A missense mutation in both hMSH2 and APC in an Ashkenazi Jewish HNPCC kindred: implications for clinical screening

EDITOR—Colorectal carcinoma (CRC), among the most common neoplasms in humans, has a moderately large hereditary component. The two most frequent hereditary CRC syndromes are hereditary non-polyposis colorectal cancer (HNPCC) and familial adenomatous polyposis (FAP), both dominantly inherited disorders. HNPCC is caused by inherited defects in the DNA mismatch repair (MMR) genes hMLH1, hMSH2, PMS1, and PMS2; FAP is caused by mutations in the APC gene.1 Between 1 and 4% of all CRC fully satisfy the international criteria for HNPCC.2-4 In addition to CRC, these families also have an excess incidence of adenocarcinoma of the endometrium and to a lesser degree, cancer of the stomach, ovary, and other sites.5 Alterations in hMSH2 or hMLH1 account for ~90% of the germline mutations detected in HNPCC.1 Mutations in hMSH6 have been described in CRC kindreds that resemble HNPCC but do not always fulfil the above mentioned criteria.4-5

Familial adenomatous polyposis (FAP) accounts for less than 1% of CRC; it is characterised by the development of a large number (>100) of colorectal polyps, which, if untreated, will inevitably lead to CRC.6 The gene underlying FAP, APC, was identified in 1991; germline mutations truncating the APC gene product are usually found in FAP.7-10 An interesting missense variant in APC, I1307K, was discovered in a 39 year old man with eight colorectal polyps11 with a family history of colorectal polyps and CRC but not FAP. The T to A polymorphism at nt 3920 in APC was postulated to predispose to cancer, not as a direct effect of the protein, but by rendering its region of APC hypermutable. The mutation does not seem to be common in populations other than Ashkenazi Jews, where it is found at a frequency of 6.1%11 (recently we have found the allele in a French Canadian kindred12). The relative risk of CRC and other neoplasms associated with I1307K APC has been investigated.13-17 Woodage et al15 concluded that the cumulative risk of CRC among first degree relatives of CRC survivors among carriers compared to non-carriers was 1.9, although this was not statistically significant. By examining a cohort of unselected Ashkenazi Jewish patients with colorectal carcinoma or adenomatous polyps, Gryfe et al16 found statistically significant (p<0.01) relative risks of colorectal neoplasia of 1.72 (95% confidence interval 1.13-2.61) and 1.48 (95% confidence interval 1.08-2.04) compared to controls from New York and Washington, DC, respectively. Recent investigations have indicated that I1307K APC is a candidate low penetrance breast cancer susceptibility allele, particularly in heterozygotes for germline mutations in BRCA1 or BRCA2.16,17 It is hoped that the identification of mutations in CRC susceptibility genes will result in decreased morbidity and mortality by the application of appropriate screening and intervention strategies. To this end, in an Ashkenazi Jewish kindred with HNPCC, we used single strand conformation analysis (SSCA) to search for mutations in MMR genes and an allele specific oligonucleotide hybridisation (ASOH) assay

Figure 1 Pedigree of the MONT02 kindred. The age at death or the current age of the subjects are shown. +/A636P or +/+ presence or absence of exon 12 mutation in hMSH2; +/I1307K or +/+ presence or absence of I1307K variant in APC.
to identify I1307K APC. The proband (fig 1, II.11) was seen by both the medical genetics and colorectal surgery services and a family history was taken, identifying the family as an Amsterdam criteria positive HNPCC kindred (MON702). There are three relatives with CRC, two of the affected subjects are mother and son, and two cases were diagnosed at less than 50 years of age (II.13 and III.2). Informed consent was received for blood donation as approved by the institutional ethics committee. To assess the occurrence of MSI in CRCs from two affected subjects, six high sensitivity MSI markers (dinucleotide repeats D2S123, D18S58, and LNS and mononucleotide repeats BAT25, BAT26, and BAT40) were used to evaluate one CRC sample from each patient. The proband’s tumour DNA exhibited instability with three of the six microsatellite markers (data not shown) and her son’s (III.2, fig 1) tumour DNA showed alterations in allele length compared to matched normal DNA with BAT25, BAT26, and D18S58 (fig 2), defining both neoplasms as MSI according to established criteria. We then used PCR-SSCA to analyse hMLH1 and hMSH2 for heterozygous mutations. A mobility shift was identified in exon 12 of hMSH2 of genomic DNA amplified from two members of MON702, II.3 and III.2. A germline heterozygous G to C transversion at nucleotide 1905, resulting in a predicted protein sequence change of alanine to proline (A636P), was identified in both subjects showing the mobility shifts. Three unaffected sibs of the affected son (III.1, III.3, and III.4; fig 1) do not carry this mutation. We sequenced all 16 hMSH2 and 19 hMLH1 exons in the two affected subjects and did not find another mutation elsewhere in either hMSH2 or hMLH1 that might otherwise account for the MSI observed.

The A636P mutation appears to be associated with MSI. To exclude the possibility that it represents a rare polymorphism over-represented in the Ashkenazi, but not associated with HNPCC, we therefore screened 100 Ashkenazi Jews who donated blood anonymously for DNA studies but were not known to have CRC. No carriers of A636P were found by ASOH analysis. Another important question is whether this is a common mutation in Ashkenazi Jewish CRC patients. In total, DNA samples from 196 unselected Jewish CRC patients were successfully amplified by PCR and tested for the presence of the A636P allele. BAT26 MSI was present in the tumour DNA extracted from the neoplasms of 15 (7.6%) of these patients. No carriers of A636P hMSH2 were identified; these findings further indicate that A636P is not a common sequence variant in this population.

Following the report that I1307K APC is common in Ashkenazi Jewish CRC families, we investigated whether this mutation was present in the MON702 family. CRCs from subjects carrying this variant are usually MSI negative. It was, therefore, not surprising that I1307 APC was not present in the affected subjects in MON702, whose CRCs were MSI. However, unaffected subjects III.3 and III.4 were found to carry I1307K APC; these positive ASOH results were confirmed by sequencing. We also observed I1307K APC in eight out of 153 samples from Ashkenazi Jewish controls (5.2%), a similar figure to those reported previously.

Most of the hMSH2 mutations described so far in HNPCC result in a truncated protein and allow an immediate inference of pathogenicity. In the absence of large kindreds with numerous affected subjects, it is difficult to evaluate the pathogenicity of non-truncating mutations. Ideally, previously conducted functional studies can shed light on the aetiological significance of missense mutations in small kindreds such as MON702; inactivating missense mutations at the ATP binding site of hMSH2 have been described. On the other hand, six missense mutations found in HNPCC patients were found not to affect protein-protein interactions of hMSH2 and hMSH6 or hMSH3. Unfortunately, however, amino acid 636 of the hMSH2 protein has not been directly examined in any of the published studies on the function of hMSH2. The APC gene has been examined in E.coli using a colorimetric assay based on an in frame fusion with the β-galactosidase gene. Andreotti-Zaugg et al designed a fusion protein assay in S.cerevisiae in which hMSH2 is inserted upstream of the ADE2 gene, in the same reading frame. When this plasmid is expressed in S.cerevisiae, high levels of active ADE2 protein are formed, resulting in white colonies in a colorimetric assay. Truncating mutations in the hMSH2 gene lead to truncated fusion protein, hence red colonies, reflecting lack of ADE2 activity. Surprisingly, some missense changes, including the HNPCC mutation G674D at the ATP binding site, resulted in pink colonies, reflecting partial activity of the ADE2 reporter gene. Since protein expression was similar, the reduced enzymatic activity of the fusion protein was inferred to be the result of incorrect protein folding, leading to a denatured protein. We introduced A636P hMSH2 into plasmid pCA37 by site directed mutagenesis (QuickChange kit, Stratagene), creating an A636P hMSH2:ADE2 fusion protein. A mutant protein of the correct relative molecular mass was observed to be expressed at comparable levels to its wild type counterpart by immunoblotting analysis of cellular extracts. Next, the phenotype of the A636P fusion protein was determined in the colorimetric in vivo assay. Colonies from cells containing the pCA37-hMSH2 A636P mutant plasmid were pink. This indicated a partial loss of function of the
fusion protein, and suggested that the mutation does affect hMSSH2 protein folding in S. cerevisiae and by implication may affect structure and function in human cells. This finding further validates the hMSSH2::ADE2 assay as capable of detecting certain non-truncating mutations in hMSSH2.

In MON702, an Amsterdam criteria positive HNPC-2 kindred, we found that the CRCs from two affected subjects (II.3 and III.2) showed MSH1. A missense G to C (nucleotide 1905) transversion mutation in hMSSH2 was identified at codon 636 in both these subjects, leading to a predicted protein change of alanine to proline in the hMSSH2 protein. This mutation has not been previously published, but was recently posted on the HNPC ICC database (http://www.nfhd.nhlbi.nih.gov, unpublished data). However, these investigators were uncertain about the pathogenicity of the A636P mutation. We consider the A636P missense mutation to be pathogenic for the following reasons: (1) the mutation segregates with the disease, and three colonoscopy negative relatives do not carry the mutation; (2) the mutation was not found in 100 Ashkenazi Jewish controls, who were not known to have CRC; (3) no other truncating or missense mutation was identified in complete screening of hMLH1 or hMSSH2 by SSCA and direct sequencing in affected subjects; (4) the mutation substitutes a tryptophan residue from a large third domain between the first and second, and may be incongruous with the third domain if the hMSSH2 protein is a fusion protein as shown in the hMSSH2::ADE2 fusion assay.

The I1307K missense mutation in APC has been reported to predispose to CRC. Virtually restricted to the Ashkenazim, it is not associated with classical FAP. We wished to study MON702 for this mutation, because it has been suggested that I1307K APC may be more frequent in CRC kindreds carrying MMR gene mutations. On testing the living members of the kindred for this mutation, we found that I1307K APC was indeed present in the family, but was carried by those who have neither CRC nor polyps. The proband and her affected son do not carry the mutation. As well, analysis of the sole available archival pathology specimen from the father (fig 1, II.10) suggested that the mutation is native to his side of the family.

There are no confirmed cases of CRC in his 10 sibs. In the MON702 HNPC kindred, affected A636P hMSSH2 carriers do not carry the I1307K APC variant; therefore, our present study does not suggest a biological relationship between mutations in MMR genes and I1307K APC. Previously, we reported a French Canadian kindred (MON1061) in which I1307K APC was segregating with a novel truncating mutation in hMLH1 (1784delT). There was no consistent relationship of the presence or absence of I1307K APC with CRC, but all tested subjects with early onset CRC were heterozygous for the hMLH1 mutation.

Clearly, further work is required to resolve this issue, including follow-up of these families and ascertainment of subjects carrying multiple mutations in the hMSSH2 gene and I1307K APC. Until that time caution should be exercised in deciding to discontinue cancer surveillance of a person in an Ashkenazi Jewish CRC family when MMR gene mutation analysis is negative, even in a family where a germline MMR mutation has been identified, unless status at APC codon 1307 has been determined. Recent studies of Ashkenazi Jewish populations have resulted in odds ratios of under for the risk of CRC associated with the I1307K allele of APC.11-15 Ashkenazi Jews carrying the I1307K allele but who have no family history of CRC have a risk of colon cancer that is only marginally increased, and more evidence that knowledge of I1307K status can prevent CRC is required to support general screening efforts. However, in an Ashkenazi Jewish family with multiple cases of CRC, APC I1307K determination of all subjects who request mutation analysis may be justified.
A PCR test for the detection of hypermethylated alleles at the retinoblastoma locus

Editor—The development of retinoblastoma, a childhood malignancy of the eye, is initiated by mutations in both alleles of the retinoblastoma gene (RB1). Mutations changing the nucleotide sequence at this locus and chromosomal mechanisms resulting in loss of heterozygosity (LOH) are the most common events responsible for gene inactivation.1,2 However, in the RB1 gene, as well as in other tumour suppressor genes including BRCAl, p15, and p16, hypermethylation of 5′ regulatory regions may also cause gene inactivation and, consequently, tumour development.2,3 Methylation of the CpG rich island at the 5′ end of the RB1 gene is observed in some 10% of unilateral sporadic retinoblastomas.3,4 Recently, the methylation pattern of tumours with hypermethylated RB1 alleles was analysed in detail by the bisulphite genomic sequencing technique.5 In most of these tumours, most CpG sites were methylated (75–100%). In one of seven tumours only, the density of methylated CpG sites was more variable, ranging from 25% to 62.5%.

Methylation analysis in tumours from patients with sporadic unilateral retinoblastoma is required for accurate risk prediction in relatives.1 Consequently, we have devised a methylation specific PCR assay (MSP)4 for rapid and reliable detection of methylation at the RB1 promoter. Bisulphite treatment of denatured DNA converts all unmethylated cytosines to uracil leaving methylated cytosines in CpG dinucleotides unaltered. After bisulphite treatment, a methylated allele differs from the unmethylated allele in nucleotide sequence at all CpG positions. The downstream PCR primer (RBcom) was designed to bind to the bisulphite treated sense strand irrespective of the methylation status (fig 1). Binding of RBcom to a methylated or unmethylated allele results in different complementary strands in the first round of the PCR. Upstream primers are designed to bind to the DNA strand synthesised in the first round of PCR. Primer RBnet binds to the strand derived from the methylated allele, whereas primer RBunmet will only bind to the DNA strand generated from the unmethylated RB1 allele. The methylated allele results in a 201 bp PCR product, whereas the unmethylated allele results in a 154 bp PCR product. As unmodified genomic DNA is not amplified, incomplete modification of genomic DNA in the bisulphite reaction will not yield specific PCR products (not shown). However, mutations affecting the primer binding sites might result in diminished or absent amplification of the corresponding PCR product and thus false negative results.

To establish the MSP at the RB1 promoter, 20 tumour DNA samples, which had previously been characterised in detail,1 were used. Characterisation included genotyping with intragenic markers, DNA sequencing, and analysis of the methylation status by Southern blot hybridisation of genomic DNA digested with methylation sensitive restriction enzyme BstHII. All tumours showed loss of heterozygosity (LOH) at the intragenic polymorphic loci RB1 and RB1.20, and an inactivating mutation was identified in the remaining allele. In eight tumours a methylated allele was identified by Southern blot hybridisation. In each of these samples, a 201 bp PCR product was clearly visible when tested in the MSP assay (fig 2, lanes 2, 4, 7, 11, and 12). As expected, DNA from tumour and blood cells not containing a methylated RB1 allele produced a 154 bp PCR product only (fig 2, lanes 1, 3, 5, 8, 9, and 10). No PCR product was obtained from unmodified genomic DNA under the conditions used here (data not shown). Trace amounts of the 154 bp PCR product were also detectable in tumours with LOH at intragenic loci. This finding might be the result of an unhomogeneous cell population consisting of cells with varying degrees of hypermethylation and non-tumour cells. Therefore, the presence of a 154 bp PCR product in the RB1-MSP assay does not necessarily indicate the presence of an unmethylated RB1 allele in the tumour. A 201 bp PCR product specific for the