a ratio of mutant to normal α2(I) chains of 0.7:1.40

The genotypes associated with subtypes of OI-II have only been studied in a few babies. The substitution of Gly by Arg at Gly 391 produced OI-IIA, at Gly 667 produced OI-IIA/IIB, and at Gly 976 produced OI-IB.35 The substitution of Gly by Val at Gly 1006 produced OI-IC, Gly 973 produced OI-IIA, and Gly 256 produced OI-IA.35 A carboxyl-propeptide mutation of the proα1(I) chain produced OI-IIB.42

Prenatal diagnosis

OI-II is often detected on routine ultrasound scans of pregnant women with a history of osteogenesis imperfecta.66 67 The skull is poorly echogenic and the limb bones are characteristically broad, shortened, and fractured. The chest is also abnormal. OI-IIA is the most common subtype.68 These scans are often undertaken at about 16 weeks but can be done earlier in families with a history of previous babies with OI-II. In the latter families, in-traterine detection of the COL1A1 or COL1A2 mutations can be used if the mutation has been determined before the pregnancy.

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