Genotype and psychological phenotype in tuberous sclerosis

J C Lewis, H V Thomas, K C Murphy, J R Sampson

Tuberous sclerosis complex (TSC, MIM 191090 and 191100) is an autosomal dominant, multisystem disorder characterised by the development of a variety of hamartomatous growths. The TSC phenotype includes renal involvement (in over 80% of patients) with angiomyolipomas and cysts; skin involvement with facial angiofibromas, hypomelanotic macules, shagreen patches, and perivascular fibromas; and cardiac, ophthalmic, and pulmonary involvement. Many of the frequent and serious complications of TSC, including epilepsy, mental retardation, and a wide range of psychiatric and behavioural disorders, reflect the cerebral involvement that occurs in over 90% of cases. Structural abnormalities in the brain include: cortical tubers that are localised areas of loss of normal hexalaminar cortical organisation, and that contain abnormal and enlarged cells categorised as cytomegalic neurones and balloon cells; subependymal nodules that are localised proliferations of abnormal cells in the periventricular zone; and migration tracts through the white matter linking subependymal and cortical lesions.

Mental retardation is estimated to occur in approximately 45% of cases. It is virtually always associated with a history of seizures correlated with early seizure onset, poor seizure control, and type of seizure at onset with the greatest risk for infantile spasms. The association between mental retardation and infantile spasms is particularly strong in the context of TSC. People with TSC are also reported to have high rates of autistic disorder, attention deficit hyperactivity disorder (ADHD), and sleep disorder. Although autistic disorder is a feature of several genetic disorders of childhood, its frequency is highest in TSC, and the strength of the association does not appear to be explained simply by the frequency of infantile spasms in TSC. Sleep disorder in TSC is associated with the presence of other behavioural problems and can be exacerbated by nocturnal seizures. There are also anecdotal reports of anxiety disorder, psychosis, and mania in patients with TSC, but these phenotypes have not been subjected to systematic study.

Two genes causing TSC have been identified: TSC1 at chromosome 9q34 and TSC2 at 16p13.3. Their protein products hamartin (TSC1) and tuberin (TSC2) form a complex that regulates the PI3-kinase/AKT pathway to control cell size and proliferation. Loss of these cellular functions is likely to be central to the pathogenesis of hamartomas associated with TSC. Hamartin has also been shown to bind ezrin and to activate the small GTPase rho, so promoting changes in the cytoskeleton and cell adhesion. Both TSC1 and TSC2 act as tumour suppressors, and somatic inactivation of the wild type allele through loss or intragenic mutation has been reported in many hamartomas associated with TSC. However, a “two hit” mechanism of pathogenesis has not been established unequivocally in relation to cortical tubers.

The relationship between genotype and phenotype in TSC has been the focus of a number of studies. A clear correlation has been established between polycystic kidney disease complicating TSC, and the presence of deletions involving both TSC2 and the immediately adjacent PKD1 gene that is mutated in autosomal dominant polycystic kidney disease type 1. Several studies have investigated aspects of disease severity in relation to TSC1 or TSC2 status. Jones et al noted that TSC1 mutations were more frequent among sporadic than familial cases with TSC. It was hypothesised that this might reflect less severe disease, on average, among cases with TSC1 mutations. These cases would be more likely to reproduce, leading to ascertainment within the context of a positive family history; whereas mildly affected sporadic cases would be more likely to remain unascertained. Jones et al also established that intellectual handicap (assessed indirectly using existing medical records, reported special educational placement, or inability to live independently as an adult) was more frequent among TSC2 than TSC1 cases, supporting this hypothesis. Dabora et al undertook a more comprehensive survey of phenotypic manifestations, including cerebral, renal, and skin findings in 224 patients with TSC. 186 (83%) of whom had characterised TSC1 (28) or TSC2 (158) mutations. Phenotypic data was extracted from patient records in several centres in the USA and Poland, using an instrument designed specifically for the study. TSC1 cases were found to have a lower frequency of seizures, moderate to severe mental retardation, subependymal nodules, cortical tubers on imaging of the brain; and less severe renal and skin

Key Points

- Tuberous sclerosis complex (TSC, MIM 191090 and 191100) is an autosomal dominant disorder caused by mutations of the TSC1 and TSC2 genes. It is characterised by hamartomas in multiple organs, epilepsy, and psychological manifestations including mental retardation and autistic disorder.
- The psychological phenotypes of 92 unrelated index cases with characterised TSC1 and TSC2 mutations were assessed using validated measures of intellectual function, autistic disorder, anxiety, depression, and behavioural disorders.
- The presence of a TSC2 mutation was found to carry a higher risk of low IQ (p = 0.0004), autistic disorder (p = 0.030), and infantile spasms (p = 0.001) than a TSC1 mutation. Cases with TSC2 mutations were also significantly more likely to have low IQ, after adjusting for history of infantile spasms by logistic regression analysis (OR = 3.50; 95% CI from 1.03 to 11.95).
- Previously unrecognised anxiety disorders were diagnosed in 20 of 36 adults with TSC who were capable of completing HADS assessment, and were frequent in cases with TSC1 and TSC2 mutations.
involvement. Two other studies have not identified significant phenotypic differences between TSC1 and TSC2 cases, but the power of one was limited by inclusion of only 38 patients, and the other did not undertake comprehensive mutation analysis at both loci.

A consistent weakness in relation to psychiatric and behavioural aspects of TSC in previous studies of genotype-phenotype correlation has been the use of non-validated tools to measure intellectual function and psychiatric and behavioural disorders. Furthermore, previous studies have not attempted to investigate the complex relationship between genotype, seizures, mental retardation, and behavioural phenotype. In the present study we have therefore addressed these issues in a cohort of 92 unrelated patients with TSC and characterised TSC1 or TSC2 mutations, using validated rating scales for the assessment of intellectual function and psychiatric and behavioural disorder.

METHODS

The study protocol was approved in November 1998 by the Multi Centre Research Ethics Committee for Wales and by the Local Research Ethics Committees with responsibility for each of the geographical locations in which patients were assessed.

Subjects

Subjects were recruited from a cohort of 157 unrelated index cases with TSC, who had been ascertained sequentially for molecular genetic research into TSC at the Institute of Medical Genetics, Cardiff. Cases ascertained were from adult and paediatric medical clinics, from regional genetics services, and learning disability services, with help from the Tuberous Sclerosis Association. All fulfilled the most recent criteria for definite clinical diagnosis of TSC. All had undergone comprehensive analysis for mutations at the TSC1 and TSC2 loci, using a range of methods for the detection of both small intragenic and splice site mutations, and larger deletions and rearrangements.

Clinical assessments

All subjects were assessed in their own homes or at a local genetics clinic by a single researcher (JCL), and their hospital medical records were reviewed. Assessments at interview included a structured clinical history detailing the onset, pattern of evolution, and treatment of seizures, and renal, skin, cardiac, and pulmonary symptoms; and a structured clinical examination. In addition, a range of standardised and validated psychological measures were used to assess intellectual level, autistic disorder, anxiety, depression, and behaviour. This involved:

- assessment of intellectual level using the Wechsler Adult Intelligence Scale (WAIS-R),
- Wechsler Intelligence Scale for Children (WISC-III),
- Raven’s Coloured Progressive Matrices (RCPM),
- or Vineland Adaptive Behaviour Scale;
- assessment of autistic disorder using Childhood Autism Rating Scale (CARS);
- assessment of problematic behaviours in children using Conner’s Parent Rating Scale (CPRS);
- Assessment of psychological symptoms using Strengths and Difficulties Scale,
- General Health Questionnaire, and
- Hospital Anxiety and Depression Scale (HADS).

Statistical analysis was undertaken using the Statistical Package for the Social Sciences (SPSS) Version 10 for Windows. Chi squared ($\chi^2$) tests examined the relationship between genotype and the variables of IQ ($< 70$ $\vee$ $\geq 70$), autistic disorder, history of infantile spasms, anxiety disorder, and depression. Logistic regression analysis was employed in a multivariate analysis, taking low IQ as the outcome variable and genotype and infantile spasms as independent variables.

RESULTS

Sample characteristics

Of the original 157 participants, 11 had died since their original ascertainment, and a further 11 were living outside mainland UK. The 135 remaining subjects (or their carers) were approached by letter with an invitation to participate in the present study; 98 agreed (response rate 78/135 = 73%), 28 declined, and 28 did not respond or could not be traced. Reanalysis of data on intellectual handicap reported by Jones et al (1999) for subjects recruited to the present study compared with subjects who had either died, declined, or could not be traced, revealed no difference between the two groups ($\chi^2 = 0.155; df = 1; p = 0.690$). Mutations had been characterised in 92 of the 98 recruited cases: 22 had TSC1 mutations (6 familial and 16 sporadic cases), and 70 had TSC2 mutations (5 familial cases, 64 sporadic cases, and one adopted case). The ages of participants at assessment for this study ranged from 6 to 70 years (mean 27 years; SD 14). TSC1 cases were significantly older than TSC2 cases (means 33 years $\vee$ 25 years, respectively; $t = 2.17; p = 0.038$, consistent with their ascertainment at a greater age.

Of the 98 participants, 47 were male and 51 female. No gender difference was found for normal or low IQ ($\chi^2 = 0.133; df = 1; p = 0.715$), history of infantile spasms ($\chi^2 = 0.006; df = 1; p = 0.936$), or autistic disorder ($\chi^2 = 0.022; df = 1; p = 0.881$). There was no gender difference between TSC1 and TSC2 probands ($\chi^2 = 0.915; df = 2; p = 0.633$).

Of the 98 cases, 93 had a history of epilepsy, including all of those (54/54) with an IQ of less than 70. Surprisingly, 20 of the 36 (56%) adults who were able to complete the HADS had anxiety related scores of 8 or above, indicative of anxiety disorder, and seven (19%) had depression related scores of 8 or above, indicative of depression. An apparent excess of these disorders in females did not reach significance ($\chi^2 = 0.1626; df = 1; p = 0.202$, and $\chi^2 = 3.201; df = 1; p = 0.074$, respectively).

Of the 98 cases, 86 were sporadic, 11 were familial, and one subject was adopted from biological parents of unknown genetic status. No significant differences in frequencies were found between familial index cases and sporadic cases for:

- low IQ (49/86 sporadic $v$ 4/11 familial; $\chi^2 = 1.672; df = 1; p = 0.196$), autistic disorder (30/86 sporadic $v$ 11/11 familial; $\chi^2 = 2.984; df = 1; p = 0.084$), anxiety (17/30 sporadic $v$ 3/6 familial; $\chi^2 = 0.090; df = 1; p = 0.764$), depression (6/30 sporadic $v$ 1/6 familial; $\chi^2 = 0.035; df = 1; p = 0.851$), or infantile spasms (40/82 sporadic $v$ 2/11 familial; $\chi^2 = 3.667; df = 1; p = 0.056$).

Locus and phenotypic heterogeneity

Phenotypic variables were considered as either present or absent. Intellectual level was categorised as either IQ of 70 or over, or IQ under 70. Intellectual level, history of infantile spasms, and presence of autistic disorder, anxiety, and depression were assessed in relation to TSC1 or TSC2 genotype. Low IQ, a history of autistic disorder, and infantile spasms were significantly more frequent in patients with TSC2 than TSC1 mutations (table 1). There was no significant difference between cases with TSC1 and TSC2 mutations in the frequency of current anxiety symptoms ($p = 1.000$), nor in the frequency of current depressive symptoms ($p = 0.674$).

Features of ADHD (assessed with the Conner’s Parent Rating Scale) and problem behaviours in children (assessed
Neither did analysis of the nucleotide position of truncating TSC2 mutations (considered as non-parametric continuous variables), using the Mann-Whitney U test, reveal a significant relationship with low IQ, autistic disorder, or infantile spasms (there were insufficient numbers of TSC1 cases for comparable analysis of mutations at that locus).

DISCUSSION

In this study we found that people with TSC2 mutations were significantly more likely than those with TSC1 mutations to have autistic disorder, a low IQ, and a history of infantile spasms. In addition, low IQ was found to be independently associated with both TSC2 mutations and a history of infantile spasms. Participants in the current study were ascertained from a variety of clinical settings, and are likely to be broadly representative of unrelated index cases with TSC who come to medical attention. The frequency of medical, psychiatric, and behavioural disorders in this group is expected to be higher than in epidemiological samples of patients with TSC that include secondarily ascertained members of multiplex families, in whom milder disease might be anticipated. Also, our sample is biased towards sporadic rather than familial cases when compared with other large series. This probably reflects our efforts to recruit sporadic cases in particular to the present study.

In this study, 55% of cases had an IQ of less than 70, compared with 44.5% in a recent epidemiological survey.

### Table 1

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total number TSC1</th>
<th>TSC2</th>
<th>χ²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>IQ ≥ 70 (all cases)</td>
<td>41</td>
<td>17 (77%)</td>
<td>24 (34%)</td>
<td>12.5</td>
</tr>
<tr>
<td>IQ &lt; 70 (all cases)</td>
<td>51</td>
<td>5 (23%)</td>
<td>46 (66%)</td>
<td></td>
</tr>
<tr>
<td>IQ = 70 (sporadics)</td>
<td>34</td>
<td>11 (69%)</td>
<td>23 (36%)</td>
<td>5.6</td>
</tr>
<tr>
<td>IQ &lt; 70 (sporadics)</td>
<td>46</td>
<td>5 (31%)</td>
<td>41 (64%)</td>
<td></td>
</tr>
<tr>
<td>No autistic disorder (all cases)</td>
<td>62</td>
<td>19 (86%)</td>
<td>43 (61%)</td>
<td>4.74</td>
</tr>
</tbody>
</table>

| Autistic disorder (all cases) | 30 | 3 (14%) | 27 (39%) |
| No autistic disorder (sporadics) | 52 | 13 (81%) | 39 (61%) | 2.32 | 0.128  |
| Autistic disorder (sporadics) | 28 | 3 (19%)  | 25 (39%) |
| No IS (all cases)            | 44 | 16 (84%) | 28 (42%) | 10.32 | 0.001  |
| IS (all cases)               | 41 | 3 (16%)  | 38 (58%) |
| No IS (sporadics)           | 35 | 10 (77%) | 25 (42%) | 5.32  | 0.021  |
| IS (sporadics)              | 38 | 3 (23%)  | 35 (58%) |

IS, infantile spasms.

*Familial plus sporadic cases; †Sporadic cases only.

### Table 2

<table>
<thead>
<tr>
<th>Determinant</th>
<th>Odds ratio</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSC2 (unadjusted)</td>
<td>4.52</td>
<td>2.14–19.83</td>
<td>0.001</td>
</tr>
<tr>
<td>TSC2 (adjusted)</td>
<td>3.50</td>
<td>1.03–11.93</td>
<td>0.045</td>
</tr>
<tr>
<td>IS (unadjusted)</td>
<td>9.71</td>
<td>3.53–26.69</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>IS (adjusted)</td>
<td>7.37</td>
<td>2.59–21.00</td>
<td>&lt;0.0005</td>
</tr>
</tbody>
</table>

CI, confidence interval; IS, infantile spasms.

### Table 3

<table>
<thead>
<tr>
<th>Clinical feature</th>
<th>Total cases</th>
<th>Truncating, 53 cases</th>
<th>Non-truncating, 17 cases</th>
<th>χ²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>IQ = 70</td>
<td>24</td>
<td>19 (36%)</td>
<td>5 (29%)</td>
<td>0.237</td>
<td>0.627</td>
</tr>
<tr>
<td>IQ = 70</td>
<td>43</td>
<td>34 (64%)</td>
<td>12 (71%)</td>
<td>0.064</td>
<td>0.800</td>
</tr>
<tr>
<td>No autistic disorder</td>
<td>33 (62%)</td>
<td>10 (59%)</td>
<td>23 (71%)</td>
<td>0.064</td>
<td>0.800</td>
</tr>
<tr>
<td>Autistic disorder</td>
<td>27</td>
<td>20 (38%)</td>
<td>7 (41%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No IS</td>
<td>29</td>
<td>22 (45%)</td>
<td>7 (44%)</td>
<td>0.060</td>
<td>0.970</td>
</tr>
<tr>
<td>IS</td>
<td>36</td>
<td>27 (55%)</td>
<td>9 (56%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IS, infantile spasms.
and 95% had a history of seizures, compared with 79% in the epidemiological sample. These differences are likely to reflect the medical ascertainment sources in the current study and the inclusion of probands only. In the present study, 33% of subjects were found to have autistic disorder, as assessed by the Childhood Autistic Disorder Rating Scale (CARS).11 CARS is based on Kanner’s criteria22 for the diagnosis of autistic disorder, and not on the wider diagnostic category of pervasive developmental disorder. Previous estimates of the frequency of autistic disorder in TSC have varied, not only because of different modes of ascertainment, but also because of differences in the diagnostic criteria that have been employed, including DSM III-R23 and ICD-10.34 Hunt and Shepherd24 identified autistic disorder in 5/21 (24%) of TSC cases ascertained through hospital departments and the Tuberous Sclerosis Association (a UK patient support group); whereas Gillberg et al.25 diagnosed autistic disorder in 17/28 (61%) of patients under 20 years of age, identified in a population based study.

Although anxiety and depression are common complications of chronic illnesses in general,19-21 it was noteworthy that 20/36 (56%) of adults capable of completing the HADS assessments scored above the threshold indicative of anxiety disorder. Anxiety disorders appeared to be under recognised in TSC, because none of the patients involved had received advice or treatment for these disorders, perhaps owing to the frequent comorbid effects of autism and intellectual handicap.

### Locus and phenotype heterogeneity

TSC2 mutations (70/92, 76%) were more frequent than TSC1 mutations (21/92, 24%) in our series, and the proportions were very similar to those reported by Dabora et al.26 in a large independent series of medically ascertained people with TSC. Our finding, that TSC2 mutations are more frequently associated with low IQ, infantile spasms, and autistic disorder than are TSC1 mutations, is consistent with two previous studies that suggested greater severity in disease determined by TSC2 than in disease determined by TSC1.27 28 It is currently unclear whether the increased risk of low IQ and autistic disorder in persons with TSC2 mutations is mediated by an increased risk of infantile spasms alone, but our data suggest some independence of genotype and infantile spasms as risk factors. This issue is of great significance to the potential for therapeutic intervention in TSC. An experimental approach to resolving the question would be a randomised trial of pre-emptive antiepileptic drug medication in cases of TSC diagnosed antenatally. Detection of cardiac rhabdomyomas on routine antenatal ultrasound would now make such a trial technically feasible. Unfortunately, symptomatic CNS manifestations have not been noted in single locus knockout animal models of TSC, so preclinical trials to address this issue. It is of interest, however, that murine Tsc2 mutations do appear to be associated with a more severe visceral phenotype than Tsc1 mutations on the same genetic background.19

Since the TSC1 and TSC2 gene products, hamartin and tuberin, have been shown to form a functional complex29-30 that acts to suppress cell growth via the P13-kinase/AKT pathway,29 31 it may not be immediately apparent why severity of disease determined by TCS1 should differ from that determined by TCS2. One possibility is that the somatic mutation rate is higher at the TCS2 locus, leading to more frequent “second hit” mutations and hence more frequent development of hamartomas. However, it remains unclear whether all the CNS manifestations of TSC result from a “two hit” mechanism. Careful molecular genetic studies of cortical tubers, including laser capture microdissection of cytomegalic neurones in one study, have failed to identify somatic “second hit” mutations in tubers, in contrast to a variety of visceral hamartomas.21 22 Alternatively, or in addition, tuberin may have currently unidentified roles that are not shared by hamartin.

The increasing evidence for severity differences between disease determined by TSC1 and TSC2 presents issues for those involved in discussing prognosis for TSC that is diagnosed antenatally or in early childhood. However, the great range of phenotypic severity seen among unrelated persons sharing identical mutations, and even among different affected members of large families, will continue to demand a cautious approach. Further genetic studies are likely to identify loci that modify the phenotypic effects of TSC1 and TSC2 mutations, and clinical studies have the potential to clarify the extent to which long term outcomes can be modified by early (or possibly pre-emptive) treatment with antiepileptic drugs. Clarification of the roles of TSC1 and TSC2 in regulating cell growth through the P13-kinase/AKT pathway29-31 has identified inhibitors of this pathway, such as rapamycin, as potential therapies when either gene is mutated.

### ACKNOWLEDGEMENTS

We thank the patients and their families who contributed to this study. Ann Hunt and Professor Patrick Bolton provided invaluable help with recruitment and research methodology. We are grateful to the Tuberous Sclerosis Association (UK) for funding to JCL, and to the Tuberous Sclerosis Alliance for funding to develop genotyping.

### Authors’ affiliations

J C Lewis, J R Sampson, Institute of Medical Genetics, University of Wales College of Medicine, Cardiff, UK

H V Thomas, Department of Psychological Medicine, University of Wales College of Medicine, Cardiff, UK

K C Murphy, Department of Psychiatry, Royal College of Surgeons in Ireland, Beaumont Hospital, Dublin, Eire

J R Sampson, Institute of Medical Genetics, University of Wales College of Medicine, Cardiff, UK

Correspondence: J R Sampson, Institute of Medical Genetics, University of Wales College of Medicine, Heath Park, Cardiff CF14 4N, UK; sampson@cf.ac.uk

Received 23 July 2003

Accepted 24 October 2003

### REFERENCES


