Molecular analysis of the human vitamin D binding protein (group specific component, Gc) in tuberous sclerosis complex (TSC)

Joseph A Rodriguez, Randall L Evans, Stephen P Daiger, Hope Northrup

Abstract

Group specific component (Gc) is an abundant plasma protein whose functional role is not clearly established. Gc protein is synthesized in the liver and is known to bind vitamin D, vitamin D metabolites, and G actin; Gc protein is also implicated in macrophage activation. Several polymorphic electrophoretic variants of Gc protein are found in all human populations; the most common alleles are Gc-1f, Gc-1s, and Gc-2. In previous studies, Gc allele frequencies, determined using isoelectric focusing or immunofixation or both, were significantly different in patients with tuberous sclerosis complex (TSC) from matched controls, with an excess of Gc-2 in patients. Linkage association between Gc and TSC is unlikely since the Gc locus maps to chromosome 4q12, whereas the two common forms of TSC map to 9q34 and 16p13.1, respectively. However, a direct cause and effect relationship between Gc protein and TSC symptoms is possible. To investigate further the relationship between the Gc locus and TSC, two Gc restriction site polymorphisms, HaeIII and StyI, were typed in 43 unrelated white subjects with TSC. The frequencies of the restriction site polymorphisms in the TSC patients did not differ from those in control populations. Therefore a direct association between Gc type and TSC is unlikely. The previously reported association was either spurious or the result of typing errors in plasma from subjects with underlying abnormalities in plasma proteins.

Keywords: tuberous sclerosis complex (TSC); group specific component (Gc); Hardy-Weinberg equilibrium; allele frequency

In 1987 the first convincing evidence of linkage for TSC was reported. The location of TSC1 was assigned to the long arm of chromosome 9 by linkage to the ABO blood group. Additional studies have further refined the genetic location of TSC1 to a 3.5 cM region flanked by markers D9S149 (centromeric) and A6 (telomeric). The TSC1 gene has yet to be isolated. Evidence of genetic heterogeneity, however, indicated that other loci would be involved in TSC. In 1993 the United States Tuberous Sclerosis Consortium reported linkage of another TSC locus to markers defining the polycystic kidney disease 1 locus at 16p13. In 1993 the TSC2 gene was cloned. Several mutations at TSC2 have since been reported.

Interestingly, in 1975 Rundle et al reported findings of abnormal frequency distributions for alleles at the Gc locus in patients with TSC. Gc typing in an additional 21 TSC patients also showed an excess of Gc-2 or a deficiency of Gc-1 or both (S P Daiger, personal communication). The polymorphic variation Rundle et al reported was a Gc allele whose frequency was different from that in control populations. Since then, several DNA polymorphisms have been identified in the Gc gene that are associated with TSC.

Tuberous sclerosis complex (TSC) is a genetically heterogeneous disease of hamartomata formation. Virtually any organ system can be affected, but the most commonly affected tissues include brain, skin, kidneys, and heart. Clinically, the disease is heterogeneous with affected family members in pedigrees having quite different disease expression. Genetically, TSC is also heterogeneous with at least two genetic loci known to be involved in causing TSC.
Table 1  Expected and observed frequencies of Gc HaeIII and StyI restriction site polymorphisms

(A) Allele frequencies of HaeIII and StyI restriction site polymorphisms (n=86)

<table>
<thead>
<tr>
<th>Allele</th>
<th>Frequency</th>
<th>Expected</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HaeIII cut (+)</td>
<td>0.65</td>
<td>49</td>
<td>86</td>
</tr>
<tr>
<td>HaeIII uncut (-)</td>
<td>0.35</td>
<td>37</td>
<td>72</td>
</tr>
<tr>
<td>StyI cut (+)</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>StyI uncut (-)</td>
<td>0.22</td>
<td>0.22</td>
<td>0.22</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>165</td>
</tr>
</tbody>
</table>

χ²_HaeIII=2.32, 0.1<p<0.20, 1 df; χ²_StyI=0.55, 0.25 <p<0.50, 1 df.

(B) Genotype frequencies of HaeIII restriction site (n=43)

<table>
<thead>
<tr>
<th>Class</th>
<th>Observed No</th>
<th>Expected proportion</th>
<th>Expected No</th>
</tr>
</thead>
<tbody>
<tr>
<td>HaeIII (+)</td>
<td>20</td>
<td>0.42</td>
<td>18</td>
</tr>
<tr>
<td>HaeIII (-)</td>
<td>16</td>
<td>0.46</td>
<td>20</td>
</tr>
<tr>
<td>HaeIII (++)</td>
<td>7</td>
<td>0.12</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>1.00</td>
<td>43</td>
</tr>
</tbody>
</table>

χ²=1.82, 0.1<p<0.20, 1 df.

(C) Genotype frequencies of StyI restriction site (n=43)

<table>
<thead>
<tr>
<th>Class</th>
<th>Observed No</th>
<th>Expected proportion</th>
<th>Expected No</th>
</tr>
</thead>
<tbody>
<tr>
<td>StyI (+)</td>
<td>2</td>
<td>0.05</td>
<td>2</td>
</tr>
<tr>
<td>StyI (-)</td>
<td>15</td>
<td>0.35</td>
<td>15</td>
</tr>
<tr>
<td>StyI (++)</td>
<td>26</td>
<td>0.60</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>1.00</td>
<td>43</td>
</tr>
</tbody>
</table>

χ²=0.00, 1<p<0.99, 1 df.

**Results**

A total of 43 white patients with TSC were enrolled in the study. The patients were unscreened for age, sex, and disease severity. Selection for ethnicity was done to minimize allele frequency differences based on population substructure. The observed genotype frequencies did not vary from those expected based on published allele frequencies in white populations (table 1). When the HaeIII and StyI allele frequencies from this study were compared to the frequencies reported in the study by Braun et al., again no significant difference is detectable (data not shown).

**Discussion**

Tuberous sclerosis complex is a heterogeneous disease of hamartoma formation. Clinical heterogeneity is quite common among affected patients and variability is detectable even among members of a single family, presumably having the same mutation. Given the heterogeneous nature of TSC it is difficult to predict the clinical course of the disease in affected subjects even when a family history of the disease is present. Modifying factors may contribute to the clinical heterogeneity seen.

In 1975, Rundle et al. surveyed tissue and serum proteins in a total of 54 cases of TSC. Interestingly, one serum protein had allele frequencies significantly different from HWE expectations, χ²=16.9, p=0.001. This marker, Gc, was also shown to have allele frequencies significantly different from a matched set of controls, χ²=50.6, p=0.001. The vitamin D binding protein, Gc, is an α-2-globulin which is
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found primarily in the plasma but is also found on cellular membranes. The gene is ubiquitously expressed and the protein is physiologically multifunctional.\footnote{1} The biological role for Gc in modifying the TSC phenotype did not seem clear; however, given the statistically significant deviation in Gc allele frequencies in patients with TSC as reported by Rundle et al., testing Gc seemed prudent. In an effort to uncover biological factors potentially responsible for clinical heterogeneity, we tested the Gc locus as a candidate modifying factor.

In order to obviate the need to do the more arduous IEF typing, we opted to use PCR to test two restriction site polymorphisms (HaeIII and StyI) that encode changes relevant to the IEF variant. The HaeIII restriction site was reported to be specific for the Gc-1s IEF allele, the StyI site specific for the Gc-2 IEF allele. The nucleotide change generating the HaeIII site is located in codon 416 and changes an aspartate to glutamate. At codon 420 the nucleotide change generating the StyI site changes a threonine to lysine.\footnote{2}

In the chi-square analysis we found no statistically significant variation from HWE expectations (table 1). There is also no variation between our sample of TSC patients and a sample of controls reported by Braun et al.\footnote{3} If extrapolated to protein IEF variation at the Gc locus,\footnote{4} no difference in the IEF Gc-2 allele frequency is noticeable between TSC patients and controls.

The most compelling difference between the population of TSC patients studied here and those reported by Rundle et al\footnote{5} may be disease severity. While our patients were unselected for disease severity, those reported by Rundle et al were all institutionalised, implying a more severe phenotype. Given this scenario, Gc might be involved in modifying TSC, causing a more severe disease phenotype. A more likely explanation, however, might be reflected in the potentially unequal plasma concentration of Gc types owing to processing of the Gc protein in the liver. It is possible that the medications used to treat some symptoms of TSC might alter liver function and consequently affect the plasma concentration of some plasma proteins or their allelic types that might be processed by the liver. More severely affected patients may be more likely to use medications which alter liver function. This type of perceived association reflected by testing the plasma proteins would, of course, not affect the allelic types determined by DNA testing.\footnote{6}

The data presented in this report exclude Gc as a modifying factor for TSC with the single caveat that our patient population was not selected for disease severity. As the genetic and mutational details of the TSC phenotype become known, it will be important to determine which factors are responsible for the inter- and intrafamilial variation seen in the disease. This report serves to initiate future studies of the factors which are likely to be involved in modifying the TSC phenotype leading to the clinical variation seen. Other epidemiological risk factors will also be evaluated, and are postulated to be involved in TSC phenotypic variation.

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