Sanfilippo syndrome type D: identification of the first mutation in the N-acetylglucosamine-6-sulphatase gene

C E Beesley, D Burke, M Jackson, A Vellodi, B G Winchester, E P Young

Mucopolysaccharidosis type IIID is the least common of the four subtypes of Sanfilippo syndrome. It is caused by a deficiency of N-acetylglucosamine-6-sulphatase, which is one of the enzymes involved in the catabolism of heparan sulphate. We present the clinical, biochemical, and, for the first time, the molecular diagnosis of a patient with Sanfilippo D disease. The patient was found to be homozygous for a single base pair deletion (c-1169delA), which will cause a frameshift and premature termination of the protein. Accurate carrier detection is now available for other members of this consanguineous family.

MATERIALS AND METHODS

Clinical information

The male patient is the third child of first cousin parents from Pakistan. He presented at clinic aged 3 years 10 months. He was born after an uneventful pregnancy with a birth weight of 3200 g. According to his parents, he had always been lively and had normal motor and cognitive development. He was born with widely set, broad, and flat ears. His nose was broad and flat. His tongue and hands were large. He had a large head with frontal bossing, a low nasal bridge, and a tendency to hypertelorism. He had very lively and examination was extremely difficult as he became very fractious. He had a hirsute facies and his facial features were quite coarse. He had a large head with frontal bossing, a low nasal bridge, and a tendency to hypertelorism. His nose was broad and flat. His tongue and hands were large. There was no hepatosplenomegaly and no audible murmurs. A mucopolysaccharidosis disorder was suspected and a skeletal survey was consistent with this diagnosis. Samples were collected and analysed further.

Analysis of urinary GAGs and enzyme assays

Quantitative analysis of urinary GAGs was performed using the dimethylmethine blue method. Two dimensional electrophoresis of urinary GAGs was carried out as described previously. The enzyme assays for the four Sanfilippo subtypes, A, B, C, and D, were carried out as previously described.

DNA analysis

The genomic DNA sequence for the G6S gene was obtained from a draft working sequence of chromosome 12 (NT_009616). Genomic DNA was obtained from a fibroblast cell line derived from the patient. Each of the 14 exons was amplified by PCR using intronic primers (table 1). A typical PCR reaction using 100 ng of genomic DNA contained 25 pmol of each primer, 1 x NH4 reaction buffer (Bioline), 0.2 mmol/l dNTPs, and 0.5 µl (2.5 units) BioPro DNA polymerase (Bioline) (added after a “hot start”). Details of the annealing temperature and MgCl2 concentrations used are provided in table 1. Cycling conditions were typically 96°C for 10 minutes, followed by 35 cycles of one minute at 96°C, one minute at 62-66°C, one minute at 72°C, and a final extension at 72°C for 10 minutes. PCR products were concentrated and separated from excess primers and dNTPs by ultracentrifugation through Microcon-100 columns (Millipore) before sequencing. Products were sequenced in both the forward and reverse directions using BigDye™ terminator technology (Applied Biosystems). Reactions were performed according to the manufacturer’s recommendations (Applied Biosystems) and samples were analysed on an ABI Prism 377 DNA sequencer (Applied Biosystems). The sequence change was confirmed by ACRS (amplification created restriction site) PCR using 5′-GACATTGCTGGCTACGACCTAAATAAGACT -3′ as the forward primer (underlined base is the mismatch) and SFD10(-) (table 1) as the reverse primer. The PCR products were then digested with the restriction enzyme TaqI.

RESULTS

Analysis of urinary GAGs

Urinary GAGs were measured on two separate occasions and found to be raised. Two dimensional electrophoresis of the urinary GAGs showed an abnormal excretion of heparan sulphate and heparin-like component (data not shown). These results were consistent with the diagnosis of Sanfilippo syndrome.

Enzyme assays

The enzymes defective in Sanfilippo disease types A, B, and C (heparin-N-sulphatase, α-N-acetylgalactosaminidase, acetyl-CoA N-acetyl transferase, respectively) were assayed in either leucocytes or plasma. Normal activities were obtained for these enzymes (table 2), thus excluding a diagnosis of
Sanfilippo types A, B, and C. A skin biopsy was obtained from the patient and N-acetylgalactosamine-6-sulphatase (deficient in Sanfilippo type D) was assayed in cultured skin fibroblasts, using the method of He et al. As a positive control for Sanfilippo D deficiency was not available, fibroblasts from a patient with I cell disease, in which there is a deficiency of all lysosomal enzymes except β-glucosidase, were also assayed. No N-acetylgalactosamine-6-sulphatase activity was detected in the fibroblasts from the patient (table 2) or the I cell patient, confirming a diagnosis of Sanfilippo syndrome type D in our patient.

DNA analysis

Even though the genomic sequence for the G6S gene had not been published, information detailing intron/exon boundaries was available in a draft working sequence of chromosome 12. The gene consists of 14 coding exons and is approximately 43 kb in length. All the exons and flanking regions of the gene from the patient and a control were amplified and sequenced. A deletion of one nucleotide (adenine residue) was found in exon 10 of the G6S gene from the patient, c1169delA (fig 1). The deletion is predicted to cause a frameshift after codon 389 and premature termination 10 amino acids downstream. The patient is homozygous for the change and material was available from both of the consanguineous parents. Confirmation of the deletion was carried out using ACRS PCR. The introduction of a specific mismatch and the presence of the deletion in the mutant allele create a TaqI restriction enzyme site (TCGA). This site cannot be created in the normal allele. PCR products were amplified from the patient, his parents, and a normal control. The products were digested with TaqI and the homozygous deletion was confirmed in the patient. As expected, both parents were found to be carriers of the deletion (data not shown).

**DISCUSSION**

In this paper, we report the clinical, biochemical, and molecular diagnosis of a case of the very rare disorder, Sanfilippo D syndrome. The deletion of one nucleotide in the G6S gene is the first reported mutation to our knowledge. Since it causes premature termination of the protein and loss of the last 163 C-terminal residues, it is likely to be disease causing. Also, the deletion causes disruption of the protein sequence two amino acids upstream of an aspartate, glycine motif conserved in G6S, and four arylsulphatases, and causes the loss of a highly homologous region towards the C-terminus of human sulphatase genes. No other sequence changes that alter the amino acid sequence were found at the intron/exon boundaries that could affect splicing of the G6S gene in this patient. Our results now permit the molecular analysis of Sanfilippo syndrome.

**Table 1** Primers and PCR conditions required for the amplification of the G6S gene

<table>
<thead>
<tr>
<th>Exon</th>
<th>Primers</th>
<th>Sequence</th>
<th>Product size (bp)</th>
<th>MgCl2 concentration (mM)</th>
<th>Annealing temperature (°C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SFD1(+)</td>
<td>5'-CCGGCCCTACGCTATGTGGTC-3'</td>
<td>333</td>
<td>1.5</td>
<td>66</td>
</tr>
<tr>
<td>2</td>
<td>SFD2(+)</td>
<td>5'-ACGGAGAAAGAGACGCA-3'</td>
<td>260</td>
<td>1.5</td>
<td>66</td>
</tr>
<tr>
<td>3</td>
<td>SFD3(+)</td>
<td>5'-GCCGGGATTCACGCTAAGA-3'</td>
<td>504</td>
<td>1.5</td>
<td>66</td>
</tr>
<tr>
<td>4</td>
<td>SFD4(+)</td>
<td>5'-CCAGCCGATTTTGCTGCCCCG-3'</td>
<td>332</td>
<td>1.0</td>
<td>66</td>
</tr>
<tr>
<td>5</td>
<td>SFD5(+)</td>
<td>5'-GTTGATCGCAGGACGGTTGC-3'</td>
<td>327</td>
<td>1.0</td>
<td>66</td>
</tr>
<tr>
<td>6</td>
<td>SFD6(+)</td>
<td>5'-GCCGGGATTTTGCTGCCCCG-3'</td>
<td>341</td>
<td>1.0</td>
<td>66</td>
</tr>
<tr>
<td>7</td>
<td>SFD7(+)</td>
<td>5'-GGAAACCAGGAAGGGGGGAGA-3'</td>
<td>311</td>
<td>1.0</td>
<td>62</td>
</tr>
<tr>
<td>8</td>
<td>SFD8(+)</td>
<td>5'-TGAGCTGTGGAAGGCTGAC-3'</td>
<td>294</td>
<td>1.5</td>
<td>62</td>
</tr>
<tr>
<td>9</td>
<td>SFD9(+)</td>
<td>5'-GCCGGCCTGATGGTGGGAAAGG-3'</td>
<td>359</td>
<td>1.5</td>
<td>64</td>
</tr>
<tr>
<td>10</td>
<td>SFD10(+)</td>
<td>5'-GGAAACCAGGAAGGGGGGAGA-3'</td>
<td>355</td>
<td>1.0</td>
<td>62</td>
</tr>
<tr>
<td>11</td>
<td>SFD11(+)</td>
<td>5'-GTTGATCGCAGGACGGTTGC-3'</td>
<td>263</td>
<td>1.5</td>
<td>66</td>
</tr>
<tr>
<td>12</td>
<td>SFD12(+)</td>
<td>5'-GCCGGGATTTTGCTGCCCCG-3'</td>
<td>282</td>
<td>1.5</td>
<td>66</td>
</tr>
<tr>
<td>13</td>
<td>SFD13(+)</td>
<td>5'-GCCGGGATTTTGCTGCCCCG-3'</td>
<td>331</td>
<td>1.5</td>
<td>64</td>
</tr>
<tr>
<td>14</td>
<td>SFD14(+)</td>
<td>5'-GCCGGGATTTTGCTGCCCCG-3'</td>
<td>292</td>
<td>1.0</td>
<td>66</td>
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</tbody>
</table>

**Table 2** Enzyme activities of heparan-N-sulphatase, acetyl-CoA N-acetyl transferase, α-N-acetylgalactosaminidase, and N-acetylgalactosamine-6-sulphatase in the patient and controls

<table>
<thead>
<tr>
<th>Cell type</th>
<th>Enzyme Activity</th>
<th>Units</th>
<th>Patient</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leucocytes</td>
<td>Heparan-N-sulphatase</td>
<td>pmol/h/mg protein</td>
<td>280</td>
<td>265 &amp; 168</td>
</tr>
<tr>
<td>Leucocytes</td>
<td>Acetyl-CoA N-acetyl transferase</td>
<td>nmol/h/mg protein</td>
<td>2.4</td>
<td>0.64-4.2</td>
</tr>
<tr>
<td>Plasma</td>
<td>α-N-acetylgalactosaminidase</td>
<td>nmol/h/mg protein</td>
<td>40</td>
<td>12-73</td>
</tr>
<tr>
<td>Fibroblasts</td>
<td>N-acetylgalactosamine-6-sulphatase</td>
<td>nmol/17h/mg protein</td>
<td>0</td>
<td>91-138</td>
</tr>
</tbody>
</table>
type D patients and carrier testing within affected families. It will be interesting to determine the mutations in the 12 patients reported world wide to see if Sanfilippo D shows the same genetic heterogeneity characteristic of Sanfilippo syndrome types A and B.

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