The elusive Angelman syndrome critical region


Abstract
DNA mapping studies in two families provide further information on the Angelman syndrome critical region, which has recently been defined by the gene UBE3A. The first family has probable familial Angelman syndrome with a maternally imprinted inheritance pattern. A 5 year old girl with this disorder has a 14 year old brother and an 11 year old male cousin who have less typical clinical features. DNA microsatellite analysis has shown that the three share a common segment of the same grandpaternal chromosome 15q11-q13 that overlaps with UBE3A. The child with typical Angelman syndrome has an additional maternal recombination 5' to UBE3A. The second family is a mother and son both of whom have mental retardation but no other features of Angelman syndrome despite an extensive DNA deletion on the telomeric side of UBE3A. Together, the two families identify a region between loci D15S210 and D15S986 which forms part of the Angelman syndrome critical region. A new microsatellite (D15S1234) is described which can be used in place of the L56-1 marker at locus D15S113.

Keywords: Angelman syndrome; recombination; microsatellites; UBE3A

Angelman syndrome (AS), first described in 1965 by Harry Angelman, is a multisystem disorder which can be difficult to diagnose, particularly in the first few years of life. Clinical features include severe mental retardation with lack of speech, delayed motor milestones, characteristic facies, inappropriate laughter, good nature, hypopigmentation, and brachycephaly. Seizures associated with a typical spike and slow wave activity on EEG are common. The incidence of AS is estimated to be 1 in 20 000. It is predominantly a sporadic disorder although familial cases have been described. At the molecular level, AS can be subdivided into: (1) ~70% of cases have a deletion involving the maternally derived chromosome 15q11-q13; (2) ~3-5% of cases result from paternal uniparental disomy of chromosome 15; (3) ~8% have an abnormality in the imprinting process; (4) the remainder are considered to have a mutation affecting a single gene, which is likely to be UBE3A. Familial recurrence has been reported in groups (3) and (4). Although not apparently imprinted in adult life, UBE3A is involved in ubiquitin dependent protein proteolysis, which would play a critical role during brain development. Four mutations have been described which lead to truncated proteins via premature stop codons or frameshifts in this gene. However, its role in the AS phenotype remains to be determined. To define further the ANCR (Angelman critical region, the minimal chromosomal region associated with AS) we have studied a family of Turkish-Cypriot origin in which the proband has features of AS but two relatives (a brother and a male cousin) are less severely affected. DNA microsatellite analysis shows that the three children share a common haplotype which overlaps UBE3A. A DNA recombination just telomeric to UBE3A in the proband and further refinement of the centromeric extent of a chromosome 15q11-q13 deletion in a second family, which does not have AS, enables the ANCR to be extended beyond UBE3A.

Materials and methods

CLINICAL REPORT
Family ML is of Turkish-Cypriot origin and came to the attention of the Genetics Clinic because of delay in speech development affecting five children who are the offspring of three sisters (fig 1). The proband (III.3) was aged 5 when recently assessed. She has features of AS which include unsteady gait, typical facies and EEG findings, delayed psychomotor development, a happy disposition, prognathism, a large mouth with widely spaced teeth, and a small head (3rd centile). Hypopigmentation was not present. Her speech defect was atypical of AS since she can use about 50 words. A cousin and brother were also assessed (III.1, II.3) and considered to be less typical of AS although review by two independent clinical geneticists confirmed that the three shared common

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The phenotypes for III.3 and her affected brother and cousin are compared to published consensus diagnostic criteria (table 1). In this family, key features of AS, including developmental delay, speech impairment, a movement disorder, and behavioural patterns such as frequent smiling, are present but to a variable degree. The proband has thefacial features of AS (fig 2) and the typical EEG pattern reported in this disorder. Facial features of her brother and cousin are provided as a contrast (fig 2). Cytogenetic studies for the proband and her brother were normal.

Molecular studies
DNA was prepared from family members and analysed for microsatellite polymorphisms at the following loci: D15S122, D15S10, D15S210, D15S986, D15S113, D15S1234, and GABRB3. All except D15S1234 have previously been reported. D15S1234 is defined by (CTTT)n, a microsatellite which we isolated from a λ phage contig prepared from YAC 229A2 (GDB accession number 698716). Methylation analysis of DNA from III.3 was undertaken with the SNRPN probe. DNA from BS and DH was analysed with microsatellite markers D15S122, D15S210, and D15S986.

Results
Clinical
The phenotypes for III.3 and her affected brother and cousin are compared to published consensus diagnostic criteria (table 1). In this family, key features of AS, including developmental delay, speech impairment, a movement disorder, and behavioural patterns such as frequent smiling, are present but to a variable degree. The proband has the facial features of AS (fig 2) and the typical EEG pattern reported in this disorder. Facial features of her brother and cousin are provided as a contrast (fig 2). Cytogenetic studies for the proband and her brother were normal.

Molecular
A difficulty with mapping in this region has been the relative positions of microsatellite markers. The location of D15S210 was defined on the basis of a λ phage contig prepared from YAC 273A2 (data not shown). It is >50 kb

Table 1  Angelman syndrome consensus criteria and comparison with family ML (from reference 9)

<table>
<thead>
<tr>
<th>Clinical features</th>
<th>III.1</th>
<th>III.2</th>
<th>III.3 (proband)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Consistent (100%)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Developmental delay, functionally severe</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Speech impairment, none or minimal use of words; receptive and non-verbal communication skills higher than verbal ones</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Movement or balance disorder, usually araxis of gait/tremulous movement of limbs</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioural uniqueness: any combination of frequent laughter/smiling, apparent happy demeanor, easily excitable personality, often with hand flapping movements; hypermototoric behaviour, short attention span</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Frequent (more than 80%)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Delayed, disproportionate growth in head circumference, usually resulting in microcephaly (absolute or relative) by age 2</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Seizures, onset usually &lt;3 years of age</td>
<td>No</td>
<td>No</td>
<td>Slow, abnormal waves</td>
</tr>
<tr>
<td>Abnormal EEG, characteristic pattern with large amplitude slow-spike waves (usually 2–3/s), facilitated by eye closure</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>(B) Associated (20–80%)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Flat occiput</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Occipital groove</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Prominent tongue</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Tongue thrusting, sucking/swallowing disorders</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Feeding problems during infancy</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Prognathism</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Wide mouth, widely spaced teeth</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Frequent drooling</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Excessive chewing/mouthing behaviours</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Strabism</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Hypopigmented skin, light hair and eye colour (compared to family), seen only in deletion cases</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Uplifted, flexed arm position especially during ambulation</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Increased sensitivity to heat</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Sleep disturbance</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Attraction to/fascination with water</td>
<td>No*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*No, but loves swimming.
Before the identification of UBE3A, approximately 15-20% of AS cases had no demonstratable molecular abnormality, that is, deletion, uniparental disomy, or methylation between D15S210 and D15S113, was uninformative in this family. The methylation imprint in III.3 was normal, that is, both maternal and paternal specific bands were detected.

Microsatellite analysis in BS/DH (the family without AS) showed that DNA from the mother and son was biallelic at markers D15S122 and D15S210 and both were deleted at D15S986. This is consistent with previous data showing an intact D15S10 and a deleted D15S113. The D15S986 result extends the centromeric extent of the deletion in BS/DH from D15S113 to D15S986.

Discussion

The long awaited breakthrough in the positional cloning for the AS gene has now come with the finding of mutations in the UBE3A gene. In terms of function, the gene, as a member of the ubiquitin protein ligases, can play a number of critical roles during development, for example, regulation of protein turnover, phosphorylation, and endocytosis. Further complexity associated with UBE3A is the finding of alternative transcripts with the potential to encode three protein isoforms which differ at their N-termini, a genomic region extending over 60 kb, and a 5' untranslated region which remains to be characterised but is presumed to be long, based on sizing of mRNA and a relatively short 3' non-coding region. Thus, definitive characterisation of UBE3A and its role in AS will take some time as extensive mutation analyses enable genotype/phenotype correlations to be completed. Already there is evidence that the 5' untranslated region requires further study since an AS family with two affected sibs has placed the mutation locus distal to D15S122, that is, either the first exon of UBE3A or further upstream.

Before the identification of UBE3A, approximately 15-20% of AS cases had no demonstratable molecular abnormality, that is, deletion, uniparental disomy, or methylation...
Figure 3. Microsatellite DNA haplotypes for family ML. The position of two crossover events is indicated by an X. The S′ end (exon 1) of the UBE3A gene is shown by — and the gene then extends beyond D15S122.

difference. It is into this group that affected subjects in family ML fall. The different phenotypes in family ML are puzzling. There is little doubt that the proband (III.3) has the syndrome and her two male relatives have a milder but related disorder. The difference could be explained by the three sharing a mutation involving UBE3A and the more severe phenotype then resulting from the recombination event which has occurred in the proband. The mutation in UBE3A would need to have minimal effect on the protein’s function, for example, a splicing defect which did not lead to a frameshift or a missense change. There are precedents for different mutations in the same gene leading to mild phenocopies, for example, cystic fibrosis and β thalassaemia. In this respect, it is noteworthy that a missense change (Cys21Tyr) in UBE3A was present in a patient with a less classical phenotype. An additional recombination event affecting a 5′ regulatory or controlling region, such as an enhancer, could further interfere with the protein’s expression or function. In the case of family ML, the recombination has occurred between D15S210 and D15S113 (fig 4). Clinically, the family again emphasises the importance of a thorough history to show the familial nature of the disorder in this case. Subject III.3, who is critical to the diagnosis, might not have been identified if more distant family members had presented initially and had subsequently been investigated superficially. This is particularly relevant for family ML which is at high risk for recurrence of AS.

The second family (BS/DH), which has a DNA deletion but no features of AS apart from the non-specific finding of mental retardation, narrows the region of interest since it excludes locus D15S986. Thus, the potential regulatory or controlling region is situated between D15S210 and D15S986 (fig 4). The size of this DNA segment remains to be defined because the relative position of D15S986 to microsatellites on either side was determined on the basis of overlapping YAC clones. It is likely to contain a recombination hot spot since, in the report by Paldi et al, all five recombinations in 86 informative female mice were detected in this segment of chromosome 15q11–q13 occurred between D15S210 and a more telomeric D15S97 locus. The two recombinations involving females in family ML occurred between D15S210 and D15S113. Only one of the 14 recombination events in males were localised to this region, the remainder being situated on the centromeric side of D15S112.

Mutation analysis involving UBE3A is proceeding in family ML, although this will take some time as the exon-intron boundaries for the gene have not been sufficiently defined to enable all exons to be characterised from genomic DNA. The more rapid RT-PCR approach using peripheral blood lymphocytes remains to be evaluated. As with all large genes, the identification of mutations in introns will lag considerably behind those found in exons. Irrespective of the potential to look for mutations in the UBE3A gene, the initial molecular approaches to laboratory confirmation of AS will continue to rely on FISH, microsatellite analysis, and methylation studies. A limitation to microsatellite analysis has been the availability of markers in this region including the potential for null alleles, for example, the LS6-1 marker for D15S113. The microsatellite D15S1234 is technically
easier to use and will prove helpful in this respect.

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